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HEALTH BELIEF MODEL TO EXPLORE ADOLESCENTS ABOUT FREE SEX IN INDONESIA

RINA SOVIANTI [1], SARWITITI SARWOPRASODJO [2], AIDA VITAYALA [3] and TIN HERAWATI [4]

[1,2,3,4] Faculty of Human Ecology, IPB University, Indonesia.

Abstract

Background: Adolescent sexuality poses a global challenge with issues such as early marriage, maternal mortality, and increasing cases of HIV/AIDS. Inadequate reproductive health education impedes the well-being of adolescents, leading to unmet health needs. Globally, millions suffer from sexually transmitted infections and new HIV cases, particularly among adolescents. Despite this, effective reproductive education remains deficient in Indonesia due to societal taboos surrounding sexuality. **Method:** This study employed a quantitative approach using Structural Equation Model Partial Least Square (SEM-PLS) software to collect primary data from two schools in Indonesia from September 1 to October 15, 2023. The analysis included 96 respondents using SPSS and Smart-PLS software for descriptive and inferential analysis. **Results:** The analysis uncovered relationships among factors like susceptibility, severity, benefit, barrier, and cues to action, influencing adolescent behavior related to free sexual conduct. While severity showed no direct effect on self-efficacy, benefit and barrier significantly affected self-efficacy. Self-efficacy emerged as a mediator between these factors and adolescent behavior concerning free sexual conduct. **Conclusion:** Adolescent sexual education is inadequately implemented in Indonesian schools due to societal constraints. Effective communication with family and educators can mitigate adolescent involvement in free sexual behavior. Open dialogue and proper reproductive health education are vital for cultivating responsible attitudes towards adolescent sexuality. Additionally, self-efficacy plays a crucial role in shaping adolescent behavior concerning free sexual conduct.

Keywords: Adolescent Free Sex, Free Sex, Health Belief Model.

INTRODUCTION

The issue of sex for teenagers remains a challenge in every country around the world. These challenges include early marriage, maternal mortality due to childbirth when they are under twenty years old, and the increase in HIV/AIDS. Low understanding and education of reproductive health makes the productivity of human resources in a country low so that the health and welfare needs of adolescents are not met. Worldwide there are 111 million cases of sexually transmitted infections (STIs) and 15 percent of new HIV cases occur among adolescents (1).

Adolescent girls are at risk for reproductive tract infections, social spectrum, and psychological consequences such as quitting education, early marriage, unplanned pregnancies, unsafe abortions, and depression(2). Good and purposeful reproductive education can play a central role in preparing young people for a safe and productive future life (3). Reproductive health generally refers to the condition of physical, mental and social well-being as a whole in all matters related to reproductive systems, functions and processes including the right and freedom to reproduce safely, effectively, appropriately, affordably and not against the law (4).

The Seybold Report
ISSN 1533-9211

Adolescent reproductive health has the scope of providing health services or care for women from premarital, prepregnancy, to postpartum and abortion prevention. In addition, providing information to adolescents about reproductive health (early sex education), sexually transmitted diseases due to free sexual relations, the dangers of drugs, young marriage. The impact of early marriage can cause high maternal mortality rates, lack of mental and psychological preparedness, and the impact of increasing divorce rates that will cause social problems (5). Sex education for adolescents is very important because it determines the health of future generations (2). Youth and education are a serious concern for the government to prepare a better generation. Access to quality education and character building as future leaders is one of the supports needed by adolescents. According to the World Health Organization, adolescents are residents aged around 10-19 years who are needed for the progress of a nation. Related to this, sexual health communication helps adolescents to be responsible for their future.

