

## BUILDING SELF-EFFICACY FOR REPRODUCTIVE HEALTH AMONG INDONESIAN MIGRANT WORKERS' CHILDREN IN MALAYSIA: AN ASSET- BASED, GAME-SUPPORTED COMMUNITY PROGRAMME

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### ABSTRACT

*Background: Indonesian migrant workers' children in Malaysia face restricted access to formal schooling and reproductive-health (SRH) information. Objective: To design and implement a community-based SRH programme that builds children's self-efficacy using an Asset-Based Community Development (ABCD) approach supported by educational gaming. Methods: A community programme at El Shaddai Learning Centre (Kuala Lumpur) engaged 30 children (7–14 years). The ABCD cycle (discover–dream–design–deliver) informed asset mapping, shared visioning, co-designed content, and delivery/evaluation. The intervention comprised age-appropriate interactive talks and a cause-and-effect “snakes-and-ladders” board game. Formative and summative assessments (structured observation, brief oral quizzes) captured SRH understanding and early self-efficacy indicators. Results: Relative to baseline, participants demonstrated improved ability to define SRH, identify age-appropriate protective behaviours, and articulate consequences of risky choices. Early self-efficacy signals (e.g., refusal of unsafe invitations; concrete steps to maintain personal boundaries) were evident during group work and gameplay. Conclusions: An ABCD-anchored, game-supported format is feasible and acceptable in migrant settings. Sustainability should leverage peer-education, youth-friendly referrals, and light process indicators for ongoing monitoring.*

**Keywords :** *Self-Efficacy, Reproductive Health, Peer Education, ABCD, Educational Games.*

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### Introduction

Over the past two decades, international migration has increased sharply. In 2019, the number of global migrants reached 272 million, including 164 million migrant workers and 38 million children (Hetmantseva et al., 2021). Based on estimates from the International Labor Organization, there were 169 million international migrant workers in 2019, with the Asia and Pacific region hosting around

24 million of them (ILO, 2021). Asia is also the largest region of origin for global migrants. According to a report by the Indonesian National Agency for the Placement and Protection of Indonesian Workers, in 2024, 51,723 Indonesian migrant workers were sent to Malaysia, making it the third largest destination country after Hong Kong and Taiwan. This trend has increased sharply, particularly in December 2024, with the number of

placements reaching 7,890 people a 151.43% jump compared to the previous month (BNP2TKI, 2025). Behind this migration flow, the children of migrant workers especially those who are undocumented experience limited access to education and health services, including information, understanding, and protection related to reproductive health.

The 2024 World Migration Report shows that undocumented migrant women face significant barriers in accessing reproductive health services challenges that also impact migrant children and adolescent girls who lack adequate education and protection (WMO, 2024). A cross-country study shows that nearly 80% of undocumented Asian and Latinx migrants face barriers in accessing sexual and reproductive health services, including limited access to contraception (PAHO, 2023). Indonesian migrant workers' children in Malaysia are at high risk of reproductive health problems due to lack of education and minimal protective measures (Sutan & Siregar, 2022). Research conducted at the Indonesian School in Kuala Lumpur shows that before receiving educational interventions, many students were unaware of the physical changes that occur during puberty, as well as the dangers of sexual violence and bullying (Porusia & Dewi, 2023). These findings highlight the urgent need for comprehensive and ongoing

reproductive health education tailored to migrant workers' children (Bouaddi et al., 2023; Larrea-Schiavon et al., 2022).

Although reproductive health education is an important component of adolescent health services, it is often overlooked in basic health worker training, especially in developing countries (Kubota et al., 2024). A study by Aibangbee et al., (2023) shows that migrant adolescents have low levels of knowledge about sexual and reproductive health and face significant barriers in accessing health services due to stigma, discrimination, and the absence of culturally appropriate education. This lack of knowledge increases their vulnerability to teenage pregnancy, sexually transmitted infections, and sexual violence.

In the context of Indonesian migrant children in Malaysia, limited understanding of puberty, bodily autonomy, and sexual violence prevention highlights the urgent need for comprehensive, safe, and youth-centered reproductive health education. Many of these children experience puberty without access to adequate education, information, or emotional support. The absence of appropriate sexual and reproductive health education significantly increases their vulnerability to risky sexual behavior, teenage pregnancy, and sexual violence. Therefore, it is crucial for migrant children to acquire accurate and age-appropriate knowledge about reproductive

health so that they can recognize bodily changes, protect themselves from health risks, make informed decisions, and take responsibility for their well-being.

### Method

We adopted an Asset-Based Community Development (ABCD) approach that positions the community as the principal owner of solutions rather than a passive recipient. ABCD guided a four-stage cycle discover–dream–design–deliver to identify and mobilise individual, institutional, social, cultural, and material assets relevant to children of Indonesian migrant workers. In the *discover* stage, participatory observation, focused group discussions with children, community teachers, parents, and volunteers, and semi-structured interviews with local leaders and health workers were used to map assets (e.g., informal educators, volunteer clinicians, community learning spaces, faith venues, and existing child-protection norms). The *dream* stage employed participatory workshops and community forums to articulate a shared vision for safe, age-appropriate reproductive-health learning and confident self-care.

