JOURNAL OF POPULATION AND SOCIAL STUDIES Volume 6 Number 1-2, July 1997 - January 1998

GENDER DECISION MAKING IN FAMILY FORMATION AND PLANNING: ACHIEVEMENT AND FUTURE DIRECTION

*Chai Podhisita**

Introduction

The idea that men should involve in all areas of family responsibility has been suggested at least since the 1984 International Conference on Population (United Nations 1984). Men's family responsibility, according to the UN suggestion, includes house-work, family planning and child-rearing. The same idea was emphasized again ten years later in the 1994 International Conference on Population and Development (ICPD) in Cairo. In addition to specific agenda in support of gender equality and empowerment of women, there was a clear recognition and even stronger suggestions at the 1994 ICPD that men should assume major responsibilities in such matters relating to the family as family planning, safe motherhood, respect for women's rights and support of gender equality (United Nation 1995). Ever since the past two World Population Conferences, attempts have been made in many developing countries, through policies and programs by governmental and non-governmental organizations, to realize the goal of involving men in the family responsibilities with women -- particularly with regard to family planning. Achievement in that direction seems to vary from place to place depending on specific cultural and socioeconomic conditions.

This paper reviews existing information related to inter-spousal communication and gender influences in fertility decision-making. Based on past research findings, the paper examines assumptions and propositions about fertility

* Institute for Population and Social Research, Mahidol University, Salaya, Phutthamonthon, Nakorn Pathom 73170

decision-making, and the role that men and women in marital union play in deciding family size and fertility regulation. The goal of the paper is to understand the extent of couple's communication and to examine relative influence (power) of husband and wife in inter-spousal communication on the family formation. Issues related to future challenges of small family are discussed in the final section of the paper.

Planning Fertility

A general assumption may be made that in pre-modern societies where natural fertility is widely practiced people do not deliberately plan how many children they want to have and when to have them. Deliberate planning of fertility exists largely where people conceptualize the family size as a matter of choice, a characteristic of transitional and post-transitional societies. In the case of pre-transitional societies, 'the calculus of conscious choice' (to use Ansley J. Coale's term [Coale 1973]) about fertility does not exist; nor do individuals have a clear notion of what the family size ought to be. Lack of what van de Walle (1992) called 'numeracy about children' is common in most pre-transitional societies. In such cases, family size is not conceptualized in terms of specific number of children. The couple simply leave it up to nature or 'up to God' as often found in fertility surveys of some developing countries. Hence, deliberate fertility limitation in the pre-modern condition is not possible. Planning of fertility becomes feasible when individuals are aware -- through programs deliberately designed to create such awareness or otherwise -- that their natural capacity to reproduce is likely to exceeds their actual demand for children, given certain survival rate (Easterlin 1978). Such awareness, when supported by availability of effective means for regulating fertility, can result in significant change of fertility behavior.

The notion that fertility is planned implies conscious choice and decision-making of the marital partners. Since marital fertility involves participation of the wife and husband who may differ with regard to their fertility preference and choice (in terms of number and sex of children, timing of birth and method to regulate fertility when

needed), successful planning and decision-making about the fertility size requires effective communication of both marital partners. Through process of communication we can understand effects of gender influence on fertility decision-making. The following sections will examine some research findings on these important issues.

Studies in couple communication on family planing

Couple communication on family planning has long been the subject of interest to researchers. As early as 1954 J.M. Stycos et al (in ESCAP 1974) presented a paper entitled 'Problems of communication between husband and wife on matter related to family limitation' at the World Population Conference in Rome. From that time several studies have been conducted in various settings in Latin America, Asia and more recently in sub-Saharan Africa. Researchers working on this issue recognize problems at two levels (see, for example, Hollerbach 1983): At one level, there are some problems in measurement and treatment of the concept of communication as static, while in itself this concept is dynamic in nature. Most investigators relied on measurement of the data obtained from wives; few studies collected data from husbands. Where both males and female were included in the sample, the data were frequently presented on the basis of an aggregate of unrelated individuals rather than paired couples (Beckman 1983; Hollerbach 1983). Most studies are retrospective, and the surveys questionnaire includes such issues as whether or not the respondents ever talked with their spouses about the number and sex of children they want to have, and contraceptive methods and use; whether spouses are in agreement; and if not, whose ideas, attitude or decision prevail. At another level, the problems lie in difficulties in systematic examination of the linkages between couple communication and contraceptive behavior and ultimately fertility outcome.