UNESCO affirms access to developmentally and culturally appropriate sexuality education is a human right (6). Adolescence is a time of exploring sexuality issues. The period of appearance of the hormones of maturity. Teenagers begin to be attracted to the opposite sex. At this time adolescents seek and receive information from various sources. These sources come from formal and informal sources. Formal sources come from schools and health workers. Informal sources come from parents, peers, and the media. Parents, peers, and the media are the most commonly relied upon informal sources of adolescent sexual information (7–9). One strategy in social and behavioral change communication is education which is a communication activity in disseminating information about reproductive health.

Education has a focus on individual and social change (10). Through sex education, teens can gauge their self-perception of sex knowledge. School is also an important environment for adolescent development. With regard to sex issues, the role of schools will help reduce the range of sex problems experienced by adolescents (11). School-based sex education, if well planned and delivered effectively, can result in good health (12). The United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2015 showed that most adolescents do not receive adequate and proper education and knowledge about sexuality, leaving them vulnerable to sexual abuse, sexually transmitted diseases and unwanted pregnancies (13). Sex education should start at home. Well-established communication between parents and adolescents will result in responsible adolescents. Parent and adolescent communication is a major factor that can prevent adolescent risk behavior. However, many parents are not prepared to become primary educators of sexuality (14). In Indonesia, the issue of sexuality is still a taboo. Society still views matters that discuss reproductive health must be discussed in a limited way (15).

Communication between parents and adolescents like in developing countries usually occurs behind closed doors, but depends on the region. Urban areas tend to be more open and rural areas tend to be closed. There are differences in the delivery of reproductive health education in rural and urban areas. This is due to the situation and condition of the social system in society (16). In rural areas, the delivery of sex education is carried out behind closed doors having

The Seybold Report
ISSN 1533-9211

different characteristics or characteristics, both physically and socio-culturally. The high rate of early marriage in rural areas (Bappenas 2020) compared to urban areas is very worrying for many parties. Rural and urban parents experience inequality in teaching their children (Rajif Dri Angga et al., 2020) about sex. The increasing number of people infected with HIV / AIDS indicates that there is still low public awareness and knowledge about sex. HIV findings in West Java until June 2021 were recorded at 51,553 cases (18). In Indonesia, sexual knowledge in adolescents is still a concern. The knowledge index on adolescent reproductive health is still low, at 58.1 percent (19).

The lack of sex education from both parents and schools makes teenagers have a high curiosity about sex and choose to find sex information through internet media. The information they get is not filtered and even inappropriate for them to digest as well as pornographic images, adult stories and even videos featuring conjugal relationships (20). The role of parents to adolescents is very large in adolescent growth. Parents who provide sexual knowledge properly and correctly will produce good knowledge to adolescents. Poor premarital sexual behavior of adolescents is influenced by the role of parents. Adolescents do not acquire good knowledge about sex from parents, because parents are afraid of the occurrence of casual sex among adolescents. Parents also think that sex is something that does not need to be discussed. Lack of sex education causes children to seek outside information that can actually plunge and harm themselves (21). Sex education is not a lesson to have sex. In Indonesia, until now there are still those who do not approve of sex education being taught at an early age because they think that sex education tells about how to have sex (22). Such an assumption still prevails in some Indonesian society, especially parents who have excessive concerns about their children. This research uses the theory of health belief model is a concept to reveal individual reasons for wanting or unwilling to do healthy behaviors or individual beliefs to behave healthily.

MATERIALS AND METHODS

This study used a quantitative approach using *Structural Equation Model Partial Least Square* (SEM-PLS) software version 3. Primary data collection from September 1, 2023 to October 15, 2023. The research locus of SMAN 4 and SMK Mahardika Cibinong. Sampling in Cibinong District because Cibinong District has the highest number of marriages in Bogor Regency at 2,169 (23). This study used marriage data on the grounds that marriage is one of the consequences of unwanted pregnancy. Unwanted pregnancy is one result of a lack of education about the right sex (24). Sampling using *purposive sampling*. The selection of the school considering that the rural element is still strong, not much influenced by urban life. The number of samples was taken using the Lemeshow formula for an unknown population resulting in a figure of 96 respondents for two schools.

