A Preliminary Study of Reproductive HealthEducation Model for Indonesian Migrant Workers

HudiWinarso[1], RenyI'tishom[2], Hanna T. Silitonga[1]

[1]*Associate Professor, Faculty of Medicine, Universitas Ciputra, Surabaya, Indonesia,* [2]*Associate Professor, Department of Medical Biology, Faculty of Medicine, Universitas Airlangga, Surabaya, Indonesia*

Abstract

Background:It is estimated that around 4.5 millions of Indonesians work abroad, and 70% of themare women, aged ranging from 18 to 35 years old. Mostly are employed in the domestic sector as housemaids. They are prone to exploitation, extortion, physical and sexual abuses, due to human trafficking. Up to present, there is no reproductive health education programmesfor Indonesian migrant workershas been established. Thereforeit is necessary to provide education modules on reproductive health for them, which targetsspecific education levels and socio-economic background.

Methods: We evaluated the effectiveness of three models of reproductive health education on 24 Indonesian migrant workers as subjects. The subjects were classified into 3 groups, 8 subjects for each group. Group A received conventional model (modules without case), group B received moduleswith few cases given alongside, and group C received modules with many cases added to the modules. The modules included: (1) Female and male reproductive organs, (2) Fertile window, menstruation, pregnancy and abortion, (3) *Human sexuality* and sexual abuse, (4) *Sex education*and sexually transmitted infections. Each modulewere given in the scheme of 4x120 minutes,twice every week. The evaluations were conducted using pre-test post-test design. The effectiveness of intervention was assessed by analysis of variance (ANOVA). Furthermore, we also conducted *focussed group discussion*(FGD) regarding the models and modules of the training in the fifth week of the experiment.

Results: There was a significant differences between subjects received module without case (Group A) compared to subjects received module with a few cases added (Group B)and modules with many cases added (Group C) at a<0.05, while there was no significant differences between subjects received module with few cases (Group B) compared with many cases added (Group B vs Group C) compared to Group A and Group B (a<0.05). Our results showed that modules with many cases added has the highest intervention effect in the reproductive health education models.

Conclusion: Our study concludes that the most effective model to builtcompetencies in reproductive health for Indonesian migrant worker is specific modules with many cases (Module C).

Keywords*: Indonesian migrant workers, competencies in reproductive health, education.*

Introduction

The Indonesian Workers Placement and Protection Agency (BNP2TKI) reported that the number of Indonesian workers in the April-June 2019 period was 70,258 people, consisting of 36,212 people (51%) working in the formal sector and 34,246 people (49%) in the informal sector. The demographic data are described in detail below[1].

The gender compositions is dominated by woman (71%) and while 29% are man. The level of education of migrant workers are as follow: 30 % are elementary schools graduates; 37 % junior high schools graduates), 31 % of high schools graduates, and the rest are(2%) university level.

The marital status is as follows: 36% unmarried, 25% divorce, and 39% marital statuses. They mainly work as

domestic workers (30%), and as many as 21%works as caregivers. The total number of complaints in these three months placement was 1,903 with various cases[1].

There are several reports said that migrant workers especially females are prone to exploitation, extortion, physical and sexual abuses, due to human trafficking[2,3]. Most of female Indonesian migrant workers did not have enough knowledge about reproductive health and there was no such modules or curriculum in place. Female migrant workersare often facing these kindsof problems during their employment in foreign countries. Non-marital pregnancy, abortion, sexually transmitted infection, and sexual abuses are some problems that are faced by female Indonesian migrant workers. Therefore, it is necessary to introduce intervention program for Indonesian migrant worker to be applied in to reproductive health education teaching model.[4,5]

Furthermore, most of Indonesian migrant workers are young in age (between 18-35 years old), with low education level, and because of that, these aspects should be taken into consideration in giving a reproductive health education for Indonesian migrant workers.[1]

The material of reproductive health education includes reproductive organs, fertile window, menstruation, pregnancy, abortion and contraception related to them as woman. In addition, materials related to sexually transmitted infection and sexology, such as sexual desire and how to behave to prevent sexual abuse are also important.[3]

This research aims to evaluate the effectiveness of the reproductive health education modules among Indonesian migrant workers. The modules that we used in this research consist of knowledge about reproductive health, attitude toward reproductive health, and knowledge of healthy and safe of sexual practice and given in an adequate time to Indonesian migrants workers[6-10].

Materials and Methods

This research was involvedof 24 subjects, which were Indonesian migrant workers from Indonesian migrant workers agency at East Java,before their departure. The subjects were classified into 3 groups, 8 subjects for each group based on educational background and origin.

Each group received modules about reproductive health that were given in the scheme of 4x120 minutes, twice every week. Group A received conventional model which is modules without case, while group B received modules with few (1 until 3) cases given alongside, and group C received modules with many (more than 5) cases, added to the modules.

The modules material included: (1) Female and male reproductive organs, (2) Fertile window, menstruation, pregnancy and abortion, (3) Human sexuality and sexual abuse, (4) Sex educationand sexually transmitted infections. The modules were presented to the subjects by trained doctors using power-point presentation (ppt).

Mixed method research model was used in this experiment. The quantitative portion used pre test-post test design to evaluate effect of intervention on the subject. Analysis of variance (ANOVA) was further applied to evaluate the most significant effect and the most significant module and $p<0.05$ was used as significance level. Questioners for the test composed of 70% knowledge, and 30% attitude.

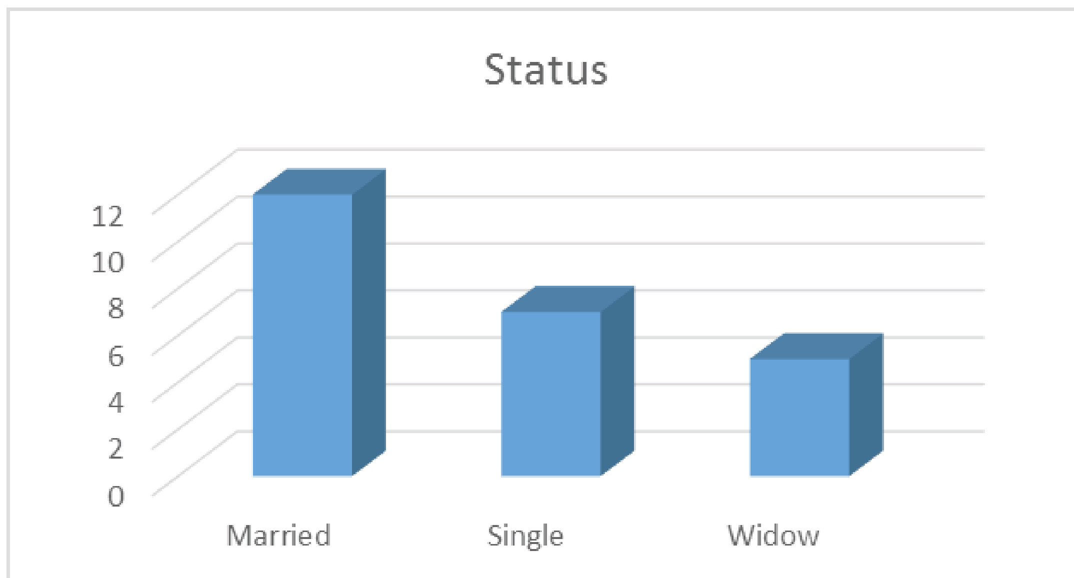
The qualitative portion used focus group discussion (FGD) and this method was conducted in the fifth week of the experiment to evaluate attitude models and modules of the training. Safe and healthy sexual practice attitude focused on communication simulation in case of sexual harassment situation.

Results

Descriptive analysis shows that majority of Indonesian migrant workersage group are less than 30 years old (63%), while age group 30 years – 35 years old is 29%, and age group more than 35 years old is 8%. The marital status is 50% married, 29% single, and 21% widow (Table 1).

