International Journal of Multicultural and Multireligious Understanding

http://ijmmu.com
editor@ijmmu.com
ISSN 2364-5369
Volume 8, Issue 3
March, 2021
Pages: 558-563

How Women's Role Against Gender Fair?

Indra Supradewi; Juli Oktalia; Ani Kusumastuti; Mega Bella Joennata; Puspa Sekar Mentari

School of Nursing, Health Polytechnics Jakarta III Kemenkes RI, Bekasi Jawa Barat, Indonesia

http://dx.doi.org/10.18415/ijmmu.v8i3.2525

Abstract

The purpose of this research is to see the relationship between women's participation, attitudes and knowledge of women in Gender Fair Service. The method used in quantitative research with the data used is primary data. The sample in this study were female service users at the Practice of Independent Midwives (PMB) Jakarta area with a total sample of 96 people. The results of this study show that as many as 31% of women who have passive involvement get gender unfair services, while among women who have active involvement as much as 17% get gender less fair services. The relationship between knowledge and gender equitable services shows that as many as 33% of women who have poor knowledge get gender less fair services, while among women who have good knowledge as much as 15% get gender less fair services. The relationship between attitudes and gender-equitable services show that as many as 33% of women who have negative attitudes get gender less fair services, while among women who have a positive attitude as much as 15% get gender less fair services.

Keywords: *Gender; Women; Health*

Introduction

Referring to the Sustainable Development Goals (SDG) document, which was agreed upon in New York, 193 UN member countries unanimously adopted a document entitled "Transforming Our World: The 2030 Agenda for Sustainable Development" or "Transferring Our World: The 2030 Agenda for Development. Sustainable (Panuluh & Fitri, 2016). One of these targets is written in the fifth goal, namely ensuring gender equality and empowering all women and women by having 9 targets.

Women are the pillars of the country because in the hands of women, this nation's generation is born and educated. Women are also the first and foremost educators in the family as human resources (Fitria, 2010). That the contribution of women in the participatory development process stage has not made an optimal contribution, because women are faced with a situation of choosing between family and environmental activities and women prioritize their families (Rinawati, Fardiah, & Kurniadi, 2007). The dynamics of family planning program policies often result in dilemma phenomena in the realization of the enforcement of reproductive rights as a basic right that must be fulfilled by the community. This can be seen from the emergence of inequality in realizing the obligation to control the number of children which is more predominantly borne by women (wives) (Putra, 2019). Until now, there is no balance between the number of male family planning acceptors and female family planning acceptors. Based on the health

profile of Jakarta in 2018, the choice of injection and pill contraceptives is also very dominant where injection is 49.9% and pills 20.9% (Novita, Qurniasih, Fauziah, & Pratiwi, 2020).

The emergence of many negative impacts felt by the wife during contraceptive use is of course a dilemma problem faced by the wife. This is also acknowledged by health workers related to contraceptive problems. Side effects that occur, admitted by experts, cannot be prevented and every woman has a different experience, which is associated with ho rmon in their respective bodies (Rinawati et al., 2007). As a consequence of their reproductive duties, women become permissive when they have to be the target of policies to control their reproductive functions. Women become easy objects for the contraceptive method of family planning program policies, which are accompanied by a variety of consequences. Judging from the current reality, it is still far from fire if it is based on the agreement on items contained in the development of the meaning of reproductive rights that are gender equitable as stated in the results of the International Conference on Population and Development (ICPD) conference in Cairo in 1994 (Sari et al., Nd).

The main problem facing Indonesia is the high maternal mortality rate, namely 305 / 100,000 live births (Indonesia, 2016). The problem of maternal mortality shows inequality in access to health services, discrimination including gender inequality and injustice. Gender disparities and gender issues, especially those experienced by women, are still found in society, both related to socio-culture and aspects of access, participation, control and benefits of health development, especially reproductive health. Women's power is defined in day-to-day decisions regarding household needs and settlement of household affairs (Nida, 2016). Sociologists emphasize that later "power" can change in the broader family dynamics and is subject to decisions by men in positions as the main economic proponents or head of the household. Gender inequality can occur due to an imbalance in the distribution of productive, reproductive and social roles between men and women. Midwives who have the ability to provide gender-fair midwifery services, with the characteristics of non-discriminatory, non-judgmental services, empowering women to prevent and eliminate gender inequality and respect reproductive health rights as human rights (Bunyamin, 2014). Gender fair midwives always strive to help eliminate the domination of male power over women's reproductive and sexual health rights.

Given that the Midwifery Service is a service from women for women. Therefore, in order to realize gender justice, it is very important to increase the ability of women to participate in health development and to access gender equitable midwifery services. Based on these facts, it is important to conduct research on the Relationship between Women's Participation and Gender Fair Midwifery Services.

Methods Research

The method used in this research is quantitative research with the data used are primary data. This primary data was obtained from questionnaires from the respondents. The design of this study is to see the relationship between women's participation, attitudes and knowledge of women in Gender Fair Midwifery Services.

Research Samples

Sampling is a process of selecting and determining the type of sample and calculating the sample size that will be the subject or object of research. So the sample size taken is 96 respondents. In this study, the sampling used a purposive technique. This technique is used in selecting samples specifically based on research objectives. The sample in this study were women who were users of services at Praktik Mandiri Midwives (PMB) in the Jakarta area

Research Instruments

The research instruments used were observation sheets, interview sheets, questionnaire sheets, and documents. The main instrument in this research is the researcher himself who is assisted and supported by other instruments. In the quantitative method, the instrument used is a questionnaire sheet. This questionnaire sheet was chosen because it makes it easy to get data in a short time and a large number of respondents. By using a questionnaire sheet given to women who come to the Mandiri Midwife Practice to get health services.

Interview

At this stage the researchers will conduct in-depth interviews with midwives and couples of childbearing age regarding women's participation in midwifery services that focus on reproductive rights and gender equity.

Questionnaire / Questionnaire

The questionnaire or questionnaire in this study aims to get an overview of the relationship between women's participation and midwifery services to see women's empowerment in terms of reproductive rights and fairness as a strategy to prevent corrupt behavior.

Result and Discussion

Women's participation in question is a form of active and voluntary women's involvement and participation, both for reasons from within (intrinsic) and from outside (extrinsic) in the entire process of the activity concerned. To show their existence, usually women are actively involved in several activities in a particular community according to their interests and desires to be achieved. The research results can be seen in table 1.

Table 1. Distribution of Respondents based on Gender Equitable Women's Participation, Knowledge, Attitudes and Services

NO	Variable	Gender Equitable Services				OR 95% CI	Pvalue
		Lack of Gender Fair		Gender Fair			
		n	%	n	%		
1.	**Women's Participation**						0.009
	Passive Engagement (≤ ∑	31	31%	19	19%	3,167	
	34.69)	17	17%	33	33%	1. 398 - 7,174	
	Active Engagement (>34.69)						
2	**Women's Knowledge about Gender Fair Midwifery**					3,248	0.005
						1,424 - 7,405	
	Services	33	33%	21	21%		
	Not good (≤ ∑11.64)	15	15%	31	31%		
	Good (> 11.64)						
3	**Attitudes towards Midwife Services**					2,378	0.044
						1,049 - 5,382	
	Negative (≤ ∑9.64)	33	33%	25	25%		
	Positive (> 9.64)	15	15%	27	27%		

Based on table 1, it shows that as many as 31% of women who have passive involvement get gender unfair services, while among women who have active involvement as much as 17% get gender less fair services. According to the Chi-square calculation, the value of p = 0.009, p value <0.05, it can be concluded that there is a significant relationship between women's participation and gender equitable services. The results of the analysis also showed that the OR value = 3.167, meaning that women who have passive involvement have a risk of 3.1 times less getting gender fair services.

The relationship between knowledge and gender equitable services shows that as many as 33% of women who have poor knowledge get gender unfair services, while among women who have good knowledge as much as 15% get gender unfair services. According to the Chi-square calculation, the value of p = 0.005, p value <0.05, it can be concluded that there is a significant relationship between women's knowledge and gender equitable services. The results of the analysis also showed that the OR value = 3.248, meaning that women who have less knowledge have a risk of 3.2 times less getting gender fair services.

The relationship between attitudes and gender-fair service shows that as many as 33% of women who have negative attitudes get gender less fair service, while among women who have a positive attitude as much as 15% get gender unfair service. According to the Chi-square calculation, the value of p = 0.044, p value> 0.05, it can be concluded that there is no significant relationship between women's attitudes and gender fair services. The results of the analysis also showed that the OR value = 2.378, meaning that women who have negative attitudes have a risk of 2.3 times less getting gender fair services.

Discussion

Based on the results of the study, there were 52% women who received gender fair services, so it can be said that almost 50% of patients who seek services have not received gender equitable services (Novita et al., 2020). Women's acceptance of midwife services in providing women's reproductive rights. This service is in an effort to eliminate gender inequality. Midwives are able to be aware of the values that disadvantage / marginalize women. Midwives do not only handle the physical problems of their patients but consider various aspects that affect women's reproductive health as human rights and women's reproductive rights (Panjaitan & Purba, 2018). Midwives who have the ability to provide midwifery services that are non-discriminatory, non-judgmental, empower women can prevent and eliminate gender inequality and respect reproductive health rights as human rights.

The main problem facing Indonesia is the high maternal mortality rate, namely 305 / 100,000 live births (Dewi & Rahmawati, 2019). The high MMR is caused by direct and indirect causes. This corresponds to 4 TOO (Too young, too much, too close too old) and 3 TOO LATE. The problem of maternal mortality shows gaps in access to health services, discrimination including gender inequality and injustice (Panjaitan & Purba, 2018). Gender disparities and gender issues, especially those experienced by women, are still found in society, both related to socio-culture and aspects of access, participation, control and benefits of health development, especially reproductive health. Whereas gender justice is a condition of justice for women and men through cultural processes and policies that remove obstacles to play for women and men.

Husbands or wives have the right to do family planning, and it does not have to be that the obligation to do family planning is always on the shoulders of women. The concept of gender is more complex than gender (Wood, 1982). The definition of gender is formed by society with categories based on genetic, biological factors, and most people assume through their lives. Gender can change over time. Humans are born male or female that is sex, but we can act in masculine and / or feminine ways that is

gender (Sari et al., Nd) . Gender is a social, symbolic construction that can change through culture, the time given to one culture in individual life and in other gender relations. Basically, the use of contraceptives is not natural for women. Naturally, by nature of women, namely pregnancy, childbirth, and breastfeeding, the rest of the use of alcohol can be used by men. Another gender bias, there is a difference in the number of alkon between men and women. Contraception in women is more than in men (Nida, 2016). Thus, the large availability of medical check-ups allows women to choose the available alternative, compared to men who are only provided with two medical check-ups, namely vasectomy and condom. Women and men are the smallest partners in a family, so that biological differentiation in nature does not mean that there is social discrimination that women as the main subject of family planning program development, through family gender interactions can be socialized. Meanwhile, family planning knowledge and decision making in fertility issues are essential elements for the control of a couple's fertility plan. Then participants feel more empowered when they have family planning decisions that have been made with their partners. Also, family planning policy makers should provide a new approach that focuses on women's health and empowerment.

Meanwhile, the findings of Wattimena's (2005) study indicate that contraceptive use in women comes from their will, women will continue to use contraceptives if this is still needed, because contraception makes them happy. Equal gender relations between husband and wife in the use of contraceptives, especially for men, will have an impact on the achievement of the fifth point of the dream agenda to improve the quality of Indonesian human life, namely population development and family planning, as well as increasing the development of women themselves starting from their families. Gender equality can occur, one of which is through the role of the family, where family members can express, dialogue, voice their opinions freely without pressure, as individuals who are empowered, and get support from those around them. Women who are empowered also take the initiative and have autonomy in making decisions, not only in domestic matters (Wirawan, 2015).

Thus, a shift in gender relations results in a redefinition of the role and meaning of the family, that the family is a place where gender equality is formed from an early age, because later the inheritance of values, norms, culture will continue from generation to generation. The socialization of equal gender relations begins with husband and wife who will later be adopted by children or other family members. So far, patriarchal culture is still the root of the problem of gender inequality that starts in the family (Iriani & Soeharto, 2015). Men as breadwinners become the party who dominates decision-making in the family, so that the affairs of the wife and family, from generation to generation, male domination has been considered normal and has become a habit. It is time to redefine the meaning of family.

Women are vulnerable to domestic violence (domestic violence) or harsh treatment that results from gender inequality. Reproductive health is more associated with women's matters such as family planning (Hubeis, 2011). In the field of family planning (KB), gender inequality is very prominent, especially in the use of contraceptives. Nowadays, the use of contraceptive tools is more targeted at women. The occurrence of inequality like this is influenced by the gender ideology of society which tends to be more detrimental to women. Then the community considers the existing gender ideology to be something standard and static. This assumption exists because of the lack of understanding and knowledge of society about gender itself. To improve conditions of inequality towards gender equality and justice, it is necessary to have public knowledge and understanding of the concept of gender as well as gender equality and justice in family life. Maternal health is the key to success in creating quality future generations. The existence of a woman who is physically, mentally and socially healthy will determine the quality of the next generation. Healthy humans are born to healthy mothers.

References

Bunyamin, B. (2014). Gender Issues in Family Planning Programs. *Parallell's Journal*, *1* (2), 151–158.

Dewi, MK, & Rahmawati, F. (2019). Perceptions Relationship, Family Support and Access to Services for Men's Participation in Family Planning. *Indonesian Journal of Midwifery*, *9* (02), 79–87.

Fitria, DI (2010). Male participation in family planning programs (a gender analysis study of men's participation in family planning programs in Serengan Village, Serengan District, Surakarta City).

Hubeis, AVS (2011). *Empowerment of women from time to time*. PT Publisher IPB Press.

Indonesia, S. (2016). *Profile of the People of Indonesia, Supas Result 2015*. Statistics Indonesia.

Iriani, DS, & Soeharto, S. (2015). Evaluation of the implementation of student industry work practices competency in catering services at SMK N 3 Purworejo. *Journal of Technology and Vocational Education*, *22* (3), 274–290.

Nida, FLK (2016). ENFORCEMENT OF WOMEN'S REPRODUCTIVE RIGHTS IN INDONESIA'S FAMILY PLANNING POLICY. *PALASTREN Journal of Gender Studies*, *6* (1), 159–184.

Novita, Y., Qurniasih, N., Fauziah, NA, & Pratiwi, AR (2020). Relationship between Husband's Support and Selection of Intravenous Contraceptives (IUD) in Wus in Wates Selatan Village, Gadingrejo District, Pringsewu Regency, 2020. *Journal of Maternitas Aisyah (JAMAN AISYAH)*, (3),172–181.

Panjaitan, AA, & Purba, CS (2018). Challenges Faced by Women in Indonesia: Hacking Gender Injustice. *Bhakti Media Law Journal*, *2* (1).

Panuluh, S., & Fitri, MR (2016). Development of the Implementation of Sustainable Development Goals (SDGs) in Indonesia. *Biefing Paper*, *2*, 1–25.

Putra, S. (2019). Opportunities for Women to Get Reproductive Health Services and Rights in Alor Village, East Nusa Tenggara. *Journal of Inada: The Study of Indonesian Women in Disadvantaged, Frontier, and Outermost Areas*, *2* (1), 42–60.

Rinawati, R., Fardiah, D., & Kurniadi, O. (2007). The involvement of women in decision making in development planning. *MIMBAR: Journal of Social and Development*, *23* (2), 157–177.

Sari, NK, Rahardjo, SS, Widyaningsih, V., Vianitati, P., Manurung, I., Gero, S.… Sujatmiko, B. (nd). Factors Affecting Use of Personal Protective Equipment and the Risk of Contact Dermatitis among Scavengers in Surakarta, Central Java: Application of Health Belief Model. In *6th International Conference on Public Health 2019* (p.107). Eleven March University.

Wattimena. (2005). Amino acid administration to premature infants directly after birth. The Journal of *Pediatrics*, *147* (4), 457–461.

Wirawan, M. (2015). Evaluation of School Operational Assistance Fund Policies in Improving the Quality of Education (Study at the Experimental 1 State Elementary School in Malang). *Journal of Public Administration*, *3* (1), 12–15.

Wood, JT (1982). Communication and relational culture: Bases for the study of human relationships. *Communication Quarterly*, *30* (2), 75–84.

Copyrights