Primary data is processed and analyzed discriptively and inferentially using SPSS software version 2.0 and Smart-PLS version 3. SEM-PLS data processing is carried out in 2 stages. The first stage is the measurement model or *outer model* to see validity and reliability. The second stage is the structural model (inner model) to see the influence between variables and mediation (Ghozali, 2014). Data processing refers to the frame of mind in figure 1.

The Seybold Report
ISSN 1533-9211

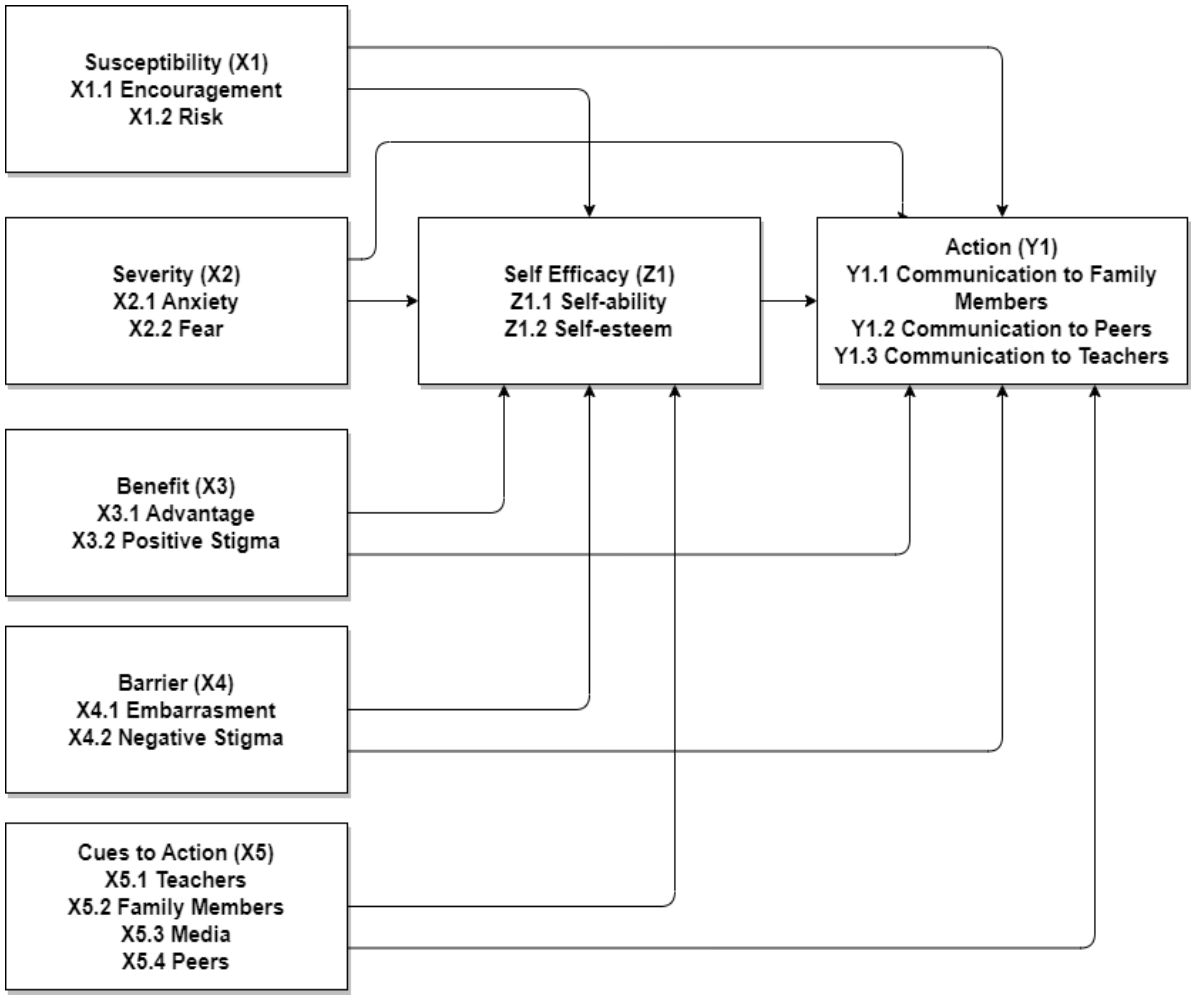

Figure 1: Research Framework

The hypotheses in this study are as follows:

