Artikel 7

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Peer educator trainning programme for enhancing their knowledge on issues around growth and development of adolescents and its risk behavior problems in Indonesian context

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Abstract

Objective: This article was to evaluate the effects an educational intervention programme on improving peer educator (PE) knowledge in issues around growth and development and its risk behavior problems of adolescents in Indonesia.

Methods: The study was conducted with 31 of PE to evaluate their knowledge in adolescents. The PE received health education and were assessed by individual work during the structured three-week programme. Data were collected before and after the training programme as pre- and post-tests.

Results: The PE demonstrated significant improvements in their knowledge after attending the three-week structured training programme. The post-test scores had significant effects on the

dimensions of PE knowledge scores. The PE become knowledgeable to maintain and monitor adolescents health issues around growth and development and its risk behavior problems of adolescents.

Conclusion: The PE become knowledgeable to respond the adolescent problems and readiness become PE during puberty.

Keywords: peer educator, adolescent development, risk behavior, assertive

1. Introduction

Adolescents are trying to the new challenging behavior that influenced their growth and development, in particularly in adolescent reproductive health issues.[1] This situation placed adolescents become vurnerable population that needed attention from parents[2] and schools[3] to prevent the risk behaviors. Meanwhile, in its development, the behavior of adolescent reproductive health is strongly influenced by peer group, both descriptive norms (peer sexual behaviors), injunctive norms (peer sexual attitudes), and peer pressure to have sex and adolescent sexual behavior outcomes (sexual activity and sexual risk behavior)[4], even though sexual behavior may be universal, which links early maturation with risky peers regardless of adverse life experiences.[5] Therefore, peer-based interventions may be best suited to the needs of at-risk adolescent behavior and issues around growth and development in the school educational promotion program.

Meanwhile, WHO promotes school health programmes as a strategic means to prevent important health risks among youth and to engage the education sector in efforts to change the educational, social, economic and political conditions that affect risk.[6] In Indonesian context, the Ministry of Health of Indonesia in 2007 lauched the Adolescent Friendly Program (Pelayanan Kesehatan Peduli Remaja/PKPR in Indonesian language) with the aim of fostering

the knowledge, attitude, skills of adolescents health[7], although this program have limited to implement in Indonesian context, because the reproductive health issues in adolescents was taboo to discuss based on social, cultural and religion in Indonesia.[8] Evidence based shown that sexuality education in schools can assist students as they navigate the physical and developmental processes of adolescent sexuality[9], while school health promotion could be change knowledge, attitude, and skills of student in clean and healthy living behavior in Indonesia.[10] Therefore, schools environment should be empowerment of adolescent to be peer educator to promote positive youth development.

Furthermore, peers could be a facilitator for adolescents to gain further insights into their knowledge, attitudes, and skills related issues around growth and development and its risk behavior problems of adolescents. Peers are trainned through educational program in the school context to improve their capabilities as change agent in their peer groups. Therefore, the purpose of this study was to evaluate the effectiveness of a structured educational intervention in adolescent health to enhance peer educators' adolescent health with regard to their knowledge on growth and development of adolescent and its risk behavior problems, as well as their knowledgeable, related services on adolescents program in schools. The ultimate objective is to enhance the quality of peer councelor capabilities in East Java, Indonesia.

2. Materials and methods

This study made use of quantitative approaches. The quasi-experimental design with pre- and post-tests and repeated measures involved 31 PE from 49 community health center (CHC) of Jember, East Java province, Indonesia. This study have approved ethical approval from University of Jember of Research Center as the institution's ethical review committee prior to starting the data collection. The researchers conducted the study to evaluate the PEs' knowledge in growth and development of adolescent and its risk behavior problem, and then

to be knowledgeable for a target group in the youth school centre in the last week of the intervention programme. A validated self-assessed of PEs' knowledge was used as a tool to measure the PEs' knowledge in growth and development of adolescent and its risk behavior problems before and after the three-week educational intervention. The validated self-assessment was explained in below.

Pre- and post-tests including demographics, a questionnaire on the PEs' knowledge in growth and development, nutrition, deliquency, smoking, reproductive health, free sex, pregnancy, HVI/AIDs and assertive behavior were used to evaluate changes in the PEs' knowledge after attending a structured PE educational intervention. The 31 PE achieved statistically significant higher median knowledge scores in the post-test phase. The majority showed increased knowledgeable and awarness after participating in the structured PE educational intervention.

The Ministry of Health of Indonesia in 2007 lauched the Adolescent Friendly Program (Pelayanan Kesehatan Peduli Remaja/PKPR in Indonesian language) with the aim of fostering the knowledge, attitude, skills of adolescents health. These program under supervision of community health center that implemented in school health program. The public health nurses (PHNs) in CHC are trainned 3 to 5 students from each schools in their CHC areas as PE. After PE have trainned, they should be planning and implement of health education for all of students in their schools to teach about adolescent health topic regarding from the trainning. Every months, PHNs will supervise the program in each schools.

35

This study was conducted in Jember, East Java province of Indonesia. In this area have 49 CHC, therefore we invaited 49 CHC to send one student from senior high schools to follow PE educational training programme. Thirty-one participants were recruited, with permission, from

40

the Department of Education and Department of Health in East Java. The participants were a

convenience sample of PEs (n = 31) aged 16–17 years old, recruited from 10 schools, who enrolled in this three-week PC educational training programme. The response rate was 63.3%.

A three-week educational training programme on adolescent healthcare was delivered for 31 of the PEs. The purpose of this study was to examine the PEs' knowledge in in issues around growth and development and its risk behavior problems of adolescents after joining the threeweek PEs' training programme. The programme planning committee, comprising three nursing academic colleagues in promoting adolescent health and a Department of Health as technical officer specialising in adolescent health, implemented the programme based on an PKPR program[7] into the curriculum for PEs' trainning. The educational tranning program was described in Figure 1.

Table 1. Description of educational intervention on issues around growth and development and its risk behavior problems of adolescents modules

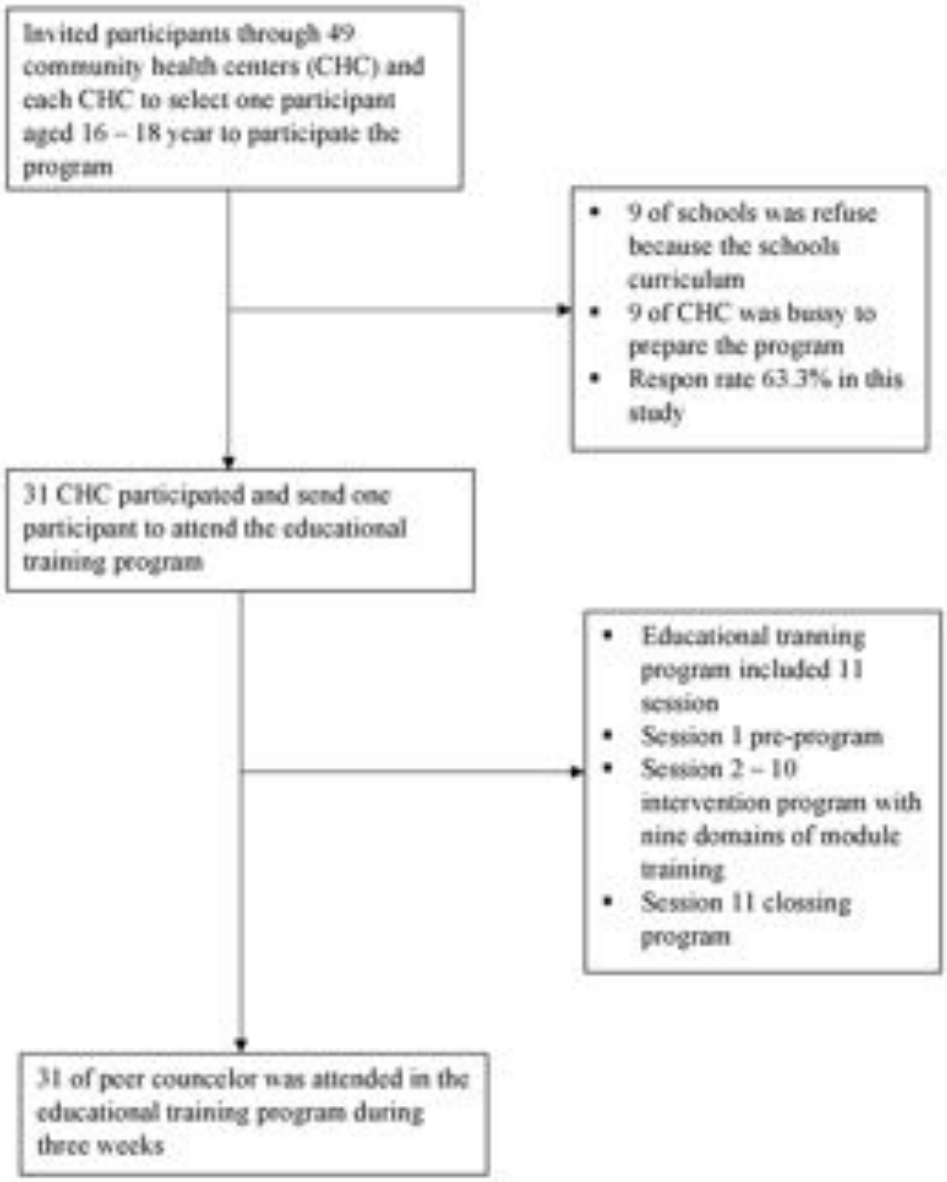
Domain of knowledge in adlescent health	Description
Growth and development	Adolescent development entails the biological, psychological and emotional changes that occur in human beings during adolescents.
Nutrition	For life and the process of growth and development, the human body requires a diverse diet consisting of nutrients, namely carbohydrates, proteins, fats, vitamins, minerals, water, fiber in a balanced amount.
Deliquency	A person's behavior or actions that are not appropriate or prohibited by the norms or provisions that apply in the community or the environment according to age but not violate the rules or provisions of applicable law.
Smoking	The pattern of tobacco use behavior among adolescents without control.
Reproductive health	Comprehensive health, including physical, mental, and social aspects, and not just the absence of disease or disorder in all matters relating to the reproductive system, function, and process itself.
Free sex	Sexual intercourse between men and women without any legal attachment / marriage either religious or legal. Usually based on likes and often change pairs.
Pregnancy	The occurrence of conception (the inclusion of spermatozoa into the egg / ovum). Occurred in Ampula

	Tuba Falopii. The result of conception is called a *zygote*. It develops in the womb until it is born as a baby.
HIV/AIDs	A collection of symptoms of illness due to a person experiencing immune system deficiency due to damage caused by the HIV virus.
Assertive behavior	The ability of teens to express their feelings without having to offend others.

The study endorsed and systematically integrated these lessons into the training programme focusing on adolescent health with needs (growth and development, nutrition, and reproductive health), assesment of risk behavior problems (deliquency, smoking, free sex, pregnancy, and HIV/AIDs), and assertive behavior to enhance the PEs' knowledge in planning adolescent health service delivery in the schools. The training manual and lecture notes were used and adopted from PKPR Handbook of tranning[9] for this training curriculum.[11] Table 1 gives a detailed description of the intervention modules, which comprised a three-week intervention schedule of lecture sessions, small group discussions, presentations, project planning and quizzes.

The PE were informed as to the date, time and location of the training programme by post letter through the head office of CHC. During registration on day 1, the information sheet was given to the PE and the researchers addressed any questions raised. The PE who decided to participate in the research study were asked to sign consent forms. Each PE was given a research number to ensure confidentiality. A questionnaire with demographic questions and the PEs' knowledge issues around growth and development and its risk behavior problems of adolescents was distributed to the participants on day 1 as the pretest phase. The training days lasted two hours including thirty minutes for coffee break and the entire course lasted three weeks for three days a week. The same questionnaire was readministered to participants on the last day of the three-week programme. The schedule of educational trainnig program was described in the Table 2.

Figure 1. Research design of educational trainning program



A validated self-assessed the PEs' knowledge issues around growth and development and its risk behavior problems of adolescents[7] was used as a tool to measure the PEs' knowledge before and after the three-week educational intervention. The instrument in this study adopted module of PKPR from Minishtry of Health Indonesia.[7] The study outcome was an evaluation of the PEs' knowledge in nine components, including: growth and development, nutrition, deliquency, smoking, reproductive health, free sex, pregnancy, HVI/AIDs and assertive behavior after attending a structured PE educational intervention. The nine components were assessed 10 question with multiple choices answers. The participants were choised the best answer, with range the right answer= 1, and the wrong answer=0. Each components of the PEs' knowledge were summed for the analyses, the high scores were indicated high knowledgeable of level on adolescent health.

Table 2. Schedule of the educational trainning program

Session	Description
Session 1	• Explanation of program • Inform consent the study • Pretest knowledge in issues around growth and development and its risk behavior problems of adolescents (nine domains)
Session 2	Domain 1: The growth and development • Explain the dimension of growth and development • Measurement the height and weight • Identify the secondary sexual development • Identify the psychological aspect during puberty
Session 3	Domain 2: Nutrition • Explain the importance nutrition for adolescents • Discuss issues about stigma of weight among adolescent "size doesn't matters" • Make a balaced menu for adolescents
Session 4	Domain 3: Deliquency • Identify the kind of deliquency • Discuss negative impact of deliquency for adolescent • Make a rule to prevent deliquency based on the schools regulation
Session 5	Domain 4: Smoking • Identify the smoking behavior among adolescent • Discuss issues of masculinm and feminism around smoking behavior • Make a program to free smoking area in schools

Session 6	Domain 5: Reproductive health • Explain the issues around reproductive health among adolescent • Discuss to make healthy around reproductive health during puberty • Discuss how to hygiene in menstruation and nocturnal emmision • Identify the anatomy the organ of reproductive and their function and also the problems during puberty
Session 7	Domain 6: Free sex • Identify issues of sexual behavior among adolescents • Discuss about cultural and social issues around sexual behavior in adolescents • Identify family norms and religion to prevent negative sexual behavior • Make a program "Say no free sex"
Session 8	Domain 7: HIV/AIDs • Explain the HIV/AIDs among adolescent • Discuss the program to prevent HIV/AIDs in adolescents
Session 9	Domain 8: Pregnancy • What is pregnancy and how it happen? • Discuss the impact pregnancy during adolescent • Make a program to family planning in the future
Session 10	Domain 9: Assertive behavior • What is dimenssion of positive youth development • How we become be assertive in adolescent? • Role play to be assertive youth behavior
Session 11	• Post test • Clossing educational trainning program

Descriptive statistics were used to compute the study sample's demographic characteristics. The Shapiro–Wilk test was adopted to examine the normality of the PEs' knowledge scores, with the results suggesting that nonparametric tests were suitable. The Wilcoxon signed-rank test was used to evaluate changes in each components of knowledge score between the pre- and post-outcomes in this group. The Mann–Whitney U test was used to evaluate variances in each knowledge score for the groups both pre- and post-test. All statistical analyses were performed using SPSS, version 22.0 (Statistical Package for Social Science, Version 22.0).

3. Results

Among 31 participants, 61.3% were girls, 71.0% were 16 years aged (16 – 17 year), 61.3% were Jawa etnic (Jawa nad Madura ethnic) and 93.5% were Islam religion.

Table 2 shows the results of the pre- and post-tests of the knowledge of adolescent health based on PKPR module[7] for the 31 PE in this study. The overall scores, mean (M) and standard deviation (SD) of the knowledge of compoenent module variables increased from the pretest to the posttest in the PC knowledge questionnaire (Mean = 46.71, SD = 6.14 to Mean = 61.94, SD = 4.10) and its nine domains: the growth and development domain (from M = 6.39, SD = 1.15 to M = 7.65, SD = 1.14), the nutrition domain (from M = 6.13, SD = 1.18 to M = 7.52, SD = 0.77), the deliquency domain (from M = 5.32, SD = 1.19 to M = 7.26, SD = 1.26), the smoking domain (from M = 6.19, SD = 1.49 to M = 7.48, SD = 0.93), the reproductive health domain (from M = 3.19, SD = 1.08 to M = 5.81, SD = 0.98), the free sex domain (from M = 5.19, SD = 0.83 to M = 6.19, SD = 0.98), the HIV/AIDs domain (from M = 5.52, SD = 0.93 to M = 7.19, SD = 0.87), the pregnancy domain (from M = 3.61, SD = 1.36 to M = 5.74, SD = 0.97), and the assertive domain (from M = 5.16, SD = 1.23 to M = 7.10, SD = 1.27). The higher the score in each subscale, the greater the improvement in knowledge in issues around growth and development and its risk behavior problems of adolescents.

Tabel 3. Comparison of peer councelor knowledge in pre- and post-tests after attending three-week educational intervention

Nine components (modules) of the peer councelor trainning	Pretest (n= 31)		Post-test (n= 31)		Z	p
	Range	Mean (SD)	Range	Mean (SD)		
1.Growth and development	4 – 8	6.39 (1.15)	5 – 10	7.651.14)	–3.97	<0.001*
2.Nutrition	4 – 8	6.13 (1.18)	6 – 9	7.52 (0.77)	–3.96	<0.001*
3.Deliquency	4 – 7	5.32 (1.19)	5 – 10	7.26 (1.26)	–4.68	<0.001*
4.Smoking	4 – 9	6.19 (1.49)	6 – 9	7.48 (0.93)	–4.40	<0.001*
5.Reproductive health	1 – 6	3.19 (1.08)	4 – 8	5.81 (0.98)	–4.92	<0.001*
6.Free sex	3 – 6	5.19 (0.83)	4 – 8	6.19 (0.98)	–4.49	<0.001*
7.HIV/AIDs	4 – 7	5.52 (0.93)	5 – 8	7.19 (0.87)	–4.89	<0.001*
8.Pregnancy	1 – 6	3.61 (1.36)	4 – 7	5.74 (0.97)	–4.66	<0.001*
9.Assertive behavior	3 – 7	5.16 (1.23)	5 – 9	7.10 (1.27)	–4.84	<0.001*
Total score of nine domains	37 – 59	46.71 (6.14)	54 – 71	61.94 (4.10)	–4.87	<0.001*

Note.

Wilcoxon signed-rank test.

The nine components (modules) of the peer councelor trainning subscale consists of 10 items; scores ranged from 0 – 10, higher the scores, higher the knowledgeable level.

Total, sum of nine subscales of the peer councelor; the total scores ranged from 0 – 90, higher the scores, higher the knowledge level.

*p<0.005.

Wilcoxon's signed-rank test was used to examine whether there were any significant differences in the knowledge variables between the pre- and post-test scores of the nine domains. There was a significant increase from the pre- to the post-test in the total score for the variables in the PKPR module ($Z = -4.87$, $p < 0.001$) and its nine aspects: the growth and development domain ($Z = -3.97$, $p < 0.001$), the nutrition domain (($Z = -3.96$, $p < 0.001$), the deliquency domain ($Z = -4.68$, $p < 0.001$), the smoking domain ($Z = -4.40$, $p < 0.001$), the reproductive health domain ($Z = -4.92$, $p < 0.001$), the free sex domain ($Z = -4.49$, $p < 0.001$), the HIV/AIDs domain ($Z = -4.89$, $p < 0.001$), the pregnancy domain ($Z = -4.66$, $p < 0.001$), and the assertive domain ($Z = -4.84$, $p < 0.001$). When examining the changes in PE' knowledge in issues around growth and development and its risk behavior problems of adolescents between the pretest and the post-test, significant differences were found in all of the adolescent health knowledge domains: (1) the growth and development subcale, (2) the nutrition subscale, (3) the deliquency subscale, (4) the smoking subscale, (5) the reproductive health subscale, (6) the free sex subscale, (7) the HIV/AIDs subscale, (8) the pregnancy subscale and (9) the assertive subscale, as shown in Table 3.

4. Discussion

In this study, the PE demonstrated significant improvements in their knowledge after attending the three-week structured training programme. The post-test scores had significant effects on the dimensions of the PE knowledge scores. The PE become knowledgeable to maintain and monitor adolescents health issues around growth and development and its risk behavior problems of adolescents. These findings are consistent with previous study in the context of participants' skills development as HIV prevention peer educators in their communities.[12]

The overall scores of the knowledge of compoenent module variables increased from the pretest to the posttest in the PC knowledge questionnaire and its nine domains. These findings are consistent with previous study in the context of peer education approach in the program PIK-KRR (Pusat Information dan Konseling Kesehatan Reproduksi Remaja in Indonesian language) became the entry point in the adolescent reproduction health education.[13] The results were reflected that the higher the score in each subscale, the greater the improvement in knowledge in issues around growth and development and its risk behavior problems of adolescents. This situations was supported that media for peer education trainning was effectively to facilitate the education trainning program. In peer education, the PE become more confidence to learn about adolescents health issues.[14] It was proven that they were more comfortable and open to discuss the matters pertaining to the issues around adolescents health with their peers. They considered their peer as having emotional closeness, equal knowledge level and being in common culture of social solidarity in which one's problem was also other's. Therefore, the peer educator trainning program is effective method to transfer the right and reliable information of the issues around growth and development and its risk behavior problems of adolescents. The peer educators played an important role in promoting, educating and counseling their peers in the issues around growth and development and its risk behavior problems of adolescents.

There was a significant increase from the pre- to the post-test in the total score for the variables in the PKPR module and its nine aspects. When examining the changes in PE' knowledge in issues around growth and development and its risk behavior problems of adolescents between the pretest and the post-test, significant differences were found in all of the adolescent health knowledge domains. These results are consistent with previous study that peer educators' enthusiasm and satisfaction with their educator role, very few postintervention changes in knowledge, communication with parents about topics covered in the course, self-

efficacy, perceived peer norms, or intentions to have sex were obtained.[15] This findings may be reflect that adolescent in peer groups can learn through theirself by lecture sessions, small group discussions, presentations, project planning and quizzes in the schools context.[16] Previous study reported that peer to peer model were effective as community strategy for improvement adolescent reproductive health[17] that supported through game therapy as media information of education of health.[18] This situation indicated that media education in trainning are important to improve the PE knowledge, although the contents of education trainning should be related to cultural, social and religion context of PE[19] and needed a encouragement from family.[20] This finding suggests that peer educator should be implement the health educational for adolescents based on school health program.

The current study was have several limitations. First, the participants is not representative that respond rate are low in this study to generalize the findings. Second, the questionnaire of knowledge PE are needed to impovement as tools standard development, although in this study, we developed this questionnaire based on PKPR module. Third, the data were collected in quantitative study that PE's perception during the trainning education program are not identified. Therefore, the mixed method study should be done in the future to compare the quantitative and qualitative data. Thus, a participatory action research could be done to evaluate the PE trying the peer education in the schools health program.

5. Conclusion

This educational intervention can improve knowledge of issues around growth and development and their risk behavior problems among PE. The PE become knowledgeable to respond the adolescent problems and readiness become the PE during puberty after participating in the three-week intensive intervention programme. Therefore, the PE should be implement the health educational for adolescents based on school health program. Thus, to

evaluate a self confidence and the sustainability of program, a participatory action research could be done to evaluate the PE trying the peer education in the schools health program.

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GENERAL COMMENTS

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PAGE 1

PAGE 2

PAGE 3

PAGE 4

PAGE 5

PAGE 6

PAGE 7

PAGE 8

PAGE 9

PAGE 10

PAGE 11

PAGE 12

PAGE 13

PAGE 14

PAGE 15

PAGE 16

PAGE 17