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ANALYSIS OF ADOLESCENT REPRODUCTIVE HEALTH EDUCATION PROGRAMS AT SENIOR HIGH SCHOOLS LEVEL IN OGAN ILIR REGENCY

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Abstract

All adolescents are entitled to access reproductive health services that are appropriate to their developmental stage, both through formal and non-formal education. Preliminary findings indicate that students generally lack adequate knowledge of reproductive health, with limited information provided both at school and within the family. Teachers report that students tend to feel embarrassed or consider discussions on marriage and reproductive health to be taboo. This study aims to analyze the implementation of adolescent reproductive health education programs at the senior high school level in Ogan Ilir Regency, Indonesia. This qualitative study employed in-depth interviews with teachers, community health center personnel, and family planning counselors, along with two key informants, four student focus group discussions (FGDs) and document analysis. The findings reveal that all schools have made efforts to implement adolescent reproductive health education through teacher-led instruction, the Youth Care Health Services (Pelayanan Kesehatan Peduli Remaja/PKPR) program, and the Youth Information and Counseling Center (Pusat Informasi dan Konseling Remaja/PIK-R) initiative. However, personnel involved in these programs require further training to enhance their knowledge and competencies. While implementation guidelines are available, several adjustments are often made during practice. Key challenges identified include limited budget allocations, insufficient facilities and resources, and restricted accessibility for some adolescents. Although reproductive health education through teacher instruction, PKPR, and PIK-R programs provides significant benefits for adolescents, further efforts are needed to optimize their implementation and outreach.

Keywords: Reproductive Health Education, PIK-R, PKPR, Adolescents

Introduction

The state holds a responsibility for the development of adolescent reproductive health, as mandated by Government Regulation No. 61 of 2014 concerning Reproductive Health. According to this regulation, every adolescent has the right to access reproductive health services appropriate to their developmental stage, including clinical services, counseling, and communication, information, and education within both formal and non-formal education settings (1).

In Indonesia, adolescent reproductive health education is integrated into the existing school curriculum. Several topics related to reproductive and adolescent health are included in subjects such as biology, physical education, and religion. However, the absence of a specific policy regarding a comprehensive reproductive health curriculum has led to variations in implementation across schools,

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with each institution providing reproductive health education based on its individual capacity and resources (2). As a result, reproductive health education in schools has yet to reach all adolescents. According to the 2017 Indonesian Health Survey, only 59% of female adolescents and 55% of male adolescents reported receiving education on human reproductive health, while even fewer received information on family planning (12% and 11%, respectively) and HIV/AIDS (48% and 46%, respectively) (3).

Preliminary interviews conducted with two students and a teacher at a vocational high school (SMK) in Ogan Ilir Regency revealed that reproductive health topics are not formally included in classroom instruction. A religious studies teacher reported that students often feel embarrassed and consider topics such as marriage and reproductive health to be taboo. A guidance and counseling teacher observed that some students exhibit excessive behavior in interactions with the opposite sex. Meanwhile, the students expressed that they have not received adequate knowledge about reproductive health, either from school or from their parents. Instead, they often seek information through the internet or by asking peers. Based on these preliminary findings and the identified challenges, this study aims to analyze the implementation of adolescent reproductive health education programs at the senior high school level using a qualitative study conducted in Ogan Ilir Regency.

Method

This study employed a qualitative research design with a phenomenological approach. Data were collected through in-depth interviews, focus group discussions (FGDs), and document analysis. The study was conducted in Ogan Ilir Regency, South Sumatra Province, Indonesia. Four educational institutions were selected as research sites, including a senior high school (SMA), a vocational high school (SMK), an Islamic senior high school (MA), and an Islamic boarding school (Pesantren). In addition, the study involved health center personnel responsible for implementing the Adolescent-Friendly Health Services (PKPR) program, and family planning counselors overseeing the Youth Information and Counseling Center (PIK-R) program at the sub-district family planning office.