H1: There is an effect of susceptibility on action.

H2: There is an effect of susceptibility on self-efficacy.

H3: There is an influence of severity on action.

H4: There is an effect of severity on self-efficacy.

H5: There is a benefit effect on action.

H6: There is a beneficial effect on self-efficiency.

H7: There is a barrier effect on action.

H8: There is a barrier effect on self-effixcacy.

H9: There is an influence of cues to action on action.

The Seybold Report
ISSN 1533-9211

H10: There is an effect of cues to action on self-efficacy.

H11: There is an effect of self-efficacy on action.

H12: Self-efficacy mediates the effect of susceptibility on action.

H13: Self-efficacy mediates the effect of severity on action.

H14: Self-efficacy mediates the effect of benefits on action.

H15: Self-efficacy mediates barrier influence on action.

H16: Self-efficacy memediasi cues to action terhadap action.

FINDINGS

Analysis SEM-PLS

Explained in two parts, namely the evaluation of the outer model and the inner model. The outer loading value of each indicator as well as validity and reliability are used to see the evaluation of the outer model. The outer loadings testing process is carried out in 2 stages through the PLS algorithm process to find out unqualified indicators. In this study using an outer loadings value of 0.60 (25). Media and Peer indicators removed for ineligibility. Media has an outer loadings value of 0.337, meaning that the outer loadings value of media is below 0.60. Peers have an outer loadings value of 0.236, meaning that the outer loadings value of peers is below 0.60. The results of the outer loadings test on media and peer indicators weakened the AVE value to 0.370 for the cues to action variable. The AVE value must be above 0.50 (Ghozali, 2014) so that media and peer indicators are omitted.

The reliability and validity of the construct shows that all latent variables have consistency above 0.7. In this study, constructs are considered reliable if *the composite reliability* is greater than 0.7. A construct is considered good if it has an AVE value between 0.5-0.7 (Ghozali, 2014). This study had an AVE value above 0.6.

Table 1: Construct Reliability and Validity

Variable	Composite Reliability	Average Variance Extracted (AVE)
X1 (Susceptibility)	0,834	0,716
X2 (Severity)	0,870	0,771
X3 (Benefit)	0,908	0,832
X4 (Barrier)	0,921	0,853
X5 (Cues to Action)	0,822	0,698
Y (Action)	0,853	0,660
Z (Self-efficacy)	0.937	0,881

The Seybold Report
ISSN 1533-9211

Test the hypothesis (bootstrapping the direct influence)