Couple communication on family planning: What we know

We know from numerous previous studies that communication between marital partners is by no means universal. Discussion about family size and family

planning is absent among substantial proportions of the couples. Where it occurs, the extent of husband-wife discussion differs from country to country, depending on specific cultural and socioeconomic conditions within which the couple live. The variation is also associated to characteristics of individual couples. For a comprehensive picture, cross-cultural variation of spousal communication is summarized in Table1. Two observations are made here on the basis of the data given in the Table.

First, the data compiled from different sources across a wide range of the developing regions fairly clearly suggest that spousal communication is quite common. Except for a few cases, the proportions reporting ever talked with spouses about the number of children and fertility limitation are close to two-thirds or greater. Variation across surveys within the same culture, e.g. in the case of Nigeria, is probably due to different operational definitions and different study populations. Second, where husbands' and wives' data are available in the same survey, reported percentages ever discussed with spouses are similar, though not identical. In most cases there is a relatively small difference between husband' and wife's reports, suggesting but a small discrepancy in the information obtained from male and female respondents. There seems to be no clear tendency toward greater frequency of communication report by male over female respondents in the data presented here.

Variation in of spousal communication at individual level has been fairly well explained in existing literature. Very frequently, a number of studies found the variation to be associated with socioeconomic characteristics of the couples, particularly those of the wives. These include current age, age at marriage, level of education, number of living children, type of marriage, participation in non-family employment (especially of women) and area of residence. For instance, in India where religious values and cultural norms regarding roles of husband and wife were unique Proffenberger et al (1969, in ESCAP 1974) observed that younger couples were freer in their communication than their elders had been at the same stage of the family life. The findings from Sri Lanka (Kane and Sivasubramaniam 1989) are very much consistent with the above result.

Among Sri Lankan couples, the proportion who said they had discussed contraception with their spouses was highest among the younger and better educated respondents. Communication was also the greatest among those who had reached desire family size. Couples in urban and rural residence were more likely to report having discussed family planning than those on tea estates. Couple with 2-4 children were the most likely to have discussed family planning, while those with no children and those with six or more children were the least likely to have done so. A multivariate analysis of the Sri Lankan data reveals that women's current age, number of living children, education and area of residence had a significant impact on the likelihood that a woman had talked with her husband about the number of children. Among these, impact of education was the most substantial. For instance, compared with women with no schooling those with 10 or more years of education were 3.5 times as likely to have spoken with their husbands about their family size. A study in Malaysia (Coombs and Fernandez 1978) gives a somewhat different finding about the role of education in couple communication. In the Malaysian data, wives with higher educational status tend to communicate with husbands with lower educational status (although there is only a small number of such category), but husbands with more education are not as likely to communicate with their wives if the latter have less education. Nevertheless, education is still important for wives. The Malaysian study also reveals that husbands are less likely to show preference for large family if they have discussed family size with their wives.

A survey of Zimbabwean male (Mbizvo and Adamchack 1991) found that men with some secondary education or higher and urban men communicated with their wives to a greater extent (i.e. 81 percent and 74 percent respectively) than did men with an elementary education and rural men (48 percent and 50 percent, respectively). Importance of the factors related to women's status in wife's communication with husband is also observed in the analysis of the 1988 Togo DHS data (Gage 1995). Among Togo women, discussion with husbands about family planning varies with type of marriage (highest among those with love marriage and monogamous marriage), age

at marriage (married at age 18 or older, highest), education (ever been to school, highest), ethnicity (Adja-Ewe, highest), current economic status (work for cash, highest), and wife's rank in the union (sole wife, highest). A multivariate analysis of the same data shows striking combined effects of women's control over selection of marital partner and their economic power on spousal communication about family planning.

Variation across societies, on the other hand, has rarely been adequately explained by empirical studies. It may be hypothesized that such difference may be understood in terms of different structural and cultural factors within which the couples live. Some of the key structural and cultural factors include religious ideology and cultural norms concerning gender role and status which impinge upon women's autonomy. For example, Islam and Catholicism are often cited as relatively less favorable for family planning. In such contexts husband-wife discussion with regard to family planning may be discouraged. Similarly, in societies where segregation of males and females is practiced to a great extent and where dominance of one sex over the other permeates in various aspects of life within and outside the family, husband-wife communication on fertility matters is likely to be low.