Data collection took place between March and April 2024. Informants were selected through purposive sampling, involving ten primary informants (five teachers, four healthcare professionals, and one family planning counselor), two key informants from the District Health Office and the Office of Women Empowerment, Child Protection, Population Control, and Family Planning (P3AP2KB) of Ogan Ilir Regency, as well as four FGD groups consisting of students from the selected schools. The study utilized both primary and secondary data. Data collection instruments included interview and FGD guides, with additional tools such as mobile phones and cameras for recording audio and video during interviews, and field notes to document relevant observations. To ensure the credibility of the findings, data validation was carried out through source and method triangulation.

Data analysis was guided by the CIPP model developed by Daniel L. Stufflebeam and Shinkfield, which serves to evaluate the effectiveness of programs by providing decision-relevant information. Within the educational context, the CIPP model evaluates four dimensions: Context, Input, Process, and Product. Data analysis was conducted continuously—before, during, and after fieldwork—through the processes of data reduction, data display, and conclusion drawing.

Results

Overview of the Context of the Adolescent Reproductive Health Education Program

The findings indicate that most teacher informants were aware of policies related to the implementation of adolescent reproductive health education in schools. These policies are established by the central government and disseminated through school principals, community health centers (Puskesmas), local health offices, and the National Population and Family Planning Agency (BKKBN).

> *"The policy comes from the central government, and is disseminated to students. There are also adolescent health posts (Posyandu Remaja) in villages."* (P-04)

All schools involved in the study had made efforts to implement reproductive health education policies. These efforts were reflected in the integration of reproductive health topics into biology classes, individual counseling sessions, awareness-raising and outreach activities, and youth training conducted in collaboration with institutions such as Puskesmas, BKKBN, the National Narcotics Agency (BNN), the police, and the formation of Youth Information and Counseling Centers (PIK-R). At the health center level, the Ministry of Health has established the Adolescent-Friendly Health Services Program (PKPR), which is implemented through village-based Posyandu Remaja. All healthcare personnel confirmed that this program has been operational within their service areas. In parallel, BKKBN also carries responsibility for reproductive health education through the PIK-R program. Among the four schools studied, two had formally established PIK-R student groups as extracurricular activities, while the remaining two had yet to establish such groups.

Overview of the Input for the Adolescent Reproductive Health Education Program

The key human resources (HR) involved in the program primarily included biology teachers and school counselors. In addition to school personnel, external stakeholders such as Puskesmas staff, the District Health Office, BKKBN, and local police were also engaged. Most informants stated that these personnel possessed the capacity to deliver reproductive health education, though many also acknowledged the need for updated training, as previous workshops were held several years ago.

> *"As a PIK-R advisor, I did participate in training, but it was a long time ago."* (G-01)

Most informants reported having access to operational guidelines, including biology textbooks, BKKBN-issued manuals, lesson plans (RPP), and learning modules (RPL). PKPR and PIK-R programs also had standardized operating procedures (SOPs), although field-level adjustments were commonly made during implementation.

Budget allocation at the school level was found to be inadequate. Most schools did not have dedicated funds for reproductive health education, with only some funds available for transportation to external training events. One school had a budget allocated for school health units (UKS) and the Indonesian Red Cross Youth (PMR), which could be used for reproductive health outreach activities.

> *"During outreach, we usually submit a proposal and invite speakers from government agencies like the health department or Puskesmas."* (G-03)

In contrast, Puskesmas had dedicated funding for PKPR through the Health Operational Assistance (BOK) budget, used primarily for transportation costs associated with Posyandu Remaja activities. In 2023, one health center collaborated with the Office of Religious Affairs (KUA) to deliver reproductive health outreach. Conversely, family planning counselors from the P3AP2KB office operated without specific funding for PIK-R, merely carrying out tasks based on their job descriptions.

While most schools had some basic infrastructure and support materials for reproductive health education, these were generally limited and insufficient.

Overview of the Process of the Adolescent Reproductive Health Education Program

Most schools integrated reproductive health education into biology classes for Grade 11 science students. One school had conducted a single reproductive health awareness activity in 2023.

"In Grade 11 under the 2013 curriculum, only science students receive the material—social studies students do not, unless during outreach events." (G-03)

Besides classroom instruction, schools also provided counseling services. However, these were underutilized, as students rarely sought guidance voluntarily unless prompted by school counselors.