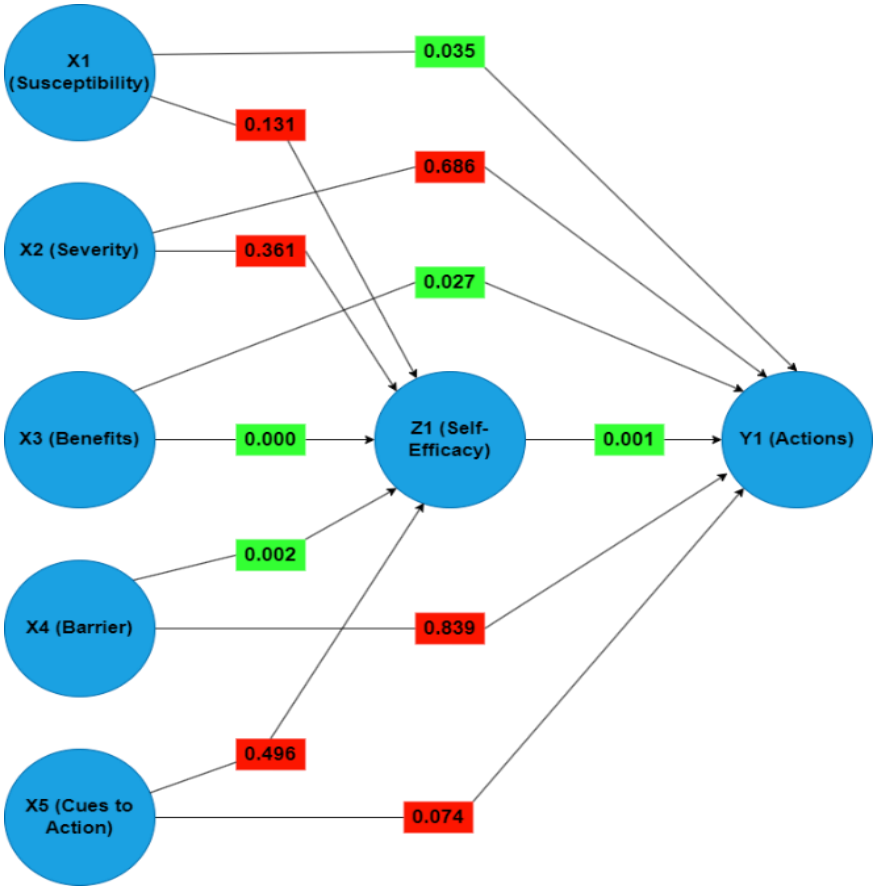

Figure 2: Bootstrapping Test Results

To find out the accepted or rejected hypothesis using p value. If the p value is less than 0.05 then the hypothesis is accepted, and vice versa if the p value is greater than 0.05 then the hypothesis is rejected (25). The data in table 2 show that susceptibility has a significant direct effect on action and has a significance of 0.037 (0.037 < 0.05). These findings are in line with Nwaozuru's that future orientation and HIV knowledge are positively associated with not having casual sex (26). However, the findings in this study severity had no direct effect on self-efficacy with a p value of 0.147 greater than 0.05.

Severity to action and susceptibility to self-efficacy had no significant effect. The p value of severity against action is 0.678 and the p value of severity against el-efficacy is 0.368. Both p values are greater than 0.05, the hypothesis is neither accepted nor rejected. Benefits have a significant effect on action and benefits also have a significant effect on self-efficacy. The p value of benefit to action is 0.037 and the p value value of benefit to self-efficacy is 0.000, meaning that the value of both p values is below 0.05 which indicates that the hypothesis is accepted. Barrier has no direct effect on action. The p value barrier to action is 0.830. The value is greater than 0.05 which means that the hypothesis for that variable is rejected. However, the

The Seybold Report
ISSN 1533-9211

barrier has a significant effect on self-efficacy with a p value of 0.002, meaning that the hypothesis is accepted. Cues to action has no significant effect on action nor does it have a significant effect on self-efficacy. The p value of both hypotheses is greater than 0.05. The p value of cues to action for action is 0.075 and the value of cues to action for self-efficacy is 0.504, meaning that both hypotheses are rejected. The p value of self-efficacy against action is 0.000, having a p value smaller than 0.05. The self-efficacy hypothesis has a significant effect on action, meaning that it is significantly accepted.