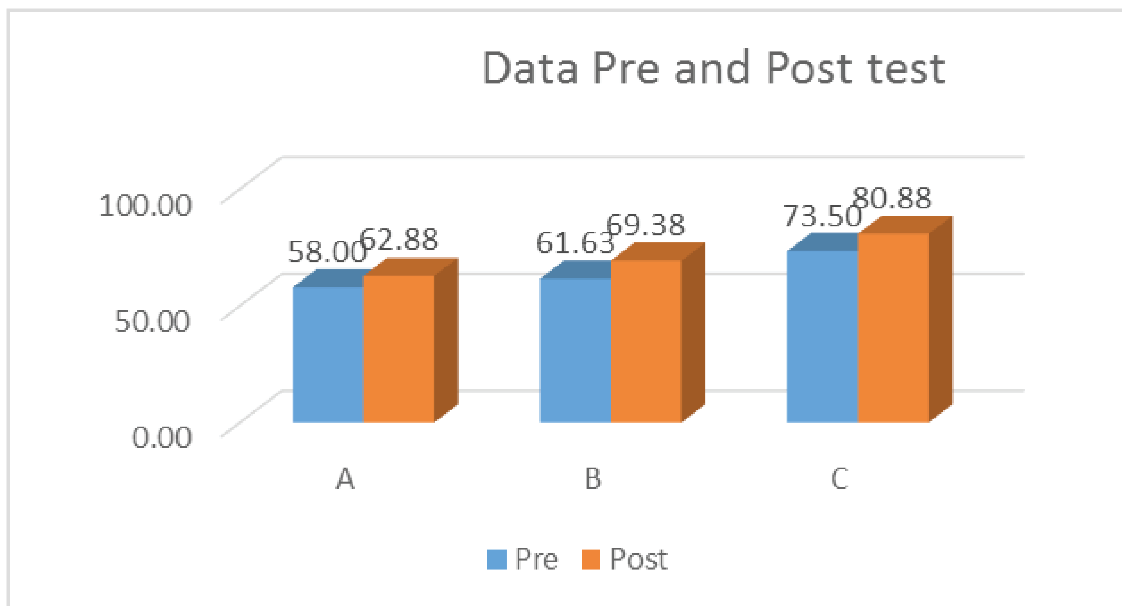
The education level, majority is senior high school (50%), followed by junior high school (25%), bachelor (21%), and lastly elementary school (4%).

Table1 : Marital status



Statistical analysis showed that the post-test score always higher compared to the pre-test score (Table 2). Group B and C showed higher post-test score compared to group A. In addition, Group C showed significant differences compared to group A, in contrast to group B and C which showed no significant differences. This results showed that modules in group B and C are more effective than group A, while modules in group C showed the most effective in term of intervention effects.

Table 2. Data Pre Test and Post Test



Discussion

Our data suggest that observation from demographic data is in line with the report from Indonesian Agency of BN2PTKI. Data from the National Agency for Placement and Protection of Indonesian Workers (BN2PTKI) states that during 2014 - March 2019, the number of Indonesian migrant workers (PMI) reached to 1.55 million workers, especially during the first quarter of 2019, the population reached to 64,062 people, which consist of 19,597 (31%) male workers, and 44,465 (70%) female workers respectively[1].

Data above confirm that the problem of migrant workers is something complex. A holistic understanding (biological-psychological-social-cultural-spiritual) is needed to get the best conclusions and studies in order to overcome the problem because the Indonesian migrant workers are more young in ages, and relatively more risky to be involved in matters related to sexuality[1]. Furthermore, data cited from WHO South-East Asiaconfirms that median age of international migrants, are 25 (2000) and 29.8 (2017) respectively[11].

Similar observation from Dai W (2015) who stated that sexual behavior in China among migrant workers, the majority (83.3%) of the migrants engaged in sexual behavior, and 58% did not use condoms in sexual intercourse[12].

Furthermore, Ullah A.A.(2010) observed that premarital pregnancies among migrants workers in domestic helpers in Hong Kong, found outthat 97 percent of respondents had premarital sex and 36 percent of them became pregnant. About 61 percent of pregnancies were "unwanted" while 39 percent were "wanted" pregnancies[13].

Similar observation has been reported byZong Z. et al (2017) who observed unmarried female migrants in Changzhou, China, and found out that there is an unmet need for reproductive health education and services where these women work as well as in their hometown communities. Further moreZong reported that asa high as 30% being reported has sexual experienced, but only 38% of them used contraception at first sex and 58% were consistently practiced unhealthy and unsafe sexual practice over the past year, which leadsto many unintended pregnancies and abortions[14].

Most of migrant workers are employed as housemaids, whether they're sent by legal or illegal procedures. These were occurring in many countries, including in ASEAN countries, due to their vulnerable conditions. Legal protections are not adequately provided by their originating government to the migrant workers who work abroad, and sadly, they've become the victims of criminal acts committed by their employers[9]. The International Convention on the Protection of All Rights of Migrant Workers and Members of Their Families is currently not implemented as it is designed, as an effort to protect migrant workers who work abroad.Although Indonesia already has a new Law on the Protection of Migrant Workers, the fact that women are still vulnerable to the threat of trafficking and violence in the destination countries still remains, even through they may still be in their village of origin[15-17].