Building on these assets and vision, the *design* stage co-created a feasible, culturally sensitive, and gender-responsive educational package: interactive sessions on puberty, hygiene, bodily autonomy, and protection from sexual violence; self-

efficacy strengthening through simulations, role-play, and brief quizzes; **peer-educator** training to support horizontal diffusion; and contextually tailored media (illustrated leaflets, posters, short videos). The *deliver* stage implemented the programme with facilitators acting as learning coaches rather than didactic instructors. Evaluation comprised **formative** assessment (structured observation of engagement, affect, and responses during sessions) and **summative** assessment (simple post-programme questionnaires capturing gains in knowledge, self-efficacy indicators, and ability to state concrete protective actions). To support sustainability, the programme encouraged formation of small peer-learning groups and informal consultation spaces with teachers or local volunteers.

Operationally, the plan sequenced eight activities: rapid baseline assessment; an age-appropriate interactive talk; a cause-and-effect “snakes-and-ladders” educational game; a brief oral post-test; reflection and written behaviour-commitment; a short refresher plus caregiver/mentor briefing (including takeaway tip-cards); documentation and monitoring (attendance logs, activity records, anonymised photos, post-test summaries); and stakeholder coordination for an exit strategy. Stakeholders included the primary participants (migrant children), parents/guardians, centre managers,

community teachers/tutors, the facilitation team, representatives of the Indonesian Embassy, health/psychosocial partners, and supporting NGOs/CSR. Assumptions for programme success were predefined (e.g., qualitative baseline capture, active participation, majority correct post-test responses, explicit individual commitments, and a simple schedule for ongoing reinforcement), enabling transparent appraisal of feasibility and groundwork for scale-up.

## **Results**

### **Participant characteristics.**

The programme was delivered at the El Shaddai community learning centre in Kuala Lumpur and engaged 30 Indonesian migrant children aged 7–14 years. Rapid baseline observation indicated limited foundational understanding of reproductive health covering definitions, the rationale for safeguarding reproductive health, and recognition of risk consequences underscoring the need for age-appropriate, context-sensitive instruction.

### **Intervention delivery and programme outputs.**

The intervention comprised two core components: an interactive talk and an educational *snakes-and-ladders* game (Figures 1–3). The talk introduced reproductive-health concepts in simple, developmentally appropriate language and linked them to everyday protective

behaviours (e.g., maintaining boundaries, seeking adult support when uncertain). The game operationalised cause–effect reasoning by mapping healthy choices to upward movement and risky choices to downward movement, allowing children to visualise how daily decisions connect to health, psychosocial, and social consequences (Figures 4–5). All planned activities were completed, including a brief post-session oral quiz and structured facilitator notes that documented key comprehension items and participant responses for feedback and programme refinement.

### **Knowledge gains and early self-efficacy indicators.**

Relative to the pre-session observation, most participants were able to articulate a basic definition of reproductive health, explain why it matters, and provide age-appropriate examples of protective behaviours. Children also identified risk behaviours and linked them to plausible outcomes. During discussion and gameplay, early indicators of self-efficacy were observed: participants voiced confidence in refusing unsafe peer invitations, described concrete steps to avoid risk-promoting situations, and consistently explained why specific choices in the game would “move up” (protective route) or “move down” (risk route)



(Figure 6).

### **Learning dynamics, facilitators, and challenges.**

Engagement was high throughout, with active participation in gameplay, discussion, and rapid-response questioning. Comprehension appeared facilitated by plain language, relatable everyday examples, and a classroom atmosphere that normalised questions. The principal implementation challenge was the wide age range (7–14 years), which required progressive scaffolding of concepts and age-tailored phrasing. To address this, facilitators decomposed complex topics into smaller units, used concrete contextual examples, and verified understanding with brief comprehension checks before advancing. A closing session documented participation and activities, providing a

transparent record for programme monitoring.



(Figure 7).

### **Discussion**

This outreach activity demonstrated an increase in understanding and early signs of strengthened self-efficacy related to reproductive health among 30 migrant workers' children aged 7–14 years at the El Shaddai Guidance Center in Kuala Lumpur. Before the intervention, participants did not have a basic understanding of the definition, urgency, and consequences of risky behavior. After a combination of interactive lectures and the educational game “snakes and ladders,” the majority were able to define reproductive health in simple terms, explain the importance of self-care, identify age-appropriate protective behaviors, and connect risky behaviors with health, psychological, and social consequences. Indications of self-efficacy were observed through statements about being able to refuse risky invitations and mentioning concrete steps to maintain boundaries in interactions, which were reinforced by the results of a post-intervention oral quiz and participants' explanations when interpreting “up/down”

on the game board as a representation of cause and effect. Overall, these findings are in line with the program's objectives of sparking reproductive health literacy and building initial self-confidence in the target group, while also confirming the feasibility and acceptability of the lecture-based game approach in the context of migrant children.