Table 2: Path Coefficient (Direct Influence)

H	Variable	T Statistic	P Values	Information
H1	X1 (Susceptibility) → Y (Action)	2.087	0.037	Accepted
H2	X1 (Susceptibility) → Z (Self-efficacy)	1.451	0.147	Rejected
H3	X2 (Severity) → Y (Action)	0.415	0.678	Rejected
H4	X2 (Severity) → Z (Self-efficacy)	0.902	0.368	Rejected
H5	X3 (Benefit) → Y (Action)	2.097	0.037	Accepted
H6	X3 (Benefit) → Z (Self-efficacy)	5.870	0.000	Accepted
H7	X4 (Barrier) → Y (Action)	0.214	0.830	Rejected
H8	X4 (Barrier) → Z (Self-efficacy)	3.152	0.002	Accepted
H9	X5 (Cues to Action) → Y (Action)	1.783	0.075	Rejected
H10	X5 (Cues to Action) → Z (Self-efficacy)	0.669	0.504	Rejected
H11	Z (Self-efficacy) → Y (Action)	3.578	0.000	Accepted

Hypothesis Testing (Bootstrapping Specific Indirect Effect or Mediation)

Table 3: Specific Indirect Effect (Mediasi)

H	Variable	T Statistic	P Values	Information
H12	X1 (Susceptibility) → Z (Self-efficacy) → Y (Action)	1.336	0.182	Rejected
H13	X2 (Severity) → Z (Self-efficacy) → Y (Action)	0.886	0.376	Rejected
H14	X3 (Benefit) → Z (Self-efficacy) → Y (Action)	2.759	0.006	Accepted
H15	X4 (Barrier) → Z (Self-efficacy) → Y (Action)	2.313	0.021	Accepted
H16	X5 (Cues to Action) → Z (Self-efficacy) → Y (Action)	0.657	0.511	Rejected

Barriers and benefits require self-efficacy to act. Self-efficacy in this study is confident not to engage in free sex activities, confident that you will not get sexually transmitted diseases, confident that you will not get pregnant / impregnate out of wedlock, and confident about a better future if you avoid free sex activities. The findings in this study self-efficacy mediated the benefits of not having free sex activities affected action with a p value of 0.006. The variable is accepted because the p value of 0.006 is smaller than 0.05. Self-efficacy also mediates barriers in free sex activities to affect action with a p value of 0.021, meaning that the hypothesis is accepted because the p value is smaller than 0.05.

The findings in table 1 in H6 are related to table 2 in H14 that adolescents who do not engage in free sex activities will be confident that they will not be exposed to sexually transmitted diseases because they already have knowledge about free sex. Effective sexual health education programs are associated with reducing risky sexual behavior for adolescents (24). Susceptibily, severity, and cues to action mediated by self-efficacy had no effect on action. These variables have p values greater than 0.05 which means that the hypothesis is rejected.

The Seybold Report
ISSN 1533-9211

DISCUSSION

The discussion regarding the findings unfolds in two parts: the evaluation of the outer model and the inner model. The assessment of the outer model revolves around the outer loading values of each indicator, validating its reliability and validity. The process involved a two-stage examination of outer loadings via the PLS algorithm. In this research, the indicators "Media" and "Peer" were found to be ineligible for inclusion due to their outer loadings values below the threshold of 0.60. Their exclusion weakened the AVE (Average Variance Extracted) value for the "Cues to Action" variable to 0.370, falling short of the desired threshold of 0.50. However, all latent variables exhibited favorable reliability with composite reliability above 0.7 and AVE values above 0.6, indicating robustness and consistency. Moving to the hypothesis testing, specifically bootstrapping the direct influence, the results established significant and non-significant direct effects. Susceptibility displayed a notable direct effect on action, aligning with similar studies that found positive associations between future orientation, HIV knowledge, and avoiding casual sex. In contrast, severity exhibited no direct influence on self-efficacy, thereby rejecting the hypothesis. Additionally, severity, as well as cues to action, showed no significant effects on action or self-efficacy. On the other hand, benefits significantly impacted both action and self-efficacy, while barriers affected self-efficacy but not action. Notably, self-efficacy had a substantial influence on action.