The backgrounds of human trafficking are very complex, and involving the economic, social and educational aspects. Thus, in order to prevent the trafficking to occur, fundamental issues should be solved, in terms of providing more opportunity in the economic factors and public education[6].

The procedures of international female migration is undoubtedly complex and require "integrative approaches" with multiple level of analysis. The arrangements of international female migration can be elucidated by three levels of analysis from the "sending side": (1) the state; (2) individuals; (3) society. Emigration policies for women tend to be value-driven rather than those for men which are economically driven, where women put in their traditional status in domestic works wherever they are[6,9].

International research collaborations and research networks which include not only the originating countries, but also the receiving countries were very lacking in number. Building such collaborations and networks would require large numbers of scholars recruitment from different parts of the world, and on top of that, the number of the subjects should be even larger[10].Prevalence of self-reported STIs among these migrant men was hightargeted interventions among migrant workers need to be strengthened for control and prevention of STIs[5].

Sakdapolrak (2002) stated that closer attention should be paid to sexual health education among migrant worker, especially women and those working in domestic and wholesale/retail occupation. Protection for migrant workers is indeed needed[16]. Moratorium from Indonesian government towards migrant agency was not effective[17].This study suggests and urgent need to implement comprehensive sexual behavior education and intervention programs targeting migrants, especially

female migrants[6,18].

Our finding suggest that appropriate reproductive health materials for Indonesian migrant workers must meet the requirements in terms of substance and the way they are delivered. In the concept of building the character of reproductive health, adequate exposure time is needed. Adding knowledge (knowledge), building attitudes (attitude), can be done with optimism. While building commitment to being able to escape facing problems (practice) when situated in a new environment is a good achievement. They also can become an agent of promotion of reproductive health (advocacy level). It is the fact that Indonesian migrant workers, who are predominantly from rural areas, have little education, so it is important that there should be be an adequate concern in building characters that have reproductive health competencies[18].

This education program must be introduced as early as possible to reach young women before they migrate.Teaching method using illustrations, pictures and cases is effective to improve participant knowledge and understanding. Training materials include knowledge, attitude and practice with simulations. Role plays about manners are also useful to prevent sexual abuse. Discussion sessions are also needed to build an interactive learning process. In addition, aFGD can give suggestions about learning model. Class setting such as U-shaped with 2 hours of duration is effective.

Besides those issues, the variety of sexual abuse incidence for every region is another issue to be given too. Specific modules related to the designated countries are very useful. For example,Indonesian migrant workers in Taiwan are more vulnerable to free sex, thus, reproductive health education related to fertile window, pregnancy, abortion, sexually transmitted infections, and also contraception are useful for them.Indonesian migrant workers in Middle East are also vulnerable for sexual abuse from "close" people, so materialsabout "how to behave" are very important to prevent sexual abuse. A good concepts about specific reproductive health problemsthat might be faced in designated countries are needed to be implemented too.

Accordingly, reproductive health education is needed to improve the knowledge of Indonesian migrant workers, not only for themselves, but also to prevent any problems related to reproductive health problems that might be faced during their employment in foreign countries. Reproductive health materials that are relevant for Indonesian migrant workers should be given before their departure to the country of destination.

The review of the receiving countries policy has shown that the situation in the receiving countries are not very favorable, especially not for women migrant worker. Nevertheless, the government policies and the enforcement of these policies can make a difference, as varying situations of migrants from different countries indicates[16].

Our study also suggests that the evaluation of reproductive health material before training (pre-test) and after training (post-test) indicates the ability to master reproductive health material (knowledge), and some attitudes (attitudes) towards reproductive health problems could be the key factors. However, to test the reliability of the concept, it is necessary to evaluate in a time series analysis when migrant workers have lived their life as migrant workers. Future improvements to the concept, and training program targeted to specifically for prospective migrant workers in specific country, together with to carry out proportional assistance (mentoring) which able to reflect towards concepts and positive attitudes in the scope of reproductive health. When providing material, grouping the same country goals is important to do because the patterns and processes of the problems are specific to each region or country of work is a must to do. Finally, exposure simulations that are appropriate to the problem of the workplace country will build the readiness and success of migrant workers in dealing with the real problems.

Conclusion

Based on the findings in our study we conclude that reproductive health education for Indonesian migrant workers should be given before their departure to the country of destination. Reproductive health education using modules with many cases is effective for Indonesian migrant workers.

We also suggest that reproductive health education must begin early before their departure.Training is suggested to be carried out on specific subjects and in the specific workplace country goals, and specific / realistic exposure so the results would be maximum.

Conflict of Interest: The authors declare that they have no competing interest

Ethical Clearance: Committee of Ethical research, School of Medicine Universitas Airlangga Surabaya, declare that this study have no ethical problems. Letter of agreement No. :231/EC/KEPK/FKUA/2019

Source of Funding: Minister of Research, Technology and Higher Education Republik Indonesia.

Acknowledgements: The authors are thankful to Minister of Research, Technology and Higher Education Republik Indonesia for the financial support.

References

1. BNP2TKI (Badan Nasional Penempatan dan Perlindungan Tenaga Kerja Indonesia) Pusat Penelitian, Pengembangan dan Informasi (PUSLITFO). Data Penempatan dan Perlindungan PMI periodeJuni 2019. 2019
2. WidyawatiA. Legal protection model for migrant workers. Journal of Indonesian Legal Studies. 2018;3(2):291-304.
3. Wang W.Prevalence and risks for Sexually Transmitted Infections among a national Sample of migrants vs. Non-migrants in China. Int J STD AIDS. 2010;2:410-415
4. Moyce SC, Schenker M. Migrant workers and their occupational health and safety. Annu. Rev. Public Health.2018;39:351-365.
5. Abdulkader RS, Kant S, Rai SK, Goswami K, Misra P.Prevalence and determinants of Sexually Transmitted Infections (STIs) among Male migrant Factory workers in Haryana, North IndiaIndian journal of Public Health. 2015;59:1-3.
6. Nuraeny H. Trafficking of Migrant Workers in Indonesia: A Legal Enforcement and Economic Perspective of Prevention and Protection Efforts. European Research Studies Journal.2017
7. Rahayu N. Indonesian Migrant Worker Policies and the Vulnerability of Women Migrant Workers to Becoming Trafficking Victims: an Overview of Recent Legislation.

Journal of Southeast Asian Human Rights.2017;1 :2:159-172.

8. Diantha IMP. Protecting Migrant Workers, An Indonesian Experience. International Journal of Business, Economics and Law. 2015;7:53-57.
9. HussinMH.Factors Influencing Indonesian Women Becomes Migrant Workers. JurnalHubunganInternasional. 2013; 2(1): 65 -74.
10. SulaksonoE. The Patterns of Human Trafficking of Indonesian Migrant Workers: Case Study of the Riau Islands and Johor Border Crossing. MASYARAKATJurnalSosiologi. 2018 ;23:167-186.
11. WHO South-East Asia Region. Health of refugees and migrants. Regional situation analysis, practices, experiences, lessons learned and ways forward. 2018
12. Dai W.Sexual behavior of migrant worker in Shanghai, China. BMC Public Health. 2015;15:1067
13. Ullah AA.Premarital Pregnancies among migrant workers: The case of domestic helpers in Hong Kong. Asian Journal of Women's Studies.2010;16.
14. Zong Z, Yang W, Sun X, Mao J, Shu X, Hearst N.Migration Experiences and Reported Sexual Behavior among Young, Unmarried female migrants in Changzhou, China. Global Health: Science and Practice. 2017;5: 3.
15. SweilehWM.Global output of research on health of international migrant workers from 2000 to 2017. SweilehGlobalization and Health. 2018; 14:105.
16. Sakdapolrak P.Protection of women migrant workers. Policies of Selected Sending and Receiving Country. World Bank Office Jakarta. 2002.
17. Platt M, Davies SG, Bennett LR.Migration, Moralities and Moratoriums: Female Labour Migrants and the Tensions of Protectionism in Indonesia. Asian StudiesReviein the destination count. 2018.
18. Mafruhah I, Sarsito T, GravitianiE. The Wealfare of the Indonesian Migrant Workers (TKI) in the Land of a Malay Nation: A Socio-Economic Analysis. Southest Asian Journal of Social and Political Issues. 2012;1: 246-270.