

Implementation of Reproductive Health Module Design Childhood on Family

Atit Tajmiati Wiwin Mintarsih Dede Gantini Yulinda
Lecturer in Health Ministry Health Polytechnic, Tasikmalaya, West Java, Indonesia

Abstract

Media development for reproductive health education to children with parents as the target of the subject is important. The purpose of this study is to describe the design of the modules of reproductive health education in early childhood in the family, describes the implementation of module design of reproductive health education in early childhood in the family, and describes the final product modules reproductive health education in early childhood in the family through the attitude and knowledge. The location was chosen as a place of research, namely Tasikmalaya and Bandung. The population in this study is a family of young children who come from six health centers in the city Tasikmalaya six health centers in the city of Bandung. Number of samples in this study are 295 families were determined by purposive sampling using questionnaires. Mechanical analysis using univariate and bivariate analysis. The results showed that the design of the module is done through the stages of development and tested on targets as well as expert consulting and validation of the validator, educational modules have been designed otherwise very decent team with an average assessment of respondents 82.41, and educational modules have been designed giving the impact of increased knowledge and attitudes meaningful significance level p value of 0.000.

Keywords : module, reproductive health, family

1. Introduction

Indonesia Demographic Data Survey results in 2007 showed the number of early marriages in Indonesia reached 50 million people with an average age of 19.1 years of marriage. Research University of Indonesia and the Australian National University in 2010 said as many as 20.9 percent of the young women in Indonesia have become pregnant outside of marriage because sex and 38.7 percent had early marriage. Other data from the Demographic and Health Survey data Indonesia in 2012 put the number of young women who give birth in the village as much as 69 per 1,000 young women in urban areas and 32 per 1,000 girls (Fadliyana & Larasati, 2009). Data from the Indonesian Child Protection Commission in 2010 claimed 32% of adolescents aged 14-18 years in Jakarta, Surabaya, and Bandung had sex. The results of the survey in 2012 stated, 1 in 4 teens Indonesia had sexual intercourse before marriage, 62.7% of teenagers losing virginity while still in junior high school, and even 21.2% of them had an abortion (Sartika et al., 2013).

Cases of abortion in Indonesia is also increasing every year. Based on data released by the National Family Planning Coordinating Board, estimated that each year the number of abortions in Indonesia reached 2.4 million, even 800 thousand of them occurred among adolescents (BKKBN, 2012). Data Indonesian Child Protection Commission (KPAI) states that the incidence of abortion in 2010 about 2.5 million people, as much as 62.6% abortion are adolescents aged 15-24 years (Dimiyati, 2012).

Data from police Resort Tasikmalaya, the incidence of sexual intercourse or lewd acts in Tasikmalaya in 2014 as many as 55 cases, 25.5% occurred in the age of 2-4 years, 23.6% occurred in the age of 6-12 years, 50% in age 13-20 years. Most abusers are people known by their victims, approximately 30% is the family that is the biological father or stepfather, and approximately 60% are others that peers, neighbors or strangers. Tasikmalaya HIV positive cases in 2014 to 56 cases (Dinkes, 2014). While in Bandung forms of violence that occurred from 2008-2014 reporting year, the psychic violence has increased every year, where in 2014 the highest psychic violence of 120 cases. Physical abuse also increase each year by 2014 as many as 40 cases. As many as 26 cases of sexual violence and economic violence highest in 2014 which amounted to 107 cases. From the number of cases managed by the Integrated Services Center for Women and Children at Bandung has a status: completed cases, still in the process, closed / referenced and does not continue and types of violence against children in the year 2014 as many as 60 cases.

Sexual behavior has a risk of adverse health and the consequences of academic for teens and young adults, such as transmitted infections (Grossman et al., 2014), unwanted pregnancy (Kahn et al., 2002; Kaestle et al., 2005), and broke schools (Von Ranson, 2000). Evidence shows that comprehensive sex education program based schools related to the reduction of risky adolescent sexual behavior (Frisco, 2008; Stewart et al., 2009). Some programs also offer the opportunity for parental involvement in the communication with their adolescent sexuality (Chin et al., 2012).

The unavailability of accurate information about reproductive health and the right to force children and teenagers to seek access to and exploration of its own. Media Internet, television, magazines and other forms of media are often used as a source by the youth to meet the demands of sexual curiosity. Parents and families also

take responsibility in providing information on reproductive health for children and adolescents have not served (Pontoh, 2013). Early adolescence is a key time to provide sex education and safe internet education for boys and girls to improve their sexual health (Tseng et al., 2015). Media should provide information about health care providers, particularly those in the mental health, are in an optimal position to improve the sexual health of physical, developmental, emotional and girls (Teitelman et al., 2009). Developments of the media to disseminate information on reproductive health in children and youth either at school or through electronic media outside the school has been developed. But still a bit of media and methods designed and developed to hold onto the parents in providing reproductive health education to children who can be used for all people in Indonesia, even special education to equip parents with the information and skills how to deliver education right on reproductive health and sexuality in children has not been done (Bambang, 2014).

Education about reproductive health and sexuality need to be delivered in a warm family atmosphere, providing the correct and scientific information, communicate with simple language that children understand (Bambang, 2014). Family involvement in order to promote sexual health for teenage son to do with long-term study (Yu, 2007; Grossman et al., 2013; Grossman et al., 2015). Active communication between parents and teens about sexuality can reduce early sexual behavior (Grossman et al., 2015; Grossman et al., 2016). Therefore, it is necessary to develop media for reproductive health education to children with parents as the target subject. So expect parents quite competent and have sufficient skills in providing reproductive health education to children in the family.

2. Literature review

2.1. Reproductive health

Reproductive health is an important component of health for both men and women but is more focused on women. The state of the disease in women are much more related to the function and capability to reproduce and the social pressure on women because of gender issues. Kusmiran (2011) for women's health is more than reproductive health.

According to the International Conference on Population and Development (ICPD) in Cairo, in 1994 that reproductive health is a physical, mental, social intact on all matters relating to the systems, functions and processes of reproduction and not just conditions that are free from disease or disability (Kusmiran, 2011). Referring to the concept put forward in the ICPD, the Ministry of Health of the Republic of Indonesia (2001) provide an understanding of reproductive health is a state of overall health including physical, mental and social life related tools, functions and processes of reproduction. Thought reproductive health is not only a condition that is free of disease, but rather how one can have a safe sex life and satisfying before and after marriage.

2.2. Reproductive health education

The primary mission of education according Syahidin (2005) there are three, namely the inheritance of knowledge (transfer of knowledge), cultural inheritance (transfer of culture), and inheritance value (transfer of value). Thus, education can be understood as a process of transformation of values in the context of the formation of personality with all aspects covered. Gunarsa (2004) stage of age in providing reproductive health education should be done from an early age.

2.3. Role of families / parents in reproductive health education

Parents are obliged and was instrumental in educating children toward social life. Social life can achieve welfare for all members of society if every element in shaping and maintaining the welfare of life in society. Gunarsa (2005) so that every member of the public can take an active role in shaping the public welfare, the family members have to experience and undergo socialization. Socialization is a process that an individual so as a rule of life, the basic principles of life, dexterity, motives, attitudes and behavior throughout formed according to the current and future role in society. A major function of the parent by Bernadib (1986) there are three, namely, the function of divinity, obligations of parents in general, and economic functions.

2.4. The module as a learning medium

Indriati & Susilowati (2010) The use of modules is often associated with independent learning activities (self-instruction). Because its function as mentioned above, the other consequences that must be met by this module is the completeness of the contents; meaning that the content or material grain of a module must complete unassessed through dish-dish so with so readers feel quite understand the specific field of study of the results of learning through this module.

3. Methodology

The design used in this study is a research and development. The location was chosen as a place of research is in the area of Tasikmalaya and Bandung for 1 (one) year starting from January to October 2015. The population in

this study is a family of young children who come from six health centers in the city of Tasikmalaya six health centers in the region Bandung. The choice of location is based on incidence data misuse / abuse of sexual behavior in children the most. Number of samples in this study are 295 families were determined by purposive sampling using questionnaires. Knowledge Questionnaire in the form of questions with correct and incorrect answers. Assessment of knowledge is measured based on the number of correct answers using Guttman scale (Azwar, 2005). Measured attitude is favorable attitudes (favorable) and an attitude that does not support the (unfavorable). In a statement favorable value of 0 is given on the answer strongly disagree, and the value 2 for the answers strongly agree. The trial questionnaire was conducted to measure the validity of the knowledge questions and the statement used in the questionnaire by using corelasi product moment. Collecting data in this study were collected after the sample size in the population who have a family of early childhood set and design of finished modules dikembangkan until the validation phase. Data analysis technique used is the analysis of univariate and bivariate. Univariate analysis is used to describe the percentage of the characteristics of the age and education, while anlisis bivariate performed using paired sample t test to determine the effectiveness of using the module as reproductive health education media.

4. Result and Discussion

4.1. Result

4.1.1. Knowledge

Before the module is given to the family to be used as media of reproductive health education early childhood in this study, first conducted the initial measurement of the knowledge and attitudes through the pre-test. Measurements were made to determine the initial conditions of the knowledge and attitudes of families about reproductive health. Based on the results of these measurements, the value of knowledge of families with three categories, namely 13.6% good category (>75), 69.5% enough category (56-75) and 16.9% less category (<56). Post test knowledge of measurement results can be seen in Figure 1.

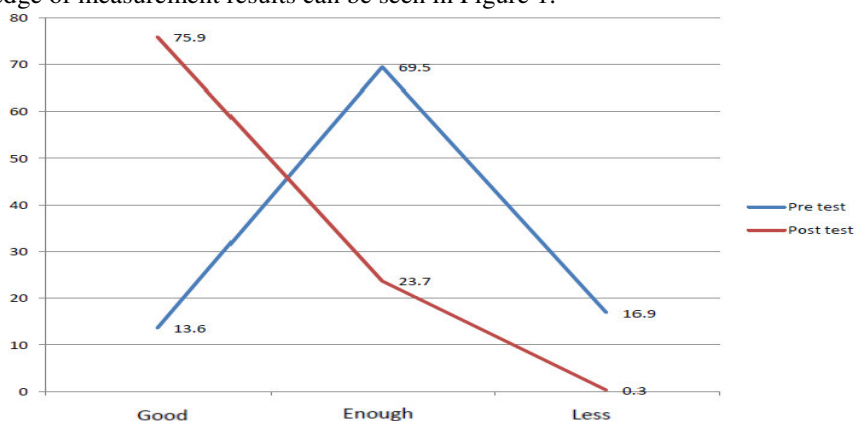


Figure 1. Results of measurement of knowledge

Results of univariate analysis obtained average pretest and post-test as well as an increase in knowledge after the given module is 16.63. It can be explained that the module causes an increase in the value of knowledge are categorized into good, sufficient and less.

4.1.2. Attitude

Attitude measurement results in this study are shown in Figure 2.

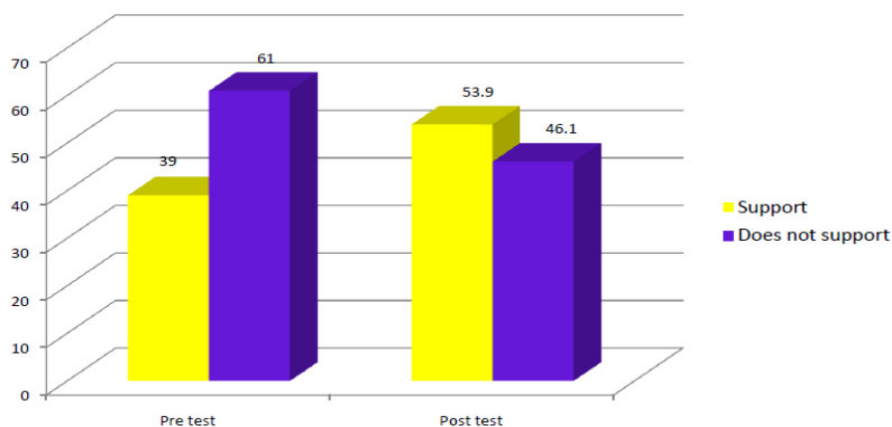


Figure 2. Measurement of attitude

Figure 2 outlines the value of the measurement results are categorized into supportive attitude and support on reproductive health education early childhood in the family. Based on the results of these measurements it is known that an increase in families that support the use of the module as a medium of reproductive health education of young children. After measuring pre-test and post-test, the data was then analyzed using computer software and the results as shown in Table 1.

Table 1. Mean pre-test and post-test measuring knowledge

Activity	Average	Increase	df	p value
Pre-test	66,85	16,63	294	0,000
Post-test	83,49			

After statistical test paired sample t test for the difference between the increase in pretest and post test, obtained P value of 0.000. It shows the statistical result is smaller than α (0.05), so stated the significant increase in knowledge before it is given to the module after a given module. The average pre-test and post-test attitude measurement are shown in Table 2.