As noted earlier, communication on family size and family planning is absent among substantial proportions of couples. What are the reasons for not discussing with spouses on these matters? Some studies suggest that absence of spousal communication has much to do with individuals' perception of fertility and fertility responsibility within marital union. Many women never discussed with their spouses about the number of children or about family planning because they believed that the number of children the couple will have is determined by God (Gage 1995; Warren et al 1990; van de Walle 1992). In some cases, however, members of the marital dyad perceive fertility to be prerogative or sole responsibility of the other partner; therefore, they tend to assume that all that need to be done about it should be left to responsibility of the other partner (Boulos et al 1991). Women in some societies do not discuss fertility with their

husbands simply because they think that their husbands do not approve of contraception; so discussion about the topic is considered unnecessary or inappropriate. Some investigators attributed lack of couple communication to "psychic costs" of fertility regulation. Because family planning is perceived as a sensitive or emotionally loaded issue, discussion about it may be considered inappropriate (PROFAM-PIACT de Mexico 1979, in Beckman 1983). Similarly, shyness or modesty on the part of the wife may also inhibit communication.

A cross-cultural study of four Asian countries found that among substantial minority who never discussed about family planning, the reasons most frequently mentioned by respondents are "It is too personal a matter to talk," I am not supposed to talk about it," "have no time or chance to talk," and "I don't think it's important" (ESCAP 1974). In addition, since kin and nonkin play an important role in fertility decision-making especially in the less developed settings (Hollerbach 1983; Hull 1983; Beckman 1983), spousal communication may simply be replaced by discussion with kin, peers, neighbors, community leaders, health professionals and significant others.

Joint decision in family planning

Couple communication, where it exists, does not necessarily imply that fertility decision is jointly made by both partners of the marital union. As shown in Table 2, evidence compiled from various sources indicates that the proportions reporting joint decision are much smaller than those reporting ever discussing fertility with spouses (cf. Table 1). Like couple communication in general, joint decision differs across cultures. The proportions, however, are much lower ranging from below one in ten cases to nearly two-thirds of the sample. It is interesting to note that in some cases (e.g. India) where couple communication is reportedly very high (as shown in Table 1), joint husband-wife decision in family planning is very low (as shown in Table 2), which is somewhat contrary to what one would expect. Perhaps, the wide gap in the observations reflects the degree of difference in relative power of husband and wife

within the marital union. In other words, the more different the relative power of husband and wife is, the wider is the gap between observed proportions of joint decision and couple communication. Variation in the observed joint decision-making may have to do with differential socio-cultural contexts and with the respondents (i.e. whether wife or husband is chosen as respondent in the survey).

Table 1 Prevalence of couple communication, selected countries

Countries	Source	Studied Pop.	% Ever discussed with spouses
Jordan	Warren et al 1990	Married men	59.0
India (rural)	ESCAP 1974	Married women	83.8
		Married men	64.2
(urban)		Married women	95.0
		Married men	81.2
Iran	ESCAP 1974	Married women	59.9
		Married men	69.9
Philippines	ESCAP 1974	Married women	70.0
		Married men	71.4
Singapore	ESCAP 1974	Married women	74.2
		Married men	79.0
Sri Lanka	Kane & Sivasu-	Married women	76.0
	bramaniam 1985	Married men	74.0
Puerto Rico	Stycos et al 1954	married women	70.0
Togo	Gage 1895	Married women	36.0
Negeria	Renne 1993	Married women	69.0
		Married men	81.0
	Mott & Mott 1985	Married women	<1/3
Zimbabwe	Mbizvo &	Married men, wives	71.0
	Adamchack 1991	under 45	
Ghana	Salway 1994	Wives	35.0
		Husbands	39.0

Table 2 Joint decision in family planning, selected countries

Countries	Source	Studied Pop.	% Joint decision
India (rural)	ESCAP 1974	Women	13.2
		Men	6.8
(urban)		Women	17.8
		Men	9.5
Iran	ESCAP 1974	Women	30.9
		Men	58.0
Philippines	ESCAP 1974	Women	30.7
		Men	30.9
Singapore	ESCAP 1974	Women	50.0
		Men	52.8
Turkey (Semi-urban)	Pop Reports 1994	Women	25.0
Turkey (Rural)	Pop Reports1994	Women	46.0
India (rural)	Pop Reports1994	Women	38.0
Egypt	Pop Reports1994	Women	61.0
Upper Egypt	Pop Reports1994	Women	36.0
Zimbabwe	Mbizvo & Adamchack 1991	Male	4-25 (varies w/ aspects of FP)
Nigeria	Isiugo-Abunihe 1994	wives	50.0
		Husbands	43.0 (on # of children)
Haiti	Boulos et al 1991	Male condom users	44

Based on the evidence reported in Table 2, two points may be noted: (1) Reports are largely based on attitudinal data (what the respondents think it should be or what they think they would do) rather than actual behavior. It is possible that parts of the responses reported in many surveys reflect the ideal rather than practice. Because of this, the proportions who actually practiced a joint decision may be difficult to accurately measured. (2) Joint decision in itself does not necessarily imply egalitarian relation between the marital dyad. It does mean participation of the dyadic members in

making a choice, but relative power of the members in decision-making process needs not be on equal terms. Often, one of the partners may exert his/her attitude and preference in the decision-making more than the other. Thus, in many cases where spousal communication takes place and joint decision is reported, the actual decision may be strongly influenced by only one partner -- more often husband. However, one thing is certain in the joint decision-making; that is, in the process of so doing attitudes, preferences and intentions of both husband and wife are brought to open discussion. Each member of the dyad is aware of the otherís desires and intentions, and this provide a favorable ground for both to work out the solution if they are conflicting. It is, of course, possible that influence of only one member is more dominant in the process of resolving disagreement. In this connection, it may be appropriate to examine gender influence in fertility decision making.

Gender influence in fertility communication and decision-making

At the outset, it is important to recognize that relative power in the marital dyad is a dynamic process. Yet, in most studies, it is measured as a more or less static relationship. Most measurements are more interested in outcome of the couple's choice rather than in the choice process by which the husband's and wife's power interact and a final decision is made. Admittedly, the process itself is very difficult to measure because it is momentary, changeable, and difficult to observe. Thus, the common measurement to ask the respondents "who makes the decision" about the issues under study (Beckman 1983). This approach may be effective for measuring power relation in the past events; but since it emphasizes more heavily the outcome of interaction, the process of power interaction is rarely adequately understood. Another complication in measuring the dyadic power relation is that the partner who undertakes decision-making may not necessarily be dominant, since he or she may be delegated to do so by the other partner who is actually more powerful. Measurement of power relation in fertility matters can be even more complicated, since fertility process works through a set of intermediate variables often considered "sensitive" in most societies. In some cases, there may be

limited chance for the power to play its role in decision making; fertility regulation may be practiced unilaterally or surreptitiously, for instance.

(a) Husbandís influence

Complications in measurement of the concept aside, most studies addressing this issue in developing societies indicate that husband's attitude, preference, intention, and decision are more important. More often it is the husbands who exert greater influence in couple communication and fertility decision-making. Results from the following studies illustrate the above statement.

A study of national sample of married women in South Korea (Kim and Lee 1973) found that husband's perceived support for family planning was significantly related to the wife's contraceptive practice. Women who did not themselves support family planning but believed that their husband supported it had a higher rate of contraceptive use than women who were in favor of the family planning but perceived their husbands as less supportive. This suggests how influential the husband is in the practice of family planning. Similarly, a study of four Indonesian metropolitan areas also found a strong influence of husbands, measured in terms of their approval of contraceptive use. The proportion using contraceptive was much greater for women whose husbands approved of their use than for those whose husbands do not or are neutral. Among women who wanted no more children, 17.4 percent of contraceptive nonuse in Medan and 27.8 percent of the same in Jakarta were attributed to husbandís disapproval. The proportions of unmet-need group with husband's disapproval is strikingly very high, ranging from 88.9 percent in Medan to 93.3 percent in Ujung Pandang (Joesoef et al 1988).

Data from sub-Saharan African societies nearly consistently support the notion that husband's attitude, preference and decision are the most decisive in determining the family size and fertility behavior of the couple. Reporting on the Ghana DHS data,

Ezeh (1993) observes that, rather than being mutual or reciprocal, spousal influence is an exclusive right exercised only by the husband. Ezeh notes that a womanís contraceptive attitude and practice are strongly influenced by her husband's attitudes and characteristics, but the reverse is not true. He argues, therefore, that this type of influence would suggest the husband as the dominant partner in decision-making. A survey of males in Sudan also reveals significant influence of males as the decision not to use family planning here was determined be men (Khalifa 1988). In Nigeria where husband-wife communication about family planning is reportedly high, men are more likely to answer that husband decides, or both spouse decide, the number of children the couple will have (Renne 1993). Male dominance in Nigeria is also observed by Isiugo-Abunihe (1994); 88 percent of men and 78 percent of women said that men's views are more influential in family decisions. Nigerian men and women, according to the study by Isiugo-Abunihe, seem to agree that most often men make reproductive decisions which include deciding the number of children, whether to have sexual relation, duration of abstinence, and making choices about the practice of family planning.

Strong male dominance in fertility and family planning in sub-Saharan Africa has been explained partly in terms of strong patriarchal family structure commonly found among most ethnic groups. Under the patriarchal family system men are heads of the household, custodians of the lineage's interests, protectors and providers. Men benefit more from children than do women. This is the institutional base favoring African men in matters affecting marital and family life (Isiugo-Abunihe 1994). Therefore, the notion that spousal dominance is a function of the prevailing socio-cultural system (Fried and Udry 1979) holds true for many African societies. This probably is also the case in other parts of the world where the cultural values favoring male dominance prevail. Hull (1983) noted that inequality in couple's relationships is widespread, and usually characterized by male dominance. Beckman (1983) noted, on the basis of some materials she examined, that although some findings do not consistently show male attitudes to be dominant in contraceptive use; they do present strong evidence that, in case of disagreement, the husband's view frequently prevails. Even

where decision was said to be jointly made, respondents almost invariably reported that the husband actually made the decision.

Some researchers look at relative gender power relation in the process of couple decision in terms of differential fertility desires and intentions and how these effect fertility outcome. Where husband and wife both desire the same small or large number of children (either by concordance or consensus) fertility outcome can be more or less expected; and the problem of relative power relation is invalid. But only when both disagree that the issue of power relation comes to play. In such condition, it is important to find out whose desires and intentions better predict the couple's behavior and, ultimately, fertility outcome. Analysis in this direction can also best indicate relative influence of the members of marital dyad.

Using the U.S Princeton Fertility Survey - a unique panel study of couple fertility in the U.S. - Thomson and colleagues (Thomson et al 1990) demonstrated that wives 'and husbands' desires and intentions have relatively equal effect on birth rates. This is evident in the finding that disagreeing couples experienced fertility rate midway between couples who both wanted the same larger number of children and those who both wanted the same smaller number of children. Husband's desires, however, became dominant under a condition where both marital partners wanted a third child but the husband wanted to delay birth. In such case, the husband's willingness to delay birth was found to have significant negative effects on birth rates. Nonetheless, as will be shown below, there are also conditions under which wives' desires and influence become more important.

(b) Wife's influence

It appears that husband dominance in couple communication and fertility decision-making is indisputable. Nonetheless, under certain conditions wife's influence can also prevail. When examined in relation to the number of surviving children and

duration of marriage, gender influence may be in favor of the wife. Bankole (1995), for example, demonstrates that in case of disagreement between husband and wife about the desired number of children, husband's fertility desires and intentions are dominant in predicting the couple's behavior, but only in the early stage of marriage when the number of children is still small. In the later stage when the couple have had more living children the wife's desires and intentions become more important. Thus, the relative importance of the couple's desires, which favors the husband in the early stage of marriage when fertility is low, reverses in favor of the wife as the number of children increases. Increase of wife's relative power with duration of marriage is also observed in traditional India, and it is considered as favoring husbands-wife communication on family matters (Proffenberger et al 1969, in ESCAP 1974). This finding suggests that the desires of both husband and wife should be taken into account in order to more accurately predict fertility behavior of the couple.

Evidence from low-fertility countries (i.e. with high prevalence rate of contraceptive use) such as the United States and Taiwan also suggests that when husband and wife disagree about additional birth, wife's views are more likely to prevail (Beckman 1983). It may be that in such societies decision to limit family size is more often dominated by wives who control most of contraceptive methods, and because most methods are relatively easy to access by women. An analysis of the U.S. data using utility models of reproductive intentions reveals that the model taking into account fertility intention of wife only (wife-alone model) is substantially stronger in predicting reproductive intention of the couple than the model taking into account fertility intention of husband only (husband-alone model) (Fried et al 1980). Bumpass and Westoff (1970), based on analysis of couple data from the Princeton Fertility Survey, found that wife's fertility desire counted significantly more important in fertility outcome, while the husband's desire counted but minimally. [However, in a later analysis of the same data Thomson et al (1990) found that although wives' and husbands' desires had equal effects on birth rate among couples who both wanted a third child, only husband's willing to delay births had significant negative effect on birth

rates. See above] These findings imply stronger influence of wife in fertility decision making in more developed countries. The evidence seems to suggest that, in the environment where contraceptive methods are available and easily accessible, wife's attitude and preference in family planning can be more influential, or at least as influential as those of the husband.

Future challenges of small family

This section addresses the challenges in terms of constraints toward achieving small family in developing countries. For convenience, the discussion is divided into two parts. The first part looks at the future trends of family planning in developing countries. This part benefits considerably from existing information in the work by Weinberger (1994) on recent trends in contraceptive use. The second part identifies some key constraints to achieving small family size in the less developed world.

a) Trends in contraceptive use

According to the United Nation's estimate, fertility in the less developed regions declined by 35 percent during the period between 1960-1965 and 1985-1990. Over this period, total fertility rate (i.e. an average number of children a married woman will have at the end of her reproductive age given specific fertility rates) in the less developed world dropped from 6.1 births per woman to 3.9. There are good reasons to believe that the decline will continue and possibly become more rapid and substantial in many countries in the future.

Fertility decline in developing countries was indisputably accounted for in terms of the rise in contraceptive use in these regions. A comparison of data from various sources including the World Fertility Survey (WFS), the Demographic and Health Survey (DHS), and other major surveys available, reveals that contraceptive use increased substantially within both urban and rural areas and among women with all

levels of education. By the middle of 1980's to the early 1990's when the DHS results from different regions were available, contraceptive prevalence within the sub-regions of Asia was already approaching advanced levels in many countries. For example, in East Asia (excluding Japan), the prevalence rates range from 72 percent in China to 88 percent in Hong Kong; in Southeast Asia, from 44 percent in the Philippines to 74 percent in Singapore; and in South Asia, from 12 percent in Pakistan to 62 percent in Sri Lanka (Table 3).

Table 3 Percentage of Married Women of Reproductive Age Currently Practicing Contraception, Selected Countries in Asia Regions

Region/ countries	Date	Sample Age range	percentage using Any method	Clinic or supply method
East Asia				
China	1988	15-49	72	71
Hong Kong	1987	15-49	81	74
Republic of Korea	1988	15-49	77	70
Southeast Asia				
Indonesia	1987/88	15-49	48	44
Malaysia	1984	15-49	51	29
Philippines	1986	15-49	44	21
Singapore	1982	15-49	74	59
Thailand	1987	15-49	68	65
Viet Nam	1988	15-49	53	35
South Asia				
Afkanistan	1972/73	EM 15-49	2	1
Bangladesh	1989	15-49	31	22
India	1988	15-49	43	39
Nepal	1986	15-49	14	13
Pakistan	1990/91	15-49	12	9
Sri Lanka	1987	15-49	62	40

Source: Adapted from Table 2 in Weinberger, 1994.

Compared with available data from some major surveys at earlier dates, the average annual increase in the prevalence rates (any methods) from around the mid-1970's to the early 1990's among East Asian countries range from 0.3 percent in China to 2.9 percent in South Korea; among Southeast Asian countries, from 0.9 percent in the Philippines to 2.7 percent in Indonesia; and among South Asian countries, from 0.4 percent in Pakistan to 2.4 percent in Sri Lanka. In none of these countries did the average annual change in the prevalence rate become negative (Table 4). Differences within urban-rural areas and with levels of education show a narrower gap in some countries and a wider gap in others (Table 5).