In the examination of specific indirect effects (mediation), it was found that self-efficacy mediated the effects of both barriers and benefits on action concerning engaging in free sex activities. Adolescents who refrained from these activities felt confident in avoiding sexually transmitted diseases and perceived a reduced risk due to adequate knowledge about free sex. This corresponds with previous studies highlighting the importance of effective sexual health education programs in reducing risky sexual behavior among adolescents. However, susceptibility, severity, and cues to action mediated by self-efficacy had no significant effect on action, as their p-values were above the 0.05 threshold, leading to the rejection of the related hypotheses.

CONCLUSION

The results of hypothesis testing show that adolescents who do not engage in free sex will be confident that they are not exposed to sexually transmitted diseases. Teenagers need discussions with people who are considered more mature to talk about sexuality. The lack of discussion with parents, teachers, and peers increases the curiosity of adolescents about sexuality issues. It is undeniable that the media has massively influenced teenagers' views on sexuality issues. However, the influence of the media can be contained by effective communication with family and teachers so that adolescents do not engage in free sex activities.

The results of this study illustrate that sexuality education for adolescents has not been widely applied in schools in Indonesia. The curriculum for sexual education is also not well structured so that the implementation of sexual education has not been evenly distributed and absorbed properly by students. Schools and parents still argue that sex education for teenagers is something taboo to give because it is like teaching students how to have sex.

The Seybold Report
ISSN 1533-9211

Study Limitations

1.Sampling Limitation: The research was conducted in specific schools within a particular district, which might not represent the diversity of adolescents in Indonesia. The findings might not be generalizable to all regions or school types.2. Omission of Indicators: Some indicators, such as Media and Peer, were removed due to their low outer loadings values, which might have affected the study's comprehensive analysis of cues to action.3. Reliance on Self-Reported Data: The study relies on self-reported data, which might be subjected to social desirability bias, affecting the accuracy of responses about sensitive topics like sexual behavior and health.4. Cultural Sensitivity: The study focuses on sensitive topics related to adolescent sexual behavior and health in a conservative societal context like Indonesia, which could influence the participants' willingness to respond accurately or comprehensively.

Strength of the study:

1. Methodological Rigor: The study employs a quantitative approach using the Structural Equation Model Partial Least Square (SEM-PLS) software, allowing for a rigorous analysis of variables and their interrelationships. 2. Relevant Research Focus: The study delves into an essential and under-addressed topic in Indonesia: adolescent sexual health and behavior, contributing to understanding the factors influencing these crucial issues. 3. Appropriate Statistical Analysis: The study utilized appropriate statistical methods to assess and test the hypotheses, providing a robust foundation for drawing conclusions. 4. Focus on Self-Efficacy: Highlighting the role of self-efficacy in shaping adolescents' behaviors regarding sexual health provides valuable insights for interventions and educational programs.

Ethical Permission:

The article does not explicitly mention details about the ethical permission obtained for conducting the study. Ethical considerations in research involving sensitive topics like adolescent sexual behavior and health are crucial, including obtaining informed consent, maintaining confidentiality, and ensuring participants' well-being throughout the study.

Conflict of Interest:

The article doesn't explicitly mention any conflict of interest. However, in research concerning sensitive issues like adolescent sexual health, it's essential to disclose any potential conflicts of interest, financial or non-financial, to ensure the study's integrity and objectivity. This abstractive summary provides an overview of the health belief model's application to explore adolescents' perceptions of free sex in Indonesia, highlighting both the strengths and limitations of the study, while addressing ethical considerations and potential conflicts of interest.

Authors' Contribution :

Rina Sovianti (First Author), responsible for writing the Introduction, methodology, primary research, and discussions (30%); Sarwititi (Second Author), involved in methodology and discussions (25%); Aida Vitayala (Third Author), responsible for writing the Introduction and discussions (25%); Tin Herawati (Fourth Author), primarily engaged in statistical analysis (20%);

The Seybold Report

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