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# The Influence Of Gender Sensitive Obstacial Care Models On Pregnant Women

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**Abstract**

The main problem faced by Indonesia is the still high maternal mortality rate, namely live births. Researcher. This study aims to get an overview of the midwifery care model for gender sensitive pregnant women in independent midwifery practice in DKI Jakarta Province. The results showed that based on the research results and data analysis, it can be concluded that the Gender Sensitive Midwifery Care model is a midwifery care approach that focuses on efforts to empower women in order to eliminate gender inequality through strategies to improve women's welfare in accessing available resources, access to health services, awareness critical, women's participation in making decisions on their reproductive rights, as well as the existence of women's control or autonomy. The availability of the Sensitive Midwifery Care model.

**Keywords :** gender, pregnant women, midwifery.

## Introduction

The gender gap has implications for increasing maternal mortality rates, infant mortality rates, the prevalence of stunting in children under five, and violence against women. The main problem faced by Indonesia is the still high maternal mortality rate, which is 305/100,000 live births (Supas, 2015). Most maternal deaths are caused by direct causes, namely bleeding, infection, eclampsia, prolonged labor and abortion complications of abortion. (Kusumawati, 2016; Ruslan, 2013; Sitorus & Siahaan, 2018). Various factors that perpetuate gender inequality include low socio-economic level, education level, position and role of women, socio-cultural factors and transportation factors, all of which influence the emergence of unfavorable conditions, such as: (1) Three Delays (late recognizing danger signs and making decisions, late reaching health facilities, and late getting services at health facilities); (2) Four Too (too young to give birth, too often to give birth, too close spacing of births, and too old to give birth) triggers the emergence of complications of pregnancy, childbirth which can end in the death of the mother and baby (Andriani et al., 2019).

Based on Law No. 4 of 2019, concerning Midwifery, it is explained that Midwifery Practice is an activity of providing services carried out by midwives in the form of midwifery care. The main goal of midwifery care is to save mothers and babies (reduce morbidity and mortality)(Koto & Ginting, 2018.). Midwives believe that every individual has the right to obtain safe and satisfying health services according to needs and cultural differences. Every individual has the right to self-determination and to obtain adequate information and to play a role in all aspects of health care. Every individual has the right to be born in a healthy manner, for this reason every woman of childbearing age, pregnant women,

giving birth and their babies have the right to get quality services. (Susanto, 2017). However, not a few women who get pregnant are not of their own choice. In the IDHS (2012) it was reported that 50% of married couples wished to limit the number of children, 62% used contraception with their wives, 2% of condoms and sexual intercourse were interrupted, and male sterilization was less than 1%. Likewise, it was reported in IDHS (2017) that most contraceptive users were women, men contributed 0.2% to MOP contraception and 3.1% to condoms and 92.5% did not use contraception, this shows gender inequality. Midwives are responsible and accountable professionals who work as women's partners to provide support, care and advice during pregnancy, labor and the postpartum period, facilitate and lead deliveries on their own responsibility and provide care for newborns, and baby (Mardiana et al., 2021; Nurjannah et al., 2018; Prawiyogi & Toyibah, 2020; Septina & Srimulyawati, 2020).

Midwives are professional health workers who are closest to women, have an important and strategic position, especially in reducing the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) (Hardiningsih et al., 2020; Hendarwan, 2018). Therefore, midwives are not only able to provide midwifery services but must be able to mobilize and empower the community, especially in improving women's health to achieve gender equality. According to the Sara Longwe model of gender analysis, there are five levels of equality including Welfare, Access, Awareness, Participation, Control. The importance of research on the Midwifery Care model based on gender equity in efforts to empower women to eliminate gender inequality. Therefore midwives should be able to fight for and empower women so that women's reproductive rights are protected or gender-based midwifery services. In order for midwives to have guidelines for providing care, it is necessary to develop gender-based midwifery model instruments. This study aims to obtain information about gender-sensitive Midwifery Care model instruments for pregnant women in Independent Midwife Practices in DKI Jakarta Province.

## Literature Review

### Gender Concept

Gender is a distinction between men and women that is socially and culturally constructed (Ginting, 2018; Nurhayati, 2018; Pollard et al., 2020; Qomariah, 2019; Stets & Burke, 2000). For example, that women are known to be gentle, beautiful, emotional, or motherly. While men are considered strong, rational, manly, mighty. Gender can change from time to time and from place to place, as well as differ from one culture to another (Faqih, 2013). Gender is a concept that refers to the roles and responsibilities of men and women that occur as a result of and can be changed by the social and cultural conditions of society. Gender problems arise when differences in rights, roles and responsibilities are found due to socio-cultural values that do not benefit one sex (usually women). In this regard, it is necessary to carry out social reconstruction so that these unfavorable socio-cultural values can be eliminated. So that reproductive health problems that are closely related to injustice and gender inequality can be avoided, especially maternal and child mortality.

Gender mainstreaming was also the result of an agreement at the Human Rights Conference in Vienna, Austria in 1993 and the International Conference on Population Development (ICPD) in Cairo, Egypt in 1994. This agreement was further confirmed by the birth of the Beijing Action Plan and the Fourth Women's Conference in Beijing, China in 1995. The Women's Conference in Beijing is often referred to as an important moment in the struggle to increase the dignity of women

worldwide (Kemenkes, 2015). Paying attention to these reproductive and sexual rights, reproductive and sexual health services include: 1) Services and counseling, providing information on family planning; 2) Care for pregnancy, childbirth and postpartum; 3) Newborn baby care; 4) Prevention and treatment of sexually transmitted diseases and reproductive tract infections; 5) Safe abortion services and handling of abortion complications; 6) Prevention and Treatment of infertility; 7) Providing Information, Education and Counseling on Reproductive and Sexual Health. Therefore midwives need to equip themselves with new information and understanding regarding Sexuality, Reproductive Health and Reproductive Rights; Gender Equality, Domestic Violence/Violence against Women, also have Interpersonal Communication Skills to understand women's feelings and needs. Ideally midwives are given more competence to be able to provide comprehensive reproductive health services (Fitriyya, 2018).

**Pregnancy Care**

Pregnancy and childbirth are not a disease, they are the natural life of a woman in carrying out her reproductive functions and processes (Elmeida, 2012; Sandra, 2018). But you can suddenly experience complications or abnormalities, that's where you need midwifery intervention or medical assistance. The process of pregnancy starts from the process of fertilization / conception. Fertilization or conception is one of the processes of the reproductive function in humans, or efforts to continue offspring (Asiyah, 2019). Fertilization is defined as the union of an egg and a sperm, which marks the beginning of a pregnancy.

Many facts show that the incidence of early pregnancy is increasing including premarital sex behavior, this condition results in unwanted pregnancies and triggers unsafe abortions which can end in maternal death. (Maesaroh & Maesaroh, 2020; Yuli Setiawati & Nurafni Ani, 2019). Pregnancy at an early age can also trigger morbidity and mortality of children born because of premature birth, narrow pelvis, or other pregnancy complications. Therefore all pregnancies should be planned at the right time and conditions (Lasut & Donsu, 2019).

Midwives are professional health care workers who focus on health services for women and their children. Midwives as women's companions in carrying out their reproductive functions and processes so that they can take place safely and satisfactorily, the children born can grow and develop in a healthy, intelligent and productive manner. The natural life of a woman is a process that goes through starting from the fetus in the womb, infancy, childhood, adolescence, adulthood/pre-conception, conception and pregnancy, labor and birth of the baby, postpartum and breastfeeding, the interval period and ends at the climacteric/ menopause.

**Methods**

This study uses a mixed method approach, namely a combination of quantitative and qualitative approaches. The approach used in this study is a mixed method approach, namely a qualitative approach used to identify models and design models of Gender Equity-Based Midwifery Care. The research sample is pregnant women. Primary data collection. Data analysis in this study uses Structural Equation Modeling (SEM) analysis.

**Types and Research Design**

This research was initiated by conducting a literature study on Gender Sensitive Midwifery Care, to develop indicators of care, then carried out item validity tests and expert tests.. Menurut Sugiyono (2013) that to determine the validity of the instrument, at least 3 experts, or experts, or resource persons are required to do so. to see

the compatibility between the components and the midwifery care process followed by the preparation of the final draft of the research instrument. The process of this research phase was carried out at PMB in the DKI Jakarta area. The minimum sample size required to reduce bias in all types of SEM estimates is 200 (Manggis et al., 2018).

## RESULTS AND DISCUSSION

### 1. Confirmatory factor analisis (CFA)

Measurement model (Measurement Model) is a technique in measuring the relationship between observed variables (Variable Indicators) in forming a latent variable (Latent Variable). Latent variables are variables that cannot be measured directly, so they require indicator variables to form latent variables determined by confirmatory factor analysis (CFA) data analysis techniques. The CFA model can be accepted if it has a good validity and reliability model data match (Wijanto, 2008).

Testing the validity of the measurement model in this study was conducted to find out whether a variable measure exactly what it is supposed to measure. According to Wijanto (2015) a variable is said to have good validity against the construct or latent variable if the factor load t value is greater than the critical value (fl ≥ 1.96) and the standard factor load is greater than (sfl ≥ 0.70). Meanwhile, regarding the relative importance and significance of the factor loading of each item, it states that the standard factor loading value (SFL) ≥ 0.50 is very significant and the observed variables can be declared valid (Hair, et al. 2014).

Testing the reliability of the measurement model in this study aims to determine the consistency of a measurement made. High reliability indicates that the observed variables have high consistency in measuring their latent constructs. In SEM reliability testing uses a composite reliability measure and a variant extracted measure.

Where is std. loading (standardized loadings) can be obtained directly from the output of the Amos program, and ej is the measurement error for each observed variable. Variant extracts reflect the number of variants. overall, in the observable variables explained by the latent variables. A construct has good reliability if the Construct Reliability (CR) value is ≥ 0.70, and the Variance Extracted (VE) value is ≥ 0.50.

### Testing the Validity and Reliability of Gender-sensitive Latent Variable Midwifery Services with Confirmatory Factor Analysis (CFA)

Gender-sensitive Midwifery Service Latent Variable (X) has 5 indicators, namely Welfare Indicator (KSJ_1) which is measured by 6 statements, Access Indicator (AKS_2) which is measured by 8 statements, Critical Awareness Indicator (KSK_3) which is measured by 9 statements, Participation Indicator (PSP_4) as measured by 8 statements and Control Indicator (KTR_5) as measured by 12 statements.

The summary of the Standardized Loading Factor values of each statement on the latent variable Midwifery Services is Gender sensitive (X) as shown in the following table.

**Table 1. Standardized Loading Factor Analysis of Latent Variable Midwifery Services Gender Sensitive (X)**

| <---Latent indicator | standardized loading Factor | Ctirical Value | Information |
|---|---|---|---|
| PKPS1 <--- Midwifery_Services_X | 0.958 | ÿ 0.50 | Valid |
| KAPL2 <--- Midwifery_Services_X | 0.977 | ÿ 0.50 | Valid |
| PKKR3 <--- Midwifery_Services_X | 0.951 | ÿ 0.50 | Valid |
| KIHM4 <--- Midwifery_Services_X | 0.968 | ÿ 0.50 | Valid |
| POPS5 <--- Midwifery_Services_X | 0.964 | ÿ 0.50 | Valid |
| Statement Item <--- Indicator | | | |
| PKP1 <--- PKPS1 | 0.800 | ÿ 0.50 | Valid |
| PKP2 <--- PKPS1 | 0.770 | ÿ 0.50 | Valid |
| PKP3 <--- PKPS1 | 0.773 | ÿ 0.50 | Valid |
| PKP4 <--- PKPS1 | 0.731 | ÿ 0.50 | Valid |
| PKP5 <--- PKPS1 | 0.285 | ÿ 0.50 | Drops |
| KAP1 <--- KAPL2 | 0.786 | ÿ 0.50 | Valid |
| KAP2 <--- KAPL2 | 0.781 | ÿ 0.50 | Valid |
| KAP3 <--- KAPL2 | 0.759 | ÿ 0.50 | Valid |
| KAP4 <--- KAPL2 | 0.781 | ÿ 0.50 | Valid |
| KAP5 <---KAPL2 | 0.743 | ÿ 0.50 | Valid |
| KAP6 <--- KAPL2 | 0.759 | ÿ 0.50 | Valid |
| PKK1 <---PKKR3 | 0.739 | ÿ 0.50 | Valid |
| PKK2 <---PKKR3 | 0.743 | ÿ 0 .50 | Valid |
| PKK3 <---PKKR3 | 0.762 | ÿ 0.50 | Valid |
| PKK4 <---PKKR3 | 0.766 | ÿ 0.50 | Valid |
| PKK5 <---PKKR3 | 0.744 | ÿ 0.50 | Valid |
| KIH1 <--- KIHM | 0.722 | ÿ 0.50 | Valid |
| KIH2 <--- KIHM | 0.787 | ÿ 0.50 | Valid |
| KIH3 <--- KIHM | 0.787 | ÿ 0.50 | Valid |
| KIH4 <---KIHM | 0.760 | ÿ 0.50 | Valid |
| KIH5 <---KIHM | 0.743 | ÿ 0.50 | Valid |
| POP1 <---POPS5 | 0.758 | ÿ 0.50 | Valid |
| POP2 <---POPS5 | 0.314 | ÿ 0.50 | Valid |
| POP3 <---POPS5 | 0.706 | ÿ 0.50 | Drops |
| POP4 <---POPS5 | | ÿ 0.50 | Valid |

Based on the results of testing the measurement model for the Midwifery Services Latent variable which is Gender sensitive (X), the Standardized Loading Factor value of each observed variable on the latent Variable Midwifery Services is Gender sensitive (X), there are several observed variables that must be excluded from the measurement model because it has a Standardized Loading Factor value <0 ,50.

On the Indicator of Increasing Satisfaction (PKPS1) there is 1 statement that must be removed from the CFA model, namely the PKP5 statement, On the Indicator for Increasing Patient Autonomy (POPS5) there is 1 statement that must be removed from the CFA model, namely the POP3 statement, because the Standard Loading Factor value is less than 0, 50 so that the CFA model must be rectified.

Based on the results of the Second Order specification model for the measurement

of the Gender-sensitive Midwifery Service Latent Variable (X) above, all observed variables meet the requirements for use in the CFA model because all observed variables have a standard loading factor value above 0.50. The Standardized Loading Factor value of each statement on the latent variable Gender-sensitive Midwifery Services (X) is summarized as in the following table.

**Table 2. Standardized Loading Factor Second Order CFA Model Respecification Gender sensitive Midwifery Services Latent Variable (X)**

| <---Latent indicator | standardized loading Factor | Ctirical Value | Information |
|---|---|---|---|
| PKPS1 <--- Midwifery_Services_X | 0.952 | ÿ 0.50 | Valid |
| KAPL2 <--- Midwifery_Services_X | 0.977 | ÿ 0.50 | Valid |
| PKKR3 <--- Midwifery_Services_X | 0.951 | ÿ 0.50 | Valid |
| KIHM4 <--- Midwifery_Services_X | 0.968 | ÿ 0.50 | Valid |
| POPS5 <--- Midwifery_Services_X | 0.962 | ÿ 0.50 | Valid |
| Statement Item <--- Indicator | | | |
| PKP1 <---PKPS1 | 0.804 | ÿ 0.50 | Valid |
| PKP2 <---PKPS1 | 0.772 | ÿ 0.50 | Valid |
| PKP3 <---PKPS1 | 0.775 | ÿ 0.50 | Valid |
| PKP4 <---PKPS1 | 0.734 | ÿ 0.50 | Valid |
| KAP1 <--- KAPL2 | 0.786 | ÿ 0.50 | Valid |
| KAP2 <--- KAPL2 | 0.78 | ÿ 0.50 | Valid |
| KAP3 <--- KAPL2 | 0.759 | ÿ 0.50 | Valid |
| KAP4 <--- KAPL2 | 0.781 | ÿ 0.50 | Valid |
| KAP5 <--- KAPL2 | 0.743 | ÿ 0.50 | Valid |
| KAP6 <--- KAPL2 | 0.759 | ÿ 0.50 | Valid |
| PKK1 <---PKKR3 | 0.739 | ÿ 0.50 | Valid |
| PKK2 <---PKKR3 | 0.743 | ÿ 0.50 | Valid |
| PKK3 <---PKKR3 | 0.762 | ÿ 0 .50 | Valid |
| PKK4 <---PKKR3 | 0.744 | ÿ 0.50 | Valid |
| PKK5 <---PKKR3 | 0.721 | ÿ 0.50 | Valid |
| KIH1 <---KIHM | 0.787 | ÿ 0.50 | Valid |
| KIH2 <---KIHM | 0.759 | ÿ 0.50 | Valid |
| KIH3 <---KIHM | 0.76 | ÿ 0.50 | Valid |
| KIH4 <---KIHM | 0.743 | ÿ 0.50 | Valid |
| KIH5 <---KIHM | 0.758 | ÿ 0.50 | Valid |
| POP1 <--- POPS5 | 0.765 | ÿ 0.50 | Valid |
| POP2 <--- POPS5 | 0.757 | ÿ 0.50 | Valid |
| POP4 <--- POPS5 | 0.75 | ÿ 0.50 | Valid |
| POP5 <--- POPS5 | | ÿ 0.50 | Valid |
| POP6 <--- POPS5 | | ÿ 0.50 | Valid |
| POP7 <--- POPS5 | | ÿ 0.50 | Valid |

SLF = Standardized Loading Factor, nilai SLF yang baik≥ 0,50

CR= Construct Reliability, nilai CR yang baik≥ 0,70

AVE = Variance Extracted, nilai VE yang baik≥ 0,50

Based on the results of testing the measurement model Specification on the Gender-sensitive Midwifery Service variable (X), all manifest/statement variables meet the requirements to be used as measuring variables forming latent variables because they have a standard loading value of ≥ 0.50 so it can be concluded that all valid manifest/statement variables are used in measure or establish latent variables.

The Construct Reliability (CR) value of the Midwifery Service Variable is Gender sensitive (X) of 0.984 with an Average Variance Extracted (AVE) Value of 0.926. The Construct Reliability (CR) value of the Gender-sensitive Midwifery Service Variable (X) is greater than the minimum requirement limit for Indicator reliability (0.984≥ 0.70) and the Average Variance Extracted (AVE) mileage is greater than the Average Variance Extracted minimum requirement limit (0.926 ≥ 0 .50) it can be concluded that all indicators that measure/form the Gender-sensitive Midwifery Service Latent variable (X) have fairly good reliability.

The model fit test or Goodness of fit aims to measure the suitability of the research data with the research model in other words to measure the suitability of the observational or actual input (covariance/correlation matrix) with the predictions of the proposed model. Conformity Test Model Confirmatory Factor Analysis of Midwifery Services Variable Gender sensitive (X) can be seen in the following table:

**Table 3. Confirmatory Model Fit Test Variable Analysis of Gender-sensitive Midwifery Services (X)**

| **Absolut Fit Measure** | | | |
|---|---|---|---|
| Goodness-of-Fit | Cut-off Value | Result | Compalitibilty |
| p-value (Sig.) | > 0,05 | 0,171 | Good fit |
| GFI(Goodness of Fit) | ≥ 0,90 | 0,903 | Good Fit |
| RMSEA(Root Mean square Error of Approximation) | ≤ 0,08 | 0,015 | Good Fit |
| RMR(Root Mean Square Residual) | ≤ 0,05 | 0,015 | Good Fit |

| **Absolut Fit Measure** | | | |
|---|---|---|---|
| Goodness-of-Fit | Cut-off Value | Result | Compalitibilty |
| **Incremental Fit Measure** | | | |
| AGFI(Adjusted Goodness of Fit Index) | ≥ 0,90 | 0,889 | Marginal Fit |
| CFI (Comparative Fit Index) | ≥ 0,90 | 0,995 | Good Fit |
| Incremental Fit Index (IFI) | ≥ 0,90 | 0,995 | Good Fit |
| Relative Fit Index (RFI) | ≥ 0,95 | 0,917 | Marginal Fit |
| **Parsimonious Fit Measure** | | | |
| PNFI (Parsimonious Normed Fit Index) | Must be Small | 0,857 | Marginal Fit |
| PGFI (Parsimonious Goodness Of Fit Index) | Mendekati 1 | 0,789 | Good fit |
| AIC (Akaike Information Criterion) | < 1122,000 | 661,608 | Good Fit |
| CAIC (Consistent Akaike Information Criterion) | < 3718,095 | 990,170 | Good Fit |

Based on the output of the Exogenous Indicator Model Fitment Test, most of the fit model criteria are in the good fit category. Meanwhile, Latan (2012: 49) states that 4-5 criteria of good nest of fit are considered sufficient to assess the feasibility of a model, provided that each criterion of good nest of fit, namely absolute fit indices, incremental fit indices and parsimony indices is represented. Thus, it can be concluded that the good nest of fit test Confirmatory Model Factor Analysis of Gender-sensitive Midwifery Service Variables (X) can be accepted in other words the research data are in accordance with the research model.

**Conclusion**

Based on the research results and data analysis, it can be concluded that the Gender Sensitive Midwifery Care model is a midwifery care approach that focuses on efforts to empower women to eliminate gender inequality through strategies to increase women's welfare in accessing available resources, access to health services, critical awareness, participation women in making decisions on their reproductive rights, as well as the existence of women's control or autonomy. The availability of Gender Sensitive Midwifery Care models can be applied in reproductive and sexual health services.

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