Table 2. Average pre-test and post-test attitude measurement

Activity	Average	Increase	df	p value
Pre-test	55,47	20,68	294	0,000
Post-test	76,15			

Attitudes towards reproductive health education in early childhood, obtained a mean value of 55.47 pre test and post-test average value was 76.15 with a mean difference of attitude is 20.68. After statistical analysis of the results obtained p value = 0.000 which means there is a significant difference between the attitudes before and after being given the attitude of reproductive health education module ($p < 0.05$).

4.2. Discussion

4.2.1. Knowledge

The result showed that most respondents have enough knowledge (69.5%) of reproductive health in early childhood. This occurred because during this time, sex education for early childhood is considered taboo among the community. Parents assume that sex education has not deserve to be given to a child. Tthe sex education given early is very influential in the lives of children when they enter adolescence. Moreover, children are now more critical, in terms of questions and behavior because at this time the kids had a great curiosity (Djiwandono, 2001).

Health in adolescence is the result of interactions between prenatal and early childhood development and changes in the biological and socio-specific roles that accompany puberty, shaped by social factors and the risk and protective factors that influence the absorption behavior related to health (Sawyer et al., 2012). Children aged 3-5 years are able to be aware of gender differences when interacting in their environment. So since the age of 3 years should receive sex education from their parents (Badriyah, 2013). Children can benefit when they can talk about sexuality with their parents. In families, teenagers prefer recognition to their mother, and their father, and eventually move their parents either gender (Crohn, 2010; Wright et al., 2012).

Sex education is not given at an early age leads to high child sexual abuse committed by those closest to children, including the family. This phenomenon shows the importance of understanding of sex education in early childhood. Sex education issues at the moment overlooked the parents so that they surrender all children to school education, including sex education. Though that would be responsible sex education in early childhood are parents, while schools only as a supplement and no school curriculum on sex education.

The role of parents in giving a true and straight, also giving honest about sex education largely determines the formation of a private good and true perception about early sex. Because the child will perceive what is being said and discussed his parents. School and family interventions have an impact on behavioral outcomes in sexual health (Erkut et al., 2012). A key factor in optimizing health in early childhood is to build the capacity of parents and the community. Although often overlooked, the capacity is integral to building the foundations of lifelong health in early childhood (Mistry et al., 2012).

4.2.2. Attitude

Statistical test results using a paired sample t test for the mean attitude score pretest and post-test showed a significant difference. This shows the significant influence the use of the module as reproductive health education media attitude towards the family. This is in accordance with the opinions expressed Azwar (2005) that training or education provided to individuals can increase the value of individual attitudes toward an object.

The changes increase the value of the respondents' attitudes toward reproductive health in early childhood family in this study occurred because the provision of education modules containing about reproductive health. Modules are delivered prior to the measurement of post-test attitude diamksudkan as media health education about reproductive health. The module content that is relevant to reproductive health can give you the experience of family knowledge about reproductive health and could ultimately underlie the family to show the attitude towards reproductive health of young children.

Improved attitudes that occurred in the treatment group and the treatment group poster booklet happen, because at the time a few days before the attitude measurement is done, both groups have gained knowledge about reproductive health. When done subsequent attitude measurement after a few days to get knowledge, respondents indicated a change in attitude for the better. It happens possible by several factors, including, that when respondents gain knowledge, then the situation would be the basis to generate the level of trust towards the object previously known. After respondents know about reproductive health through the media booklets and posters, then there will be a reaction that is supportive of reproductive health. The condition is reinforced by the opinions Rachmat (2005) stated that although the effects of mass media on the formation and change of attitude is very small, it can serve to strengthen certain attitude and nature as media converters, especially strengthening the weak opinion.

Supportive stance seen by the results of measurements on the family after a given module is the effect of health education using modules that have been prepared. The health education delivery resulted in increased knowledge of the respondent, so that the knowledge which has been owned by the respondent can be a basis to bring attitude. This is consistent with the statement Azwar (2005) that attitudes may appear starting from something known by the people then perceived as a good thing or a bad thing.

5. Conclusion

1. The design of the module is done through the stages of development and tested on targets as well as expert consulting and validation of validator.
2. The education module that has been designed otherwise very decent team with an average assessment of respondents 82.41.
3. The education module that has been designed giving the impact of increased knowledge and attitudes meaningful significance level p value of 0.000

Suggestions from this study is health education about reproductive early childhood needs to be conveyed to parents periodically and sustainable use of the media developed as needed as well as an activity that is independent so that the necessary intervention and monitoring of various parties so that families can learn better in the study material reproductive health in the modules.

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