Table 4 Recent Trends in Contraceptive Use Among Married Women aged 15-49, Selected Countries in Asia Region

Countries/region	Earlier survey Year	Prevalence	Recent survey Year	Prevalence	Average annual change (%)
East Asia					
China	1982	71	1988	72	0.3
Hong Kong	1977	72	1987	81	0.9
Rep. Of Korea	1974	37	1988	77	2.9
Southeast Asia					
Indonesia	1976	18	1987	48	2.7
Malaysia	1974	33	1984	51	1.9
Philippines	1978	38	1986	44	0.9
Singapore	1973	60	1982	74	1.6
Thailand	1978/79	53	1987	68	1.7
South Asia					
Bangladesh	1979	12	1989	31	2.0
India	1980	34	1988	43	1.1
Nepal	1976	2	1986	14	1.1
Pakistan	1975	5	1990/91	12	0.4
Sri Lanka	1975	34	1987	62	2.4

Source: Adapted from Table 3 in Wienberger, 1994.

Table 5 Difference in Contraceptive Prevalence Between WFS and DSH Surveys, By urban-rural Residence and Education, Selected Countries in Asia

Countries	Survey	Year	Residence Urban minus rural (%)	Education 10+ minus 0 yrs (%)
Indonesia	WFS	1976	3	29
	DHS	1987	9	34
Sri Lanka	WFS	1975	8	27
	DHS	1987	4	7
Thailand	WFS	1975	15	21
	DHS	1987	3	11

Source: Adapted from Tables 6 and 7 in Wienberger, 1994

Factors explaining universal increase of contraceptive use among developing countries in Asia and elsewhere are diverse, and related to socioeconomic conditions of individual countries. In addition, changes in important proximate variables may also account for much of the reduction in fertility rates in developing countries over the period of WFS and DHS surveys.

b) Future challenge

It appears from the data presented above that family size in the less developed world is declining, and probably will continue to be reduced while contraceptive use increases. What then are the future challenges on the path to small family among

developing countries? And how can they be overcome? In a brief discussion below, I focus on identifying key constraints to achieving small family in developing countries.

1) *Policy:* Needless to say, where national policy about population and family planning is absent, or where the policy is unclear, it is difficult to reduce the family size through effective intervention programs. Without a clear policy, it is hardly possible to achieve small family size to a great extent even where there are manifested demands for smaller family on part of the people. A clear policy provides an essential ground for commitment on the part of organizations and individuals who actually carry out activities to effect the family size. It is unfortunate that a clear population policy aiming at reducing family size is yet to be formulated in many countries. On the other hand, a clear but pronatalist policy -- such as in the case of Malaysia (so-called seventy-million population policy) and Singapore ("Three or More" policy) -- can be considered a challenge if small family is the goal.[1]

2) *Structural factors:* All other things equal, two developing societies may differ significantly when provided with similar family planning inputs. The country such as Thailand has proceeded faster than some other countries in the region, for instance. The question is why there is such difference. One of the popular hypotheses in this respect is to link slow response to family planning program in some countries to difference of factors at structural levels. Religious ideology, family system, and economic conditions are among important structural factors that are believed to play an important role, i.e. either inhibit or facilitate family planning program. Spousal communication and women's autonomy, which is favorable for fertility limitation, are also associated with factors at structural level.

That structural factors are important for fertility decline is indisputable. The question is how important they are, and what they imply in terms of the policy and

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1 In the case of Singapore, a recent look at the policy impact indicates that although the policy succeeds in increasing annual number of births, fertility remains under replacement level (Yap 1995).

programs. Does it mean that developing countries have to wait till they overcome all challenges stemming from structural factors before they can achieve small family size? Can fertility in the less developing world be reduced without substantial socioeconomic development? How can less developed countries afford to raise level of socioeconomic development in order to achieve small family? These questions need to be debated, and the debate should take in to consideration existing conditions in particular context rather than the global conditions.

3) *Women's status:* That relative status of women in society is lower than men's status seems to be true for most, if not all, developing countries. However, the lower status of women - although in itself can inhibit fertility limitation to a variable extent-does not seem to have as strong effects on family planning as the gap between men's and women's statuses within the same society. Experiences of many developing countries seem to suggest that where the gap between women's and men's relative statuses is wide, it proves to be more difficult to reduce fertility than where the gap is narrow. To a great extent, this challenge is closely related to structural factors, i.e. to level of socioeconomic development. To overcome this challenge requires continuing long-term efforts; and the road seems long for many countries.

