

# The Study of Male Reproductive Health in Surabaya City

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**Abstract**—Increase male participation in reproductive health in line with efforts to develop family quality based on gender equality. This study aimed to determine the knowledge of men about reproductive health. The study was conducted in two sub-districts in Surabaya, namely Tegalsari representing urban areas and Tandes representing sub-urban areas. The population of this study was married male. Sampling using multistage random sampling. These randomly selected respondents came from urban and sub-urban areas respectively. Questionnaire data were then analyzed using Chi-square statistical test. The results stated that there was no difference between respondent knowledge in reproductive health in urban and suburban areas. Education levels clearly distinguish their knowledge of reproductive health in urban areas, but not in suburban areas.

**Keywords**— knowledge, male, reproductive health

## I. INTRODUCTION

The success of the Family Planning Program as an effort to regulate birth in the context of improving the welfare of mothers and children in Indonesia has been recognized by the wider community. The success of the Family Planning Program reduces the birth rate, it needs to be followed up by efforts to civilize the Prosperous and Happy Small Family. This means the pressure of the Family Planning Program is not only on the use of contraceptives but also on the culture of reproductive health.

Efforts to achieve reproductive health will be achieved if individual reproductive rights are protected. The reproductive rights according to [1] are human rights which include three basic rights: First, the right of each person or husband and wife to be responsible and determine how many children are wanted and the right to obtain information about everything; Second, the right to sexual and reproductive health insurance; and Third, the right to make decisions free of discrimination, coercion and violence.

[2] stated summarize models and frameworks developed to conceptualize youth participation, and assess research that has attempted to evaluate the implementation and impact of youth participation in the field of sexual and reproductive health and rights (SRHR). And youth participation in program and policy development should still be a priority.

According to [3] stated These approaches promote alternative norms and understandings of masculinity and behaviors in intimate relationships that involve mutual respect and equitable decision making, sharing responsibilities for reproductive health (e.g., condom use), and the greater involvement of men as fathers.

According to [4] stated in Portugal Adolescents today have more and more access to information; however, there seems to be a certain mismatch between the information provided and the level of knowledge about sexually transmitted infections as well as assuming attitudes that promote sexual and reproductive health. For this reason, instructional interventions with various networked training agents, such as within the and peers, should be structured. These interventions should be monitored using tools that will evaluate the educational impact in terms of knowledge about sexually transmitted infections. This training must also be sensitive to adolescents aspirations and concerns. Analysing the results by gender, the t-test for independent samples reveals that girls have much more knowledge about sexually transmitted infections than boys, with explanatory t value.

[5] stated students who had sex education in school mentioned more often having had fewer sexual risk behaviors (less occasional partners, less sex associated to alcohol and drugs, less STIs, less unwanted pregnancies and abortions). Most young people have the reasonable knowledge, positive attitudes about contraception/STIs, and skills of condom use. Our study demonstrates positive associations between receiving sex education and protective sexual behaviors, knowledge, motivation, and skills.

Indonesia has a marriage law [6]stated that the husband is the head of the family, and the wife is the head of the household. In article 34, verse 1 stated that the obligation of the husband is to provide necessities of life for the family, while the wife's obligation is to maintain and keep the child. From the article shows that the role of men in the production field, and the role of women in the reproduction field.

In the marriage law, there is a difference of age for marriage between men and women. The minimum marital limit for women is 16 years, while men are at least 19 years.

This difference certainly has an impact on sexual health and reproductive health. Referring to the marriage law, as mentioned above, shows that women, as a wife is positioned under men.

The results of the annual meeting between BKKBN districts with BKKBN provinces in the BKKBN office of East Java province [7] stated that the role of husband (Father), mother health, and reproductive health requires serious attention. To realize the success of reproduction health culture according to [8] need to involve and increase men participation, because reproductive health problem not only related to physical health of mother and child free from disease or disability but also related to mental health and social welfare as a whole all matters relating to reproductive systems, functions, and processes. Increased male participation in reproductive health is also in line with the effort to build a quality family based on gender equality and justice.

## II. RESEARCH METHOD

This study was an observational study because of the absence of treatment on the subjects of study and using a sectional cross design. This study was conducted in Surabaya City. The study population was a married male adult. Sampling was done by multistage random sampling with the following conditions: (a) Surabaya city was divided into two major groups namely urban and suburban, so there were two strata. (b) From each stratum randomly selected one sub-district, which will be the location of the study, (c) From each selected sub-district (Tegalsari sub-district as an urban area, Tandes subdistrict as sub-urban area), some sub-subdistrict was taken randomly. (d) From selected sub-subdistricts (Tegalsari subdistrict: Tegalsari, Dr. Sutomo, and Wonorejo sub-subdistrict) Tandes subdistrict: Manukan Kulon rich and Tandes Lor sub-subdistrict) were randomly taken from 200 married adult male.

The variables used in this study were : 1) characteristic of respondent, including age, respondent's education, respondent's occupation, 2) Knowledge of reproductive health included about age of marriage, contraceptive, signs of puberty, fertility age, safe age of delivery, distance of birth, high risk of pregnancy, sexually transmitted diseases and modes of transmission, abortion and its dangers.

The data was collected by using interviews by using questionnaires. Data that has been collected then tabulated. Data of knowledge was then scored. Each variable indicator was summed, so it is known the number of scores from each respondent. Each score was summed and averaged then categorized under the following conditions : (1) If the score of respondents was below the average then it was categorized as less, (2) If the respondents score above average was categorized as good.

Data obtained was analyzed descriptively by considering the relationship and the relation of various items. While to know the difference and relationship of variables in each region analyzed by Chi-Square

## III. RESULT AND DISCUSSION

### A. RESULT

#### 1. Respondent's Knowledge of Reproductive Health

The calculation result of knowledge and scoring obtained the results as shown in Table 1 below:

TABLE 1. DISTRIBUTION OF RESPONDENT'S KNOWLEDGE ON REPRODUCTIVE HEALTH BASED ON RESPONDENT REGIONS

Knowledge	Tegalsari subdistrict		Tandes subdistrict	
	Freq.	%	Freq.	%
Less	57	57%	60	60%
Good	43	43%	40	40%

Source: Primary data, 2003

Table 1 above it can be seen that 57% of respondents in Tegalsari subdistrict had less knowledge about reproductive health, and 60% of respondents in the subdistrict. 43% of respondents in Tegalsari subdistrict had good knowledge about reproductive health and 40% of respondents in Tandes subdistrict.

There were still many respondents who did not know the contraceptives such as spiral, diaphragm, tissue, jelly, and sterilization in women and men. Most of the respondents also did not know the high risk in women such as height less than 145 cm, age under 20 years and above 30 years, and the number of children more than four. Similarly, knowledge of some of the signs of puberty in men and women, the dangers of abortion, and the reasons allowed having an abortion.

Some of the respondent known enough about the age of first marriage in women associated with safe age of delivery in women, partial signs of puberty in men and women, fertility age in men and women, sexually transmitted diseases, and knowledge of abortion.

If the knowledge of respondents is seen based on the characteristics studied, then obtained the results as follows:

#### 1. Knowledge of reproductive health based on respondent's education

By using Chi-Square test, it was found that in Tegalsari subdistrict there was a difference of knowledge about reproduction health between respondent with the education of junior high school and lower, and senior high and above with significance level of 0.053 (less than  $\alpha = 10\%$ ) and Chi-Square value = 3.728. In contrast to Tandes subdistrict, there were no significant differences between respondent with education lower than junior high school and above senior high with a significance level of 0.139 (greater than  $\alpha = 10\%$ ) and Chi-Square = 2.195.

TABLE 2. DISTRIBUTION OF RESPONDENT'S KNOWLEDGE ON REPRODUCTIVE HEALTH BASED ON EDUCATION AND RESPONDENT REGIONS

Education	Tegalsari subdistrict		Tandes subdistrict	
	Less	Good	Less	Good
Junior high school	17	5	18	6
Senior high school	49	38	42	34
Chi-square value	3.728		2.195	
p value	0.053		0.138	

Source: Primary data, 2003

## 2. Knowledge of reproductive health based on respondent region

Distribution of data and statistical test resulted (by using Chi-Square test), which try to see whether or not the difference of respondent knowledge about reproductive health based on respondent region, is as follows:

TABLE 3. DISTRIBUTION OF RESPONDENT'S KNOWLEDGE ON REPRODUCTIVE HEALTH BASED ON RESPONDENT REGIONS

Knowledge	Region	
	Tegalsari	Tandes
Less	57	40
Good	43	69
p value	0.082	0.774

Source: Primary data, 2003

Table 3 above shows that respondents from urban areas had the same knowledge about reproductive health with respondents from the suburban areas with a significance level of 0.774.

### B. DISCUSSION

From the results of the study found that the knowledge of respondents about reproductive health was almost balanced between less knowledge and good knowledge. The level of education turned out to distinguish knowledge about reproductive health. The respondent with senior high and above had a higher knowledge than respondent with education junior high school and lower, this condition related to the education level of respondents, most of the respondents were senior high school and above, so the experience in finding knowledge was more and longer.

In line with [9] stated in Uganda, knowledge of other sexually transmitted infections (STIs) improved but remains low; only half of the respondents know signs and symptoms of STIs, and less than half know what action to take when infected youths represent 20% of the population, and the burden of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), is substantial. Youths knowing where to get HIV tests increased from <40% to 80% (both sexes); the number of youths reporting ever having an HIV test increased from 8% to 48% (males) and 10% to 64% (females). Similarly with adolescents in Malaysia as stated by [10] lack of knowledge about sexuality and reproductive health in Malaysian adolescents.

[11] stated The community-based friendly health clinic (CFHC) with manual participatory learning (MPL) intervention can improve the ARH knowledge, attitudes, and skills of adolescents in the rural area, but can only improve the adolescent reproductive health (ARH) knowledge of adolescents in the urban area. The ARH program must be designed based on the characteristics of

these adolescents to improve their life skills during puberty. [12] stated involving men in reproductive health can lead a positive influence in strengthening relationship as a couple and improve better health to families.

### IV. CONCLUSION

Based on the above description, it can be concluded that there was no difference in respondents' knowledge about reproductive health in the urban and suburban region. Education levels clearly distinguish their knowledge of reproductive health in urban areas, but not in suburban areas.

### ACKNOWLEDGMENT

This research can be completed with the assistance of FISH UNESA through faculty policy funds in 2017.

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