According to the cognitive-social framework, self-confidence comes from four sources: successful experiences (mastery), vicarious experiences (imitation), verbal persuasion (feedback), and affective-physiological states. These four things form the basis for creating learning strategies that make people believe “I can do it” (Pacicco et al., 2025). In this program, mastery is activated through correct answers on quizzes and “leveling up” on the game board; vicarious references are provided through observation of peers and facilitators making safe choices; verbal reinforcement from facilitators boosts confidence; and a safe play environment helps reduce anxiety. All of these, in theory, should make children more likely to reject risky behaviors (Pacicco et al., 2025). Empirical evidence shows that comprehensive sexual and reproductive health (SRH) education improves knowledge and protective behaviors among children and adolescents, thus forming the basis for the lecture component of this intervention (Kim et al., 2023).

Furthermore, game-based and serious game methodologies facilitate active participation, concept retention, and attitude and confidence reinforcement, making them suitable for sensitive topics such as reproductive health. In the field of adolescent sexual and reproductive health, digital and activity-based interventions consistently show improvements in safe behavior and risk mitigation (Ilskens et al., 2022). This reinforces the premise that active participatory methodologies, such as interactive lectures combined with board games, are relevant for developing early self-confidence in migrant children (Borji-Navan et al., 2024).

From ages 7 to 14, children develop from a very concrete mindset (late childhood phase) to a more abstract mindset and cognitive control (early adolescence phase). Therefore, KRR material should begin with concrete visual examples, simple language, and structured exercises, then gradually transition to conceptual reasoning and decision-making (Luciana et al., 2023). At this stage, cognitive/executive control (planning, inhibition, and flexibility) is still developing (Badre, 2025). Learning designs that set clear goals, provide rapid feedback, and ask students to repeat the same exercises multiple times will help them understand and remember without overloading their brains (Debra et al.,

2024). Recent literature supports that a safe and supportive educational environment facilitated through games, structured discussions, and modeling promotes emotional regulation and participants' readiness to make self-protective decisions. The latest global SRR references separate learning objectives by age group (e.g., 5–8; 9–12; 12–15 years) so that concept reinforcement can be structured from basic knowledge about the body and emotions to more complex topics such as consent and decision-making, in line with developmental capacity (Albert Sekhar et al., 2024). The KRR guidelines for out-of-school settings also emphasize adaptation to different ages and situations. For example, cause-and-effect “up-and-down” boards are useful for groups learning in community centers (United Nations Population Fund (UNFPA), 2020). In addition, the 2024 policy review states that Comprehensive Sexuality Education (CSE) should be age- and developmentally-appropriate when creating materials and methods, especially for vulnerable groups such as migrant children (Childrens Human Rights, 2019).

Transforming knowledge-attention-action outcomes into consistent protective practices requires learning in a safe, inclusive, and supportive environment, as a positive classroom climate is essential for meaningful engagement and skill

development (World Health Organization, 2021). Recent meta-analysis evidence shows that positive teacher-student relationships and supportive teacher behaviors have a moderate to strong correlation with student learning participation, highlighting the importance of safe interaction dynamics in promoting active engagement (Li & Xue, 2023). The “Safe to Learn” agenda emphasizes that ending violence and ensuring children have a safe place to learn are prerequisites for them to learn, participate, and develop to their full potential (EVAC, 2023). “Welcoming Diversity” guide emphasizes similar principles by outlining inclusive teaching practices that create a sense of safety and belonging for students from diverse backgrounds (Kaplan, 2022). OECD survey results on social-emotional skills consistently show that schools with a positive climate and strong SEL support tend to promote increased student participation and well-being, highlighting the need for policies that deliberately strengthen that climate (OECD, 2024). The 2022–2030 Comprehensive School Safety Framework establishes safety, sustainability, and continuity of learning as an all-hazards framework applicable to schools and community learning centers, thereby ensuring participation in the realm of child protection (UNICEF, 2022).

This study has several limitations that make it difficult to draw strong conclusions and apply the results to other situations. The single pre-post design without a comparison group reduces the ability to evaluate causality and is susceptible to maturation and testing effects. The limited sample size (n=30) at one location, covering a diverse age range (7–14 years), may introduce cluster/age bias and limit the generalization of results to other migrant children. Outcome measurements were conducted immediately after the intervention through an unvalidated oral quiz and depended on facilitator assessment, making them susceptible to social desirability bias, observer bias, and the Hawthorne effect. Significant covariate data (e.g., gender, length of stay, parental education, prior exposure to media/KRR education) were not accounted for, allowing residual confounding factors to influence the results. Furthermore, implementation fidelity (adherence to materