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DOI Number: 10.5958/0976-5506.2018.01494.8 Youth Resilience Capabilities Avoid Free Sex, HIV/AIDS and Drugs based on Sekaa Teruna GA Marhaeni1, IGA Surati1, Ni Wayan Armini1, I Putu Suiraoka2 1Department of Midwifery, 2Department of Nutrition, Health Polytechnic, Ministry of Health, Denpasar Bali ABSTRACT Adolescence is the age where individuals integrate with adult society. Integration in society has an effective aspect, more or less related to puberty, including striking intellectual changes.

Adolescents are more prone to risk behavior due to psycho-social influences, namely limited ability to think logically, the ability to regulate weak emotions, and the influence of peers. The purpose of this study was to improve the ability of adolescent resilience to avoid free sex, HIV / AIDS and drugs based on Sekaa Teruna in the Nongan village, Karangasem and Ketewel village, Gianyar.

The quasi experimental research with Pre test-posttest control group design was carried out in the villages of Nongan, Karangasem and Ketewel, Gianyar from August to September 2017. Data collection instruments are Spritually Resilient Assessment Packet version 44. Data analysis was performed including descriptive analysis and bivariate analysis with Wilcoxon test and Mann- Whitney test.

The ability of adolescent resilience (about free sex, HIV-AIDS, and drugs) before treatment in the control group, 45.0% of resilient adolescents and in the treatment group 76.7% of resilient adolescents. The ability of adolescent resilience after treatment in the control group, 55.0% of resilient adolescents and in the treatment group 100% of resilient adolescents.

There are differences in adolescent resilience before and after being treated both in the

control group and in the treatment group There are differences in adolescent resilience in both the control and treatment groups Keywords: Adolescent, Resilience, Sekaa Teruna

INTRODUCTION Many challenges must be faced by teenagers in the era of globalization. The challenge comes from increasing school demands, free communication / internet access, and access to print and electronic media broadcasts.

If adolescents are not able to respond to challenges positively, it will have a negative impact on family, community, social environment, and even threaten and endanger the future of the nation and the state. Adolescence is the age where individuals integrate with adult society. Integration in society has an effective aspect, more or less related to puberty, including striking intellectual changes (Piaget in Hurlock) (1).

At this time mood can change very quickly. Drastic mood changes in teenagers are often due to homework, school work, or daily activities at home. Sometimes teenagers do things _that are outside the norm to get recognition about their existence in the community (2) There are many problems in young people include: behaviors that contribute to acts of violence and accidental accidents, use of illegal drugs and smoking, having unsafe sex, unsafe diet, and inadequate physical activity (3–5). Adolescents are more prone to risk behavior due to psycho-social influences (6).

Premarital sexual behavior is all sexual behavior that is driven by the opposite sex sexual desire that is done before marriage (2). Approximately 47.0% of the population of teenagers aged 10 to 19 years in the world have had active sexual intercourse and around 2.4% end up with pregnancy before marriage (5). The impact of premarital sex behavior is experienced more heavily in women than men. This impact includes

biological, social and psychological aspects (7–11).

The holder of the control of the lives of the Balinese people is the traditional village, so that almost all individual activities are full of traditional sequences. Adat also means rules, laws, moral standards that guide everyone. Balinese people are said to succeed in maintaining cultural values because religious traditions are still strong.

Changes in social solidarity in the community in Bali, such as premarital sex behavior is not a social problem but a personal problem that must be solved personally (12). Premarital sexual behavior that spreads very quickly and widely in the neighborhood where people live has been considered normal, in addition to the consequences of weak traditional sanctions today.

Thus, it is necessary to explore the role of resilience and other factors that influence teenage premarital sex behavior in Bali. Delinquency and abuse of drugs that occur involve a lot of teenagers. In addition, many teenagers also have deviant sexual behavior. The intervention program for adolescents should be through positive youth development programs. One reliable way for teenagers in Bali is Sekaa Teruna.

Sekaa Teruna is a youth organization that functions as a forum for developing youth creativity. This organization can also be a place to preserve local culture and traditions. Local governments need to improve the function of Sekaa taruna to protect teenagers. The results of interviews with the community leader at Nongan and Ketewel Village showed that Sekaa Teruna as a youth organization had not carried out its role well.

Resilience is the ability to respond healthily and productively when facing obstacles or trauma (13). Resilience is a tenacious and resilient attitude that a person has when faced with difficult conditions (14). The problem in this study is how the influence of Sekaa Teruna-based counseling on adolescent resilience? The purpose of this study was to improve the ability of adolescent resilience to avoid free sex, HIV/AIDS and drugs based on Sekaa Teruna in the Nongan village, Karangasem and Ketewel village, Gianyar MATERIALS AND METHOD This type of research is quasi experimental research with Pre test-posttest control group design (15).

The _research was carried out in the villages of Nongan, Karangasem and Ketewel, Gianyar from August to September 2017. Consideration of research location selection due to the high incidence of drug abuse and deviant sexual behavior by teenagers in the village. The population is all adolescents in the village of Nongan, Karangasem and Ketewel, Gianyar with the unit of analysis are adolescents members sekaa teruna.

Sample selection is nonprobability. The inclusion criteria included: registered as a member of a group of Nongan Karangasem Village cadets and Ketewel Village, Gianyar; no psychiatric disorder based on family member information; without chronic diseases; can read and write.

The sample size is calculated by the large sample formula developed by Isaac and Michael with a 5% error rate (16) and an additional 10% to anticipate drop out so that the sample size becomes 60 people. Data collection instruments are standardized questionnaires, namely SRA-44 which was coined by Jared K and Lynn K. from the Institute of Contemplative Edication, Cambridge. The questionnaire has seven answer choices.

However, in this study the choice of answers was modified into four answer choices. Data analysis was performed including descriptive analysis and bivariate analysis with Wilcoxon test and Mann- Whitney test. RESULT AND DISCUSSION Result Nongan village is an intervention group where it is treated in the form of health counseling with media modules and leaflets.

This village consists of 14 banjars. The population of Nongan Village is 6646 people consisting of 3319 female and 3327 male. The number of teenagers is 867 people, with 463 male and 404 female. Ketewel Village is a control group with convensional health counseling using leaflets. This village consists of 15 banjars. The population is 10,298,000 people consisting of 5,192,000 women and 5,106,000 men.

The number of adolescents is 1,267 with details of 654 male and 613 female. Characteristics of respondents observed included: gender, age, and education. The data is presented in Table 1.

Table 1: Demographic characteristics of Respondents Characteristics _Intervention group _Control group _ _ _f _% _f _% _ _Gender Male Female _ 27 33 _ 45 55 _ 21 39 _ 35 65 _ _ Education level Middle school High school Diploma Bachelor _ 4 50 6 0 _ 6.7 83.3 10.0 0.0 _ 1 32 7 20 _ 1.7 53.3 11.7 33.3

_ _Total _60 _100 _60 _100 _ _Age (year) Minimum Maximum Average Standard deviation _ 17.0 27.0 19.8 2.3 _ 17.0 29.0 22.0 2.3 _ _In table 1, it can be seen that the respondents in the intervention group were more women (55%), as well as in the control group more women (65%). Based on the level of education in the treatment group, the respondents were mostly high school (83.3%), and in the control group some were high school (53.3%).

Based on the age of respondents in the intervention group, the average age was 19.8±2.33 years, while in the intervention group was 22,016±2.38 years. Table 2: Descriptive of Adolescent Resilience Ability Descriptive _Intervention group _Control group _ _Before intervention _ _ _ _Mean _82.45 _84.40 _ _Median _82.00 _85.00 _ _Standard deviation _0.90 _4.26 _ _Minimum _80.00 _71.00 _ _Maximum _85.00 _95.00 _ _After intervention _ _ _ _Mean _104.05 _128.00 _ _Median _104.00 _128.00 _ _Standard deviation _3.08 _0.00 _ _Minimum _97.00 _128.00 _ _Maximum _116.00 _128.00 _ _From table 2, it is known that the average ability of adolescent resilience before treatment in the control group was 82.45 and after treatment 104.05.

The average ability of adolescent resilience before treatment in the treatment group was 84.40 and after treatment became 128.00.

Table 3: Frequency Distribution of Adolescent Resilience Ability Resilience Ability _Intervention group _Control group _ _ _f _% _f _% _ _Before intervention _ _ _ _ _ _Resilient _46 _76.7 _27 _45.0 _ _Not resilient _14 _23.3 _33 _55.0 _ _After intervention _ _ _ _ _ _Resilient _60 _100 _33 _55.0

_ _Not resilient _0 _0 _27 _45.0 _ _Total _60 _100 _60 _100 _ _Before the treatment, respondents from the treatment group mostly (76.7%) had the ability to resilience, while from the control group who had the ability to resilience less than half (45%). After the treatment, there was an increase, namely that in all the respondents, the intervention group had the ability to resilience (100%) and while in the control group who had the ability to resilience to 55%.

The difference in the ability of adolescent resilience about free sex, HIV/AIDS and drugs before and after the intervention was carried out using the Wilcoxon test. Table 4: Differences in Adolescent Resilience in Treatment and Control Groups Deskriptive _Intervention group _Control Group _ _ _Pre _Post _p Value _Pre _Post _p Value _ _Mean Median Standard deviation Minimum Maximum _84.40 85.0 4.26 71.0 95.0 _128.00 128.00 0.00 128.00 128.00 _ 0.00 _82.45 82.0 0.90 80.0 85.0 _104.05 104.0

3.08 97.0 116.0 _ 0.00 _ _

In table 6 it can be seen that there is an increase in ability which means teenage resilience in the treatment group ($p<0.05$) and the control group ($p<0.05$). The difference in the effect of treatment in the treatment group and control on the ability of adolescent resilience before and after the intervention was done with the Mann Whitney test. The test results showed an increase in the effect of adolescent resilience the treatment group was higher than the control which was 45.75.

Health education using modules, and leaflets can significantly improve teenage resilience ($p<0.05$). DISCUSSION Adolescents must have the ability to avoid problems that might occur. Even if teenagers have to face and _overcome problems, they must become stronger. The conditions mentioned above are called resilience.

The results of the study showed that adolescents at both research sites had resilience abilities about free sex, HIV/AIDS and drugs. The results showed that in the treatment group there was an increase in resilience in adolescents up to 100% and in the control group there was an increase of up to 55%.

Thus it can be concluded that health counseling with the lecture method, discussion and question and answer as well as supplemented with leaflets in the control group as well as modules and leaflets for the treatment group can improve youth resilience. Resilience in other studies is also interpreted as the ability to bounce back to continue living after experiencing problems getting better.

In this case the

relation to the condition if, for example, teenagers are faced with conditions already undergoing risky behaviors namely free sex, HIV-AIDS and drugs. The factors that influence resilience are not only individual and genetic but also cultures that might increase or decrease resilience. In the results of the study there was an increase in the ability of adolescent resilience in the control group and the treatment group.

The results of this study are in accordance with Delyana's (2015) study in Yogyakarta which found that the knowledge and attitudes of adolescents about premarital sex changed significantly before and after being given sexual education. In line with Sarwono's (2011) theory that sexual education is an effective way to prevent risky behavior in adolescents, especially premarital sex behavior.

Respondents from the treatment and control groups, in addition to being given exposure or counseling about resilience, but also equipped with modules and leaflets, with the hope that teenagers are able to read again about tips and tricks to be resilient towards risky behavior. This is consistent with Azwar's (2011) theory that changes in adolescent knowledge and attitudes, should be supported by personal experience, support from the environment, including the mass media, especially support from parents.

The more often teenagers get positive support and information about resilience, then the ability of adolescents will increase to prevent risky behavior. Teenagers who have high resilience have the possibility to develop faster and be happier than adolescents who do not have or have the ability to bounce back from adversity (Reivich & Shatte, 2002).

The fundamental assumption in the study of resilience is that some individuals remain fine, even though they have experienced adversity and risk-laden situations, while some other individuals fail to adapt and fall into adversity or even heavier risks. The results showed that health education with a module and leaflet media in treatment and leaflet groups in the control group could increase adolescent resilience ($p<0.05$).

Reivich & Shatte states that: People can increase their resilience by learning to understand their thingking styles and developing skills to circumvent them so that you can see the true causes of adversity and its effect of life. Thingking style is what causes us to respond emotionally to events, so it's your thingking _style that determines your level of resilience the ability to overcome, steer through, and bounce back when adversity strikes. A person can use his thinking style to overcome the negative consequences of a debilitating event.

This type of counseling media is diverse. The use of media aims to clarify the information conveyed in the counseling. The more media used, the more teenagers understand the material presented. Pri Hastuti and Luluk Mahaningsih (2009) found that lecturing by giving modules was more effective than lectures by giving leaflets.

The module contains more detailed information than leaflets, allowing respondents to learn more independently. Resilient ability in adolescents increases when information is, received complete, clear and consistent. This requirement can be accommodated in a module, as a learning medium. However, the module will not function effectively if it is not accompanied by counseling.

In the extension process, there is a perception stage where participants are invited to equalize perceptions between the instructor and participants. Perception is very important to equalize the information conveyed. The results of this study are different from the results of Pahalani's (2016) study, which revealed emotion regulation therapy using modules as guidelines did not have a significant influence on the ability of teenagers resilience living in orphanages.

It is explained that many factors influence youth resilience, especially support from parents and the surrounding environment. CONCLUSION The ability of adolescent resilience (about free sex, HIV-AIDS, and drugs) before treatment in the control group, 45.0% of resilient adolescents and in the treatment group 76.7% of resilient adolescents The ability of adolescent resilience after treatment in the control group, 55.0% of resilient adolescents and in the treatment group 100% of resilient adolescents There are differences in adolescent resilience before and after being treated both in the control group and in the treatment group There are differences in adolescent resilience in both the control and treatment groups

Recommendation Based on the results of the study it can be suggested as follows: 1) For policyholders in the field of Reproductive Health in order to carry out socialization activities on Adolescent Reproductive Health in the form of counseling to Sekaa Teruna regularly and continuously.

2) For the Indigenous village leader to facilitate socialization activities on risky behavior in adolescents. 3) For teenagers to actively seek information so that they have good knowledge and are able to choose healthy things to do. Conflict of Interest: Authors declare that there is no conflict of interest within this research, publication paper and funding support Etichal Clearence: Ethical Clearance obtained from the university committee and respondent assignment.

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