4) *Creation of demand and provision of the means for family limitation:* Many developing countries still face fundamental problems of creating demand for limiting the family size and provision of family planning supplies to meet the need of those couples who want to limit the number of their children. Effective means to get the family planning information across to the public, and particularly to those who need it, is certainly needed. But equally important, or maybe more so, is how much the information is relevant and meaningful to the target population, given their social, cultural and economic contexts. Only when the small family ideology makes sense to them that individual couples can have the demand to plan their family size, and eventually begin to change their reproductive behavior. This is a rather subtle question - - especially when use of contraceptive methods is in conflict with religious ideology or

even personal values of the people. Social research is essential to inform decision making body of suitable strategies to achieve the goal of creating demand for family planning in many developing societies.

On the other hand, where demands exist, many developing countries are facing the challenge on the supply side, partly because of limited resources available and partly because of lack of appropriate management. Where the internal resources are limited, help from international sources may be crucial. Regardless of where supplies come from, however, effective and efficient management is essential. Again, experience of many developing countries indicates that this still becomes an important challenge to the national family planning program. Perhaps, many aspects of family planning program management can be learned and shared among a number of developing countries.

5. *Participation of the husband:* Several studies have noted significance of the role that husbands play in the use of contraception. We have noted in the review above that where husbands' attitudes and intentions are positive, or where husbands approve of family planning and cooperate, use of contraception is high. Research results from all over the world indisputably agree on this point. Yet, relative husbands' share in contraceptive use is very small in all societies regardless of stages of socioeconomic development. Part of the reasons, however, is obvious enough; male contraceptive methods are much more limited comparing to the female-specific methods. Had more male methods become available, couples would have had more choices, and small family size would have been achieved in a number of developing countries by now. This challenge still awaits technological development of effective, easy-to-use male contraceptive methods. But this seems to take a long time.

Conclusion

We have seen from our review of previous studies above that couple's communication in general, and that with regard to family size they want to have in

particular, is an important factor that can result in contraceptive use. The extent to which husbands and wives discuss family size and family planning differs from society to society, reflecting differences in social structure and cultural norms. At individual level, the difference is found to be associated with personal attributes such as demographic and social backgrounds of the couples, particularly those of the wives. Studies have found that characteristics related to women status are especially important factors that can influence couple communication on fertility and family planning. Thus, raising the women's status in developing countries can eventually result in inter-spousal exchange. On the other hand, lack of spousal communication which is found among smaller, but substantial, proportions of the couples in most developing societies may be understood in terms of lack of favorable socio-cultural environment and specific individual characteristics. Among others, education (particularly women's education), rural-urban residence, and participation in the market economy are of greater importance.

We know but a little about joint decision of husband and wife in fertility. Most studies in the past give retrospective data on joint decision which, like spousal communication, varies from society to society. The process of joint decision is rarely known, especially with regard to how disagreement (when it occurs) is resolved, and how wife's and husband's influences interact and result in actual fertility behavior. This area remains to be investigated. At any rate, joint decision -- where it exists -- does not necessarily imply equal power relation of the couple; but it does imply participation of the husband and wife in the decision-making, an act which provides a favorable condition for fertility limitation in most cases.

Relationship of husband and wife in their communication is not all egalitarian. Studies do not show consistent results, but by and large husband's influence dominates in the couple's decision-making on the family size and fertility limitation. Female dominance in fertility decision, when it exists, is associated with conditions where fertility is at a relatively low level, where access to family planning methods is relatively easy, or where women have greater control of contraceptive methods.

Based on the evidence examined above, it appears that a desirable future direction in terms of the programs to effect family planning would be to increase husband-wife communication on family size and, along with that, to encourage equal participation in fertility decision-making. Ideally, one would also aim at achieving greater involvement of males in actually using family planning. Desirable as it may be, the work in that direction is not without challenges stemming from several sources at individual, structural, as well as technological levels. Thus, the work toward small family needs to proceed in multiple directions, many of which lie beyond the routine provision of contraceptive methods. Indeed, development in nearly, if not all, aspects can result in small family, one way or another. However, based on today's situations in many developing countries, the more effective kind of development seems to be the one which directly results in higher status of women.

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