"Very few students approach voluntarily to ask about reproductive health—in fact, I'd say none at all." (G-04)

PKPR activities, particularly Posyandu Remaja, were village-based rather than school-based, making it difficult to reach adolescents. As a result, healthcare workers often visited schools to conduct physical checkups, counseling, and education sessions. PIK-R activities included peer discussions, counseling, and training workshops.

Implementation faced several obstacles. Counseling teachers lacked instructional hours in classrooms, limiting their ability to deliver reproductive health education broadly. The cultural taboo surrounding reproductive topics required teachers to exercise caution in delivering the material.

"As a female teacher, discussing such topics requires sensitivity—it's seen as taboo." (G-05)

Health workers cited logistical challenges such as scheduling, distance between villages, and responsibility for multiple programs. These difficulties were echoed by key informants, who noted the low attendance and engagement of adolescents in village-based Posyandu Remaja activities.

"In the field, the youth health posts are not popular. It's hard to gather adolescents." (D-01)

Limited access to learning aids and support tools also hampered program delivery. While some materials, such as posters, were available, most facilities were still lacking.

"We only have a few posters so far; we definitely need more." (G-01)

Though PIK-R and Puskesmas facilities had some resources, many were outdated or damaged. Teachers also reported limited knowledge about budget allocations for reproductive health activities. At Puskesmas, the BOK fund usage was well-documented, although still insufficient for optimal implementation. For PIK-R, no additional budget was allocated for training activities.

Biology teachers stated that teaching activities were conducted according to plan, while other informants acknowledged incomplete implementation due to various constraints. Health professionals and family planning counselors reported making adjustments to activities, although outcomes remained suboptimal.

Monitoring and evaluation specifically related to adolescent reproductive health had not been systematically conducted. Barriers such as limited teacher capacity, cultural taboos, and budgetary constraints continued to hinder implementation.

Overview of the Product of the Adolescent Reproductive Health Education Program

FGDs with students from the four schools revealed that most had a basic understanding of reproductive health, especially those from general senior high schools and Islamic boarding schools. However, others struggled to articulate their thoughts clearly.

"Reproductive health means having healthy reproductive organs and avoiding diseases like HIV, which can be transmitted through risky behaviors like unprotected sex or shared needles." (S-09)

Students cited sources of information as teachers, social media, the internet, personal experience, parents, and peers. Some had also participated in outreach events by the police and PIK-R activities.

Teachers, healthcare workers, and family planning counselors confirmed that reproductive health education had reached its intended demographic—adolescents—but noted that coverage remained incomplete. Students from science streams learned the subject through biology, physical education (PJOK), and student orientation (PBAK), while social studies students encountered related topics in geography, sociology, economics, PJOK, and PBAK. Teachers also used informal moments to convey messages, such as during viral news events.

"As social studies students, we don't get biology, so sometimes the topic comes up in geography or sociology." (S-04)

Despite these efforts, many students reported never having heard of PKPR. Some recalled height and weight checks conducted by healthcare workers, but most had not received PIK-R outreach. Among the schools with PIK-R programs, activities were held monthly and included peer-sharing sessions and multimedia presentations. However, students criticized the delivery method.

"It was too monotonous—just talking and talking. We're young people, we need something different." (S-07)

The program's reach remained limited, with only around 20 students actively participating in PIK-R groups. However, these students were expected to serve as peer educators. Students acknowledged the value of the information received, noting positive behavioral changes and increased awareness about appropriate conduct with the opposite sex.

Discussion

Context (Policy) of Adolescent Reproductive Health Education Program

This study demonstrates that all schools have made efforts to implement reproductive health education policies for students in accordance with government directives related to adolescent reproductive health services. The adolescent reproductive health service policy is articulated in Government Regulation Number 61 of 2014 concerning Reproductive Health, specifically in Article 11 Clause 1 and Article 12, which describe service delivery efforts, including the provision of communication, information, and education services that can be conducted through formal and non-formal educational activities (1).

Community health centers (Puskesmas) have implemented Adolescent Reproductive Health Programs (PKPR), a policy initiative by the Indonesian Ministry of Health related to adolescent reproductive health education. Various national policy and strategy documents regulating adolescent health services have been issued and disseminated to PKPR service providers, including the National Strategy Guidelines for Adolescent-Friendly Health Services and the Adolescent-Friendly Health Services Guidelines at Puskesmas (4). The National Population and Family Planning Board (BKKBN) has also developed policies related to adolescent reproductive health education through the establishment of the PIK-R program, which has been nationally socialized down to the regional level. The PIK-R program policy is detailed in the BKKBN Head Regulation Number 88/PER/F2/2012

concerning Guidelines for the Management of Youth/Student Information and Counseling Centers (5).

Input of Adolescent Reproductive Health Education Program

Human resources (HR) involved in adolescent reproductive health education in schools come from diverse educational backgrounds, with the majority being biology teachers and counseling staff. According to the Senior High School Level Adolescent Reproductive Health Education Module, the primary implementers of reproductive health education in schools are teachers, with the expectation that they integrate various reproductive health information and aspects into learning processes and daily life habits within the school environment (6). This finding aligns with the study by Kamila, Handayani, and Nurhayati, which identified biology teachers as the most active participants in adolescent reproductive health education programs (7). Enhancing educators' knowledge is essential, as supported by research from Arsani, Agustini, and Purnomo, showing that HR involved in adolescent reproductive health services routinely receive training three times a year (8). Additionally, these HR personnel have access to manuals or guidelines. This corresponds with findings from Suciana, which confirmed that PKPR implementation is based on guidelines issued by the Ministry of Health (9).

The government, through the Ministry of Health, has allocated budgets for PKPR activities within the Health Operational Assistance (BOK) fund. Specifically, annual funds are allocated from BOK to each Puskesmas for PKPR activities. This study aligns with Mumtazah and Sulistiadi's findings that most funding for PKPR at Puskesmas is sourced from BOK funds. Conversely, funding for PIK-R is managed at the program site (10). Safrizan and Fajriati found that PIK-R program funding is not specifically budgeted but rather comes from general funds allocated to the program's operational venue. The availability of facilities and supporting tools for adolescent health reporting remains insufficient both in quantity and adequacy, a constraint also identified by Safrizan and Fajriati as a key impediment to the sustainability of the PIK-R program (11).

All HR involved have developed annual activity plans. This is consistent with Laila, Oktova, and Humaira, who reported that PKPR program planning is conducted annually at the Padang City Health Office and Andalas Puskesmas, with the PKPR team integrating the plan across all Puskesmas programs. Meanwhile, PIK-R programs have their own specific planning process, especially in youth health promotion and PIK-R management, with monthly training conducted at least once per formed PIK-R group (12).

Process of Adolescent Reproductive Health Education Program

Most schools deliver reproductive health education through biology lessons, which are limited to 11th-grade students in the science stream (IPA). Students in other grades or non-science streams do not receive biology lessons. This aligns with Rahmawati's study showing that human reproductive system material in high schools under the School-Based Curriculum (KTSP) is only covered in grade XI semester 2 (13). Widodo noted that reproductive health education is provided through biology, physical education, and counseling lessons, corresponding to each field of study (14).

Beyond classroom activities, schools provide counseling services; however, these are underutilized by students. Sakinah and Septiawan found that while schools have counseling rooms for students, very few seek advice on reproductive health from teachers, preferring to discuss such issues with peers (15).

Taboos around discussing reproductive health topics persist among adolescents, requiring teachers to approach the subject carefully. Fitriana and Siswaantara reported that some teachers still feel uncomfortable addressing reproductive health with students. Additionally, health workers face

challenges in scheduling youth health posts (posyandu remaja) to reach mostly school-going adolescents, as activities are often held after working hours (16).

Facilities and supporting tools are critical factors in the implementation of these activities. According to the National PKPR Standards, service providers must utilize available infrastructure without discrimination based on social or economic status, both inside and outside facilities (4). Budget utilization also plays a vital role in program implementation. Although BOK funds are available at Puskesmas, they remain insufficient to fully support optimal activities. Laila, Oktova, and Humaira also found funding constraints to be a major limitation in PKPR implementation (12).

PKPR activities by Puskesmas and PIK-R by family planning counselors have been implemented according to plans, with some adjustments; however, outcomes have yet to reach optimal levels. Laila, Oktova, and Humaira noted that PKPR implementation at Puskesmas is progressing well but faces challenges, particularly with activities outside the Puskesmas, leading to suboptimal execution at Andalas Puskesmas. Monitoring and evaluation efforts specifically addressing adolescent reproductive health have not yet been realized. The challenges reported align with Laila, Oktova, and Humaira's findings, which highlighted the difficulties in implementing activities outside Puskesmas or in schools due to issues such as gathering participants and academic priorities (12).

Providing reproductive health education to students is crucial for enhancing their knowledge and understanding of reproductive health and its importance. Supporting this assertion, Pranata et al. emphasized the need for dedicated services to address adolescent reproductive health issues (17). Similarly, Widodo underscored the significance of reproductive health education due to its relevance to daily adolescent life (14).

Product of Adolescent Reproductive Health Education Program

The outcomes of adolescent reproductive health education activities reflect positive results, with most students demonstrating good knowledge of reproductive health. Students capable of explaining reproductive health concepts mostly come from the science stream and have received related material. This aligns with Masfiah, Shaluhiyah, and Suryoputro, who found that students' academic streams influence their knowledge levels, with science students having higher reproductive health knowledge compared to social science students (2).

This study also found that none of the students were aware of the PKPR program, although some had received health counseling and check-ups from Puskesmas staff at school. Suciana similarly reported low student awareness of PKPR programs in schools. Regarding the PIK-R program, many students had not heard of it nor received outreach from family planning counselors, although all high school informants were aware of PIK-R, which functions as an extracurricular activity in their schools (9). The counseling methods used were found to be monotonous and less engaging, a finding consistent with Afindra and Diniaty, who noted that peer educators and counselors often lack the skills to effectively deliver PIK-R material and counseling services (18).

Students reported numerous benefits following reproductive health education, including increased understanding of reproductive hygiene, healthy social interaction boundaries, and self-care practices. This corresponds with Rukmady et al., who found that education leads to greater student awareness and behavioral changes such as improved hygiene and moderated social interactions with the opposite sex (19).

Sustained implementation of reproductive health education in schools is expected to have greater impact. Teachers, as primary implementers, are encouraged to integrate comprehensive reproductive health information into daily learning and habits within the school environment (6). Overall, reproductive health education activities conducted in 2023 still require enhancement to achieve more optimal outcomes.

Conclusion

The government has established policies on Adolescent Reproductive Health Education. All schools have endeavored to implement these policies through teacher-led education, counseling, outreach, and socialization activities conducted in collaboration with other institutions. Community health centers (Puskesmas) have implemented these policies through the Adolescent Reproductive Health Program (PKPR), while the Population Control and Family Planning Agency (Dinas P3AP2KB) has operationalized the policies via family planning counselors who form Youth Information and Counseling Groups (PIK-R) in schools.

Most human resources involved possess relevant capacities and educational backgrounds related to adolescent reproductive health; however, ongoing training is needed to further enhance their competencies. The majority of schools do not allocate specific budgets for reproductive health education activities. The PKPR program benefits from a Health Operational Assistance (BOK) budget, which covers expenses such as transportation for adolescent health post officers. In contrast, the PIK-R program lacks dedicated funding for field activities. Availability of facilities and supporting tools for adolescent reproductive health education remains insufficient in both quantity and adequacy to meet adolescents' needs.

In the implementation process, schools provide adolescent reproductive health education through teacher-led sessions, PKPR activities by Puskesmas, and PIK-R programs led by family planning counselors. Monitoring and evaluation efforts have not been conducted optimally; no dedicated monitoring specifically targets adolescent reproductive health education activities, and only general program oversight exists. The reproductive health education efforts have not yet reached all students within schools. Students report benefiting from the reproductive health materials and education provided by teachers, experiencing significant positive changes following receipt of the information, education, and advice on reproductive health.

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