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Putting Men in the Picture: Problems of Male Reproductive Health in Southeast Asia

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Abstract:

Southeast Asian men exhibit a series of distinct behaviours related to sexuality and reproductive health. Traditional circumcision practices, use of penis implants, the practice of 'dry' sex, and the avoidance of condom use or vasectomy are behaviours that can place men and their partners at risk of disease and dysfunctional sexual relationships. This paper examines these issues with particular attention to Indonesia. While most married men worry about their wives' reproductive health, substantial portions practice risky behaviours extramaritally. Many maintain exploitative expectations of sexual relations, sometimes based on gender-inequitable religious teachings. Programs to promote reproductive health in Southeast Asia need to address indigenous concepts of gender and sexuality more effectively. Concepts of maleness are often defined in terms of sexual rights, sexual prowess, and sexual performance. The ideas underlying dangerous sexual behaviour are based on concepts of appropriate gender relations that must be addressed more effectively through the school and health services systems, and promoted through public education campaigns. Otherwise men will remain 'accessories' rather than central subjects of reproductive health programs.

Introduction: Men as clients of reproductive health care programs

The 1994 International Conference on Population and Development in Cairo produced a Programme of Action aimed primarily at the improvement of women's reproductive health. This was understandable given global levels of maternal morbidity and mortality, and the fact that the dominant technologies for birth control are designed for use by women. To a large degree concerns about sexually transmitted diseases focus on the potential impact of these infections on the fecundity of women. To the extent that men are mentioned in the document it is in terms of their responsibilities to support the efforts to obtain quality reproductive health services for their spouses, and their responsibilities to avoid violent and sexually risky behaviour. Certainly the health promotion messages of ICPD can be read as injunctions equally relevant for women and

men, but the tone of the document, and the scope of reproductive health issues canvassed, give little direct consideration to issues of sexuality and reproductive health from a male perspective. For this reason efforts to implement the ICPD agenda are largely also framed in terms of women's needs and male responsibilities. While this might be fully justified in terms of the relative risks of morbidity and mortality, and the predominant weight of gender bias in terms of political power and economic empowerment, the female focus of the document does not contribute to efforts to consider appropriate constellations of services directed to alleviating men's reproductive health problems.

This paper reviews some uniquely male reproductive health issues in Southeast Asia, and speculates on the forms of service delivery systems and priorities that might be effective in addressing these concerns. Of particular interest are the various forms of 'genital cutting' (including religious rites of circumcision) and different types of 'penis augmentation' carried out across the region. While these issues are male focussed, they are by no means irrelevant to women. The traditions and innovations underlying the behaviour reflect particular constructions of gender role formation that define maleness and femaleness in the societies. The behaviours in themselves may not pose a general public health problem since they seldom produce high levels of morbidity or mortality. However, as markers of misguided or exploitative gender relations they do reveal areas of social psychology related to more important pathologies worthy of attention and public health treatment. The paper concludes that by putting men more effectively in the picture of reproductive health services, programs are likely to address issues of importance to women more effectively.

Male genital cutting in Southeast Asia

Around the world different cultures have developed a variety of ways of dealing with problems of penile hygiene and some relatively rare issues of malformations of the genital foreskin. In some societies great stress is placed on regular bathing and the resort to traditional medications for any problems. In others preventive measures are stressed, including the practice of circumcision to remove the foreskin before any problems of infection or phimosis[1] can develop. Over centuries the origins of such practices may be forgotten and various religious explanations may link the behaviour to individual identity with a group, to a rite of passage to adulthood, or to an interpretation of appropriate gender relationships. Broadly speaking, across Southeast Asia and into Melanesia there are three general patterns of male genital cutting:

- the dominant norm for male circumcision among Muslims as an expression of Muslim identity.
- the widespread traditional practice of circumcision among peoples of the Philippines, and many groups in Eastern Indonesia and Melanesia, for a variety of spiritual, identity or hygiene reasons, and
- the absence of circumcision in Vietnam, Laos, Cambodia, Thailand, Burma, many groups in Melanesia and among the Chinese diaspora.

[1] Phimosis, from the Greek work 'to muzzle', is the constriction of the foreskin with the result that it cannot retract. This can make sex and urination painful. In non-circumcising societies (such as Japan) the condition affects less than one percent of men, and is treated by either cutting the foreskin laterally or with a full circumcision.

Indonesian case study

In the course of the life cycle genital cutting[2] is usually the first serious reproductive health issue to be faced by both males and females. In Indonesia virtually all Muslim males and about a quarter to half of Christian males are expected to be circumcised. Most often male circumcision is carried out on young boys between the ages of five and eighteen, but in urban settings some neonatal procedures are performed, and among some ethnic groups of eastern Indonesia adult males undergo traditional circumcision procedures.

The safety of the most common practices of male circumcision in Indonesia is uncertain. This reflects the lack of any monitoring or systematic management of infection in the circumcision of adolescent Muslims. While there is obviously great concern among both patients and practitioners for safety, the institutions providing circumcision do not reflect these concerns in the formulation of standards or supervision. Traditional practitioners (such as the famous *Bong Supit* in Central Java whose clients include the children of the Jakarta elite) are skilled but they are not medically trained or professionally qualified to respond to complications. Community groups often arrange for 'mass circumcisions' for children of poor families. The practitioners in these events tend to be medical students (anywhere from second to final year students have been found to take part), male nurses, and young general practitioners attached to local government clinics. Observation indicates that the techniques used by these different groups vary greatly, and sometimes include practices of dubious clinical value, such as the retention of parts of the prepuce at the request of parents. The retained skin is tied in a 'bundle' or left as a flap with a hole that can be used to occasionally attach horsehair or other stimulants prior to intercourse. While circumcisers would usually not question such requests, the motive appears to be to prepare the young boy for a more pleasurable marital sex life. Clearly such procedures would be improved through the development and application of Standard Operating Procedures among the medically trained personnel (general practitioners, male nurses and medical students) who carry out most procedures.

Circumcision is not included in most Indonesian textbooks on surgery or general practice, and by and large specialists would regard the operation as too simple to be included in their practice. A detailed handbook on the procedure (Karakata and Bachsinar 1994) was compiled by a specialist urologist and is intended to be a guide for general practitioners. It describes two approaches to circumcision (dorsal slit and the guillotine or 'classical' cut) and recommends the use of local anaesthesia and careful suturing to prevent bleeding. It has no national standing as a statement of Standard Operating Procedure (SOP). Most practitioners we have interviewed about the procedure say that they never read about techniques prior to joining a mass circumcision event and learning by observation and assisting a male nurse. The approach of learning by doing (*magang*) is widespread in medical training facilities in Indonesia.

In fact it is unclear which professional organization or government agency would be responsible to issue and enforce the SOP for any common form of genital cutting, since so many of the procedures are carried out by nurses, paramedics, or traditional practitioners. Such people are not associated with the major medical professional associations (Indonesian Medical Association IDI, the Obstetrics and Gynecology Association POGI, and related groups) and tend to work outside the influence of the Ministry of Health. Observation and interviews indicate that procedures are often carried out without anaesthesia due to cost considerations. Infections are said to be rare due to the prophylactic use of antibiotics, but there are no studies to indicate the

[2] The term genital cutting is preferred to circumcision since it focusses on all practices involving potential blood-letting in the genital area, and is applicable to both men and women. It can encompass various operations including circumcision, subincision, female genital mutilation, scarification, and the insertion or implant of various materials.

incidence of infection or the prevalence of any other serious complications. While European nations have low rates of circumcision and campaigns are being waged in the Americas, the United Kingdom and Australia to reduce the practice of routine neo-natal circumcision, religious pressures in Indonesia have promoted circumcision as a secular orthodoxy for reasons of hygiene. It may be that most procedures carried out by medical professionals are safe, but there are no studies to verify that, nor are there procedures in place to record any problems that might exist.

For a significant minority of Indonesian men genital cutting takes on far more dangerous and socially problematic forms. Very dangerous procedures are used for circumcision of young (and sometimes older) men in Timor, Irian and other areas of Eastern Indonesia. During January 1997 newspapers, medical staff, and social researchers in Kupang, West Timor reported the deaths of three men who had undertaken traditional circumcision ceremonies with the encouragement of their wives or lovers. Traditional healers carried out the ceremonies in the mountains at the site of cold mountain springs. They used bamboo clamps to fix the four sides of the prepuce in turn, then slicing off the skin with a sharp razor or knife. In each case the men bled profusely despite following the healers' instruction to sit in the cold water. They died before obtaining medical attention.

Health professionals have also observed serious morbidity and mortality among prisoners who attempted to carry out circumcisions on themselves, following encouragement by their peers to 'become men' through cutting. Non-governmental organizations in Timor, Papua New Guinea and Vanuatu have offered the services of doctors to visit prisons monthly to carry out circumcisions on men who would otherwise be tempted to do the procedure alone or with the help of other inmates. While such medical intervention might save a few lives, it does not address the broader issues of motivation. Men in Eastern Indonesian and Melanesia need counseling and education to overcome the real hygiene issues they suffer and clarify the notions of identity that they imagine to be related to cutting. The practice of adult circumcision was recorded many centuries ago in Timor as a stage of maturation leading to the recognition of a male as a headhunting warrior (McWilliam 1994). The practices in Timor and some other Easter Indonesian islands have undergone great changes over the last century as the ceremonial foundations have been modified through the suppression of headhunting, and the promotion of some traditional activities as indicators of broader ethnic rather than narrow village group identity. There is some indication that the motivation for Timorese circumcision today is being reinterpreted as a requirement for sexual hygiene, which may explain why some women encourage their partners to be circumcised.

What is strange to the foreign eye, though, are some of the other traditional practices that have been maintained in Timor. Called *sifon,* the practices are widespread throughout the western part of Timor island in the cultural area of the *Atoin Meto* (Lake 1999). A few days after circumcision, when the man has developed a scab on the wound, he must have sexual relations with a woman (not his wife) who has had a number of children. After another period of recovery he has sex again, this time with a woman who has never had a child. Each time the purpose of the activity is to break the scab and 'cool' the wound. The women involved in providing sexual services could be commercial sex workers, but most often in rural areas they are recruited to the practice[3] through the attraction of participating in a traditional health service that promises both them and the men health and spiritual benefits. During the time of the circumcision and the *sifon*

[3] Referred to as 'women of the road' the participants in *sifon* are often widows who provide sexual services for a variety of traditional rituals. In the town of Kupang at least one circumciser has set up his practice in a house close to a large established brothel, and he relies on prostitutes to service his clients.

the man absents himself from his home. At the end of the process he is ritually welcomed back into his home by his wife through an exchange of betel nut.

Throughout the region the methods of traditional circumcision vary. Some are less drastic than the Timorese procedures. On the island of Roti to the west of Timor young boys form circumcision groups of 6 to 8 boys and go together to traditional leaders to receive advice and guidance of this rite of passage (Fox 2000). They are given or they make a small bamboo clamp which is fixed to the prepuce to cut of the flow of blood to the superfluous skin. The clamp is released when they need to urinate, and then replaced. After a couple of weeks the prepuce has shriveled and can be cut away without any bleeding. It is important in Rotinese ritual that this be a bloodless process, but it is unknown whether the procedure poses any serious threats to the boys' immediate or long term reproductive health.

Circumcision is an ideal issue and opportunity to consider male reproductive health needs and risks in Indonesia, Malaysia and the Philippines. The fact that the vast majority of men in these countries are circumcised makes the process of widespread interest. Unlike the case of female genital cutting (see Annex 2), the procedure for the male is not usually secret, and in fact it may be the focus of social celebration. The procedures are not well monitored, nor are they subject to research into safety, but there are reasons to think that for many boys and men the procedure may carry serious consequences.

Traditional and modern forms of 'penile augmentation'

Men in some areas of Indonesia, the Philippines, Thailand and Malaysia have a long history of inserting or implanting various objects in their penises. The origin of the practices is unclear, but some writers say that they were copied from Chinese traders who visited Southeast Asia, while others argue it is an indigenous innovation related to the use of other forms of amulets and inserts for medicinal and spiritual purposes. The objects used range from the very simple (the implant of ball bearings under the skin), to the magical (the use of specially selected semi-precious stones), or the elaborate (gold bars -- *palang* -- or rings inserted through the glans). While this might seem an odd and esoteric practice that should be relegated to museums recent research is finding that the use of inserts is spreading among working class men in the Southeast Asian and Melanesian regions. Researchers should pay attention to the modern manifestations of inserts and implants because of the possibility that they will cause vaginal wounds, inflammation and infection. They can also cause permanent damage to males, particularly when the cutting involved is carried out under unhygienic conditions. For an accessible overview of some of these practices see (Hammel and Friou 1997: 184).

In February 2000 we examined the records of a random sample of over 700 men undergoing pre-employment checks for work in the shipping, hotel and banking industries[4]. This was an exploratory study to determine the likelihood of obtaining information on male reproductive health issues from conventional clinic records. It was found that one percent of the applicants for shipping industry jobs were wearing some form of penis implant. Anecdotal evidence indicates that prevalence of the practice is found in clusters. Since most of these men were young and inexperienced this might be taken as a minimum prevalence among sailors. Interviews with

[4] Thanks to the Klinik Baruna staff and particularly Tien Irawati and Dr. Santi Rahayu Dewi for providing access to the data, and assistance in interpreting some of the results. Data collection was carried out by Lila Amaliah, Laily Hanifah, and Maryuni..

social workers and commercial sex workers[5] suggest that upwards of ten to twenty percent of regular clients of brothels have either penis implants or holes in the glans or skin of their penises. The holes may be normally for rings or studs, but during intercourse the ring is replaced by a piece of horsehair of the strand of a stiff-leaved plant which is tied through the hole, and clipped off to a length of three or four centimetres as a 'tickler'. The putative reason for the practice is to 'please the woman', and men with inserts argue quite strongly that 'women love it'. However in the absence of systematic interviews with the lovers of such men, the testimony of commercial sex workers may be regarded as a useful commentary on the practice. Generally the women who earn their living from sex regard the use of inserts and ticklers is both strange and discomforting. One respondent recalled how one man using horsehair had caused her to bleed, while another caused great discomfort. She laughed at the idea that the devices were to 'please the woman'. 'That is what they say, but actually they only want the woman to reach orgasm before they ejaculate. It is a sign of their manliness to have such control.'[6]

Variations on a theme: Methods of penis augmentation

The difficulty of determining the exact spread of various penis augmentation practices lies in the fact that they are inspired and implemented in a highly informal way. Respondents have reported that they made their own implants from plastic or from semi-precious stones. Prisoners, seafarers, male sex workers and bored teenagers have also been recorded as having experimented with different forms of inserts[7]. It appears that groups of working class males living in isolated circumstances are quite likely to discuss and attempt these practices.

Interviews in a number of Indonesian cities indicate that it is not uncommon for the men to carry out this procedure on themselves or their friends, with no reference to medical facilities. Under these conditions the healing time is prolonged to perhaps two weeks. In the Philippines a variety of clinics advertise the provision of services to insert *boletas* or *humps*. These procedures involve the use of dissolvable sutures and it is estimated that the average time for healing the wound is only four or five days.

Basic inserts – ball bearings.

Workers in forestry and mining industries take ball-bearings from machinery, boil them and soak them in antiseptic, and then insert them under the skin of the penis, about a centimetre back from the glans. Some informants report having used three or four ball bearings simultaneously.

Silicon

Certain sub-populations in Southeast Asia have taken up the subdermal injection of silicon with enthusiasm. Both men and women engaged in commercial sex activities use silicon to accentuate features such as lips, cheeks, or breasts[8]. The technology to do this is available in many urban beauty parlors. As this practice has spread some men have used the same techniques to inject silicon under the skin of their penises to produce 'humps' that they think will enhance the sexual pleasure of their partners.

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[5] Thanks to Dr Firman Lubis of Yayasan Kusuma Buana for meetings with his field staff Jeremius Wutun, Deden Wibawa, Endang Sudarmi and Titin Suprihatin.

[6] Future research on penis inserts should concentrate on attempts to gauge the incidence and prevalence of both inserts and rings by collecting information from massage parlours and high turn-over brothels. Interviews with male users of such penis augmentation devices could also be supplemented with interviews with their lovers to compare and contrast the claims of sexual impacts of the devices.

[7] Among the more extreme practices are cases of men in Papua using discarded syringes to inject tree sap into their penises, and workers from Java using illegally obtained drugs to stimulate erections. Such cases are quite rare, but cause very serious complications.

[8] Thanks to Dr Dede Oetomo for anecdotal information on this practice in Surabaya.

Semi-precious stones and gold – Investing objects with power
Historical records and some contemporary practitioners report that some men regard the inserts as both symbols of power and symbols of wealth. Some men choose particular kinds of semi-precious stones, pearls, or precious metals as implants in the expectation that they will be invested with special sexual powers.

Plastics – Tops of toothpaste tubes
Men in prisons in Indonesia and Papua New Guinea have faced problems obtaining the preferred materials for penis inserts, and resort instead to some unusual alternatives. Some melt down the plastic from tops of toothpaste tubes and form them into small balls of plastic. They then scrape the handles of toothbrushes to sharpen the ends, and use this tool to effect an incision in the skin of the penis. It is unclear whether those undertaking these small operations have the resources at hand to prevent infections or properly protect the wounds.

From the ad hoc interviews we have been able to carry out over the years, these men use the devices before marriage, but have them removed when they settle down with one woman. Why, if the purpose is to please a woman? One explained, 'You can't really be sure about these things – what if something went wrong? You wouldn't want to take a risk with your wife.' Indeed, doctors and sex workers do report the occasional accident when a ring or stud or other sharp object is left in a vagina, or where women have suffered cuts or severe pain from the men's experiments.

We are currently engaged in a four-country study of the use of these various penile inserts and implants in order to determine the motivations behind the practices and the reactions of women to the experience of sexual relations under these conditions. One working hypothesis is that in both Malay and Melanesian societies men use the

Sexually transmitted diseases

One of the most important effects of the broadening of family planning programs to address reproductive health has been the recognition of sexually transmitted diseases as a priority for education, diagnosis and treatment. The development of syndromic approaches has increased the potential of primary care facilities to deal with gonorrhoea, chlamydia, and trichomoniasis (Wasserheit and K.K. 1992). In addition the staff training and treatments required for these common STDs can be adapted to the promotion of general health of sex organs, and improvements in personal hygiene and self care. Such measures can be important in reducing the prevalence of genital warts and facilitate the prevention of genital herpes.

Perhaps the most challenging aspect of STD services in Indonesia is the need to approach diagnosis and treatment in terms of couples. This has long been a major issue among specialists running public STD clinics, and for most of them the issue is regarded as too complex. While by no means a rule, there is a tendency among doctors discovering genital infections in women to prescribe appropriate treatments without indicating the sexual source of the infection or suggesting that the woman's partner be examined or treated. When asked why they take such an approach, they say they do not want to cause trouble between the woman and her partner, implying that argument or violence could result in serious consequences, such as divorce. It is fair to say that partner notification and treatment is the exception rather than the rule in venereal disease clinics, which may in part explain why the levels and trends of STDs in the population are so relatively high and persistent.

While there may be many good reasons to provoke debates about STDs in communities and in families, it seems that the resistance of the medical profession and the intolerance of prominent religious and secular leaders would very likely re-direct such debates. Instead of asking how best to treat infected people and prevent further infections through condom use and abstinence they will focus on the common scapegoats of commercial sex workers and other targets for charges of immorality as they have so often done in the past (see (Hull, Sulistyaningsih and Jones 1999): 37-43).

An as yet unexplored aspect of genital infections is the cultural preference for 'dry sex' among a portion of the Indonesian population. This appears to arise from the notion that intercourse will be more pleasurable for the man if friction is maximized. Women in many cities consume traditional herbs to dry and tighten their vaginas, and some purchase astringent rods called *tongkat putih* to insert in their vaginas before intercourse. The impact of these practices is to increase the risk of irritation and inflammation of the sexual organs of both partners, and create the possibility of open sores and wounds susceptible to infection. Both women and men need education and counseling to alert them to the dangers of such practices, and to introduce them to alternative approaches to achieve mutually satisfying sexual relations.

Other reproductive health issues

The Indonesian Family Planning Movement under the Suharto regime was almost exclusively concerned with the reduction of population growth rates. Thus they offered virtually no advice or services to the four to ten percent of couple whose reproductive health concern was infertility. Newspapers in large cities reported developments in major hospitals providing *in vitro* fertilization services for high fees, but average families could seldom consider such options. What made this situation all the more difficult was the near universal assumption that infertility was a failure of the woman, and offspring was the right of the man, especially in patrifocal societies of most of Indonesia. While there are some fairly simple procedures that can be followed to offer primary care for infertility at the level of a community clinic, the hard reality is that some portion of the population are unlikely to have children without extremely expensive intervention, and even then the results are not guaranteed. Efforts to engage and serve men concerned about infertility need to be directed to broadening understanding of the causes of infertility, assisting to identify options involving adoption or adjustment to childlessness, and ensuring that the biological realities of infertility do not destroy marital relationships. Recognition of this as a priority reproductive health issue would also facilitate a national dialogue on the issue of childlessness and the inequities experienced by women who suffer ostracism by husbands and family members. By serving men such initiatives would go a long way to alleviating difficulties experienced by many women.

The Family Planning Movement also placed heavy emphasis on the number and timing of women's pregnancies. 'Two is enough' has been combined with calls for later first births, longer birth intervals, and fewer pregnancies. The result is that only women aged 20-29 are regarded as being 'fit' for childbearing – despite the fact that many elite women are just finishing university at 25 and marrying as late as 30. Ironically the question of when men should father children is never questioned. Old men marrying young women is not unusual, and the general reaction is that the man is reproductively 'ripe' much longer than are women. Studies have recently been undertaken in Europe to determine the effect of paternal age on the frailty of infants, and resultant infant mortality (Gourbin and Wunsch 1999). Not only is paternal age significantly related to neonatal mortality, under some conditions it appears to be more important than the age of the mother. While these results are drawn from low mortality societies (where the impact of

congenital conditions on IMR are greater than infectious or environmental conditions), they should inspire research into similar issues in medium and high mortality situations such as those faced in Indonesia. Meanwhile, men might well be advised to consider permanent cessation of childbearing as they reach middle age just as women are now told to think about retiring reproductively at 30.

In recent years readers of the metropolitan newspapers have been alerted to the dangers of cancer of the penis, testes and prostate, and a few men are responding to the call for early testing and diagnosis as an important means of reducing the risks of mortality. While nowhere near the prevalence or virulence of cancers of women's reproductive organs, men share with women the problem that specialised medical services are beyond the reach – both financially and geographically – of most Indonesians, so most people who are diagnosed have little chance of recovery. This does not mean that the reproductive health program should ignore cancers and other rare diseases of male sexual organs. These diseases can be important talking points in families and communities, helping to overcome barriers to discussion. While it may not be possible to have a major immediate impact on cancer morbidity and mortality, discussions and education about cancer can assist people to address related issues of infectious diseases and sexual behaviour in IEC programs. The Indonesian word for embarrassment is *malu* and the euphemism for sexual organ is *kemaluan*. Programs discussing the diseases of sexual organs need to find ways to take the *malu* out of *kemaluan*. The appellation *cancer* may divest the discussion of embarrassing implications of sexuality and set the foundations for more effective communication of reproductive health issues.

Recognising the issues of male reproductive health: Social perspectives

The literature on gender in Indonesian society is rich and rapidly growing, with major contributions being made by both indigenous and foreign scholars. The portion of this literature concerned with reproductive health issues has been greatly enriched through studies edited by Rosalia Sciortino[9]. In both her own work (see especially the Indonesian language collection of some of her writings (Sciortino 1999)), and the work she commissioned (eg (Adrina et al. 1998; Mohamad 1998; Notosusanto and Poerwandari 1997; Suyanto et al. 1997)), Sciortino promoted an understanding of reproductive health issues recognising the social context of behaviour and attitudes. One of the consistent themes of these studies is the way in which religious and secular leaders promote concepts of women's roles that systematically disadvantage women.

These are not limited to the notion that women have the biologically determined fate to bear children, and the consequent fate to play the central role of mother in the family. They detail the need for women to 'serve' her husband's biological needs sexually. She is also meant to serve his social needs as a helpmate and hostess. Her needs are subordinate to his and their children's. Her position is highly respected because of the sacrifice it demands. In fact the detail with which leaders have attempted to determine women's roles in Indonesia has been so strong as to inspire social critic Julia Suryakusuma to refer to it as *State Ibuism* (roughly: State defined Motherhood). This is a structure that exists as a patriarchal caricature of culture and reality in Indonesia, a nation famous for matrifocal traditions, and notable for strong independent roles of women in the economy and society. It is this structure that stands as the challenge for a reproductive health program promoting gender equity. This is also the foundation for resistance to change of sexual education and services. In terms of ICPD, the reified Indonesian statements

[9] Sciortino, an anthropologist with field experience analysing the position of nurses in village health centres, transferred to the Manila office of the Ford Foundation and recently established the new Regional Office of the Rockefeller Foundation in Bangkok. Dr Meiwita Budiharsana, a specialist on public health issues surrounding reproductive health, replaced her in Jakarta.

of women's proper roles are the 'religious and ethical values and cultural backgrounds' that many leaders wish to defend against potential threat from actions implemented for gender equitable reproductive health.

Luckily large numbers of men and women find the realities of their daily lives, and the strength of their cultural tolerance is more appropriately oriented to gender equity than to the latter day construct of male dominance. They are thus amenable to information and interested in devising ways to direct their lives to goals of mutual benefit. Greene has argued persuasively that the 'most compelling reason for involving men in reproductive health is to use the forum of reproductive health programs to promote gender equity and the transformation of men's and women's social roles'(Greene 1998). Her call should be directed not to the patriarchal leaders who would reject it out of hand as an attack on their 'culture', but rather to the ordinary men and women who see reproductive health problems as issues to be solved jointly and with full awareness of each others needs.

Conclusion: Engaging and serving men enhances women's reproductive health.

The Indonesian family planning program has long called for the involvement of men to promote contraceptive use by women. It has not been able to engage men to take a personal interest in adopting male methods, nor been able to develop a broader range of services addressing male reproductive health issues in ways that promote gender equity.

Engaging and serving men's reproductive health needs requires more than an effort to educate men to their responsibilities for their partners and offspring. The reproductive health program must recognise men's reproductive health needs and provide appropriate services to promote their personal reproductive health. Done correctly this offers an effective means of encouraging them to assist in meeting the reproductive health needs of their partners. The situation in Indonesia highlights the needs of men because of a series of long ignored reproductive health issues including:

> **Widespread practices of male genital cutting** raise issues of infection and bleeding. Religiously inspired circumcision undergone by the majority of males in Indonesia are of dubious safety and efficacy. Appropriate interventions in those cases could be as simple as invoking proper standards of hygiene and ensuring rigorous Standard Operating Procedures are followed by all circumcisers. This is a difficult task since it requires strong leadership from the Minister of Health, and cooperation from the many stakeholders in the medical and religious communities of the multi-cultural nation.
>
> Men in Timor (and areas of Papua) are putting themselves and their sexual partners at high risk of infection through the **traditional circumcision practices involving multiple sexual partnering** (*sifon).* They also risk serious morbidity and mortality as a direct result of the cutting. Provincial level reproductive health programs need to develop comprehensive interventions to change behaviour. They must eliminate or at least ameliorate the multiple risks of the traditional practices. The benefits of such interventions will accrue not only to the men, but also to their partners who would thus be at a reduced risk of STDs including HIV. Such steps do not represent an additional burden on the health system, nor would they detract from women's reproductive health needs. Rather they would build on the actions already adopted to promote quality reproductive health care and a client-centred approach (Hull 1996).

Penis implants, inserts and other augmentation devices are potentially dangerous to both men and women, and of questionable value in bringing pleasure to women.

Promotion of vasectomy needs to be directed at men as clients, but the benefits accrue to their partners as well as themselves. Ironically it will be important to advertise the potential failure rates of vasectomy to both gain religious acceptance, and overcome problems experience by wives of vasectomised men who become pregnant.

Condoms need to be promoted as devices with multiple purposes – contraception, disease control, control of pre-mature ejaculation, and novelty in sexual relations – so as to overcome the stigma of immorality they have attracted.

Treatment of men for Sexually Transmitted Diseases should include more effective information and counselling to support partner notification and treatment. Such services need to be available locally through clinics resourced to carry out syndromic approaches to STD diagnosis and treatment.

The type of reproductive health services needed by men in Indonesia today complement rather than compete with the services needed by women. The services men need may be seen as having both pragmatic and normative dimensions.

The pragmatic dimension presses for **efficiency and efficacy** in the design of services. It is not possible to promise widespread programs of prostate cancer treatment in a country with limited financial and lack of trained personnel. Likewise it is clear that the development of specialised men's reproductive health services would claim resources currently devoted to other priorities, including women's and children's health care. Thus any innovations are best set within the framework of community based primary health care and an emphasis on preventive measures. This allows the addition of services for men to be integrated within a broad general program of reproductive health. Men's reproductive health services need to be promoted through existing clinical and IEC programs. They can be supported and justified by increasing the quality of care for all RH services, consolidating problem based clinical services for couples, and ensuring that services are available at times and in venues that are welcoming to men and couples.

The latter dimension refers to the norms of **gender equity, responsible reproduction and human rights** promoted in various United Nations conventions and the ICPD. The efforts to engage and serve men should not be undertaken if they reduce services for women or are based on patriarchal notions of male dominance.

Annex 1. Initiatives to Promote Feasible and Gender Equitable Male Reproductive Health Services in Indonesia.

Proposed Reproductive Health Initiatives for Men	**Potential Lead Agencies***	**Complementarity with Reproductive Health Initiatives for Women**
Circumcision: Development of SOP for routine male circumcision.	MOH, IDI, MUI, PERINASIA,	Promotion of SOPs enhances all clinical services for both men and women. Consideration of SOPs for male circumcision raises critical questions concerning FGC.
Elimination of dangerous male circumcision practices.	PEMDA NTT and Papua, MOH,	Discouragement of traditional practices involving multiple sexual partners – reduction of risk of STDs.
Elimination or amelioration of other dangerous genital cutting practices.	MOH	Enhanced education of couples concerning dangers of penis implants and dry sex practices will improve women's reproductive health.
Sexuality Education: Promotion of accurate and gender equitable concepts	MENDIKNAS, BKKBN	Reduction of inappropriate attitudes and behaviour by both men and women.
Infections of the sex organs: Diagnosis and treatment of partners. (Subsume the morally sensitive issue of STDs into prevention, diagnosis and effective treatment of all infections).	MOH, BKKBN, POGI	Adoption of more clinically effective treatment strategy prevents re-infection among women. Creation of awareness of need to prevent or treat non-sexually transmitted infections and avoid 'dry sex' practices.
Promotion of male contraceptive practices (Condoms, Vasectomy, etc.)	MOH, BKKBN, MENPERTA	Reduction of pressure on women for contraceptive adoption. Enhancement of gender equitable family planning.
Awareness of Issues and Options Surrounding Infertility	MOH, BKKBN	Reduction of infertility induced marital disharmony.
Awareness of other diseases of reproductive organs	MOH, BKKBN	Promotion among men and women of practical information on healthy reproductive practices, including pragmatic information on self-examination, early diagnosis, and feasible treatment of various forms of cancer, benign tumours, and non-sexually transmissible conditions.

* MOH – Ministry of Health; MENDIKNAS – National Ministry for Education; BKKBN – National Family Planning Coordinating Board; MENPERTA -- Ministry for the Empowerment of Women; MENKEP – Ministry for Population and Transmigration; POGI – Association of Obstetricians and Gynaecologists; IDI – Indonesian Doctor's Association; PERINASIA – Indonesian Association of Perinatology; MUI – Indonesian Council of Ulamas (Islamic Religious Leaders); PEMDA NTT and Papua – Local governments of Nusatenggara Timur and Papua.

Annex 2. Notes on Female Genital Cutting

Discussions of Female Genital Cutting (FGC) in Indonesia have long been hampered by confusion over definitions. Often the term female circumcision (a translation of *sunatan perempuan*) is used to describe ceremonies and rituals carried out on female babies or children. It is not always clear that these involve any cutting or bleeding. One of Indonesia's most eminent anthropologists has dismissed the idea that female circumcision would have any health consequences. He described practices in Central Java involving incantations, prayers, and the cutting of a piece of turmeric that was then rubbed on the baby girl's labia (Kuntjaraningrat 1957). It was largely true that these traditional Javanese rituals did not involve cutting of skin or other tissue and as such could be regarded as clinically benign. In recent years emerging research has indicated that this sanguine view is no longer valid.

First, there is clear evidence that the practice of cutting is increasing over time (Feillard 1998). The changes found in the practice of male circumcision – growing Islamisation of the population, and medicalisation of the procedure – are also having an impact on female circumcision. Ethnic ceremonies are giving way to religiously based procedures.

Second, irrespective of the fact that the minor tissue loss common in Indonesia has produced no clinical evidence of long-term complications, the motivations driving the practice are certainly antithetical to notions of gender equity. On these grounds some Islamic feminist scholars in Jakarta have called for religious leaders to support changes to *sunatan* to eliminate all cutting and the patriarchal overtones of some of the teachings surrounding the practice. Others (eg (Rahman 1998?)) regard the elimination of FGC as an impossibility, and argue instead that Standard Operating Procedures to avoid tissue loss would be more useful. These would then need to be socialised among the midwives and nurses who are most often the medical practitioners charged with postnatal care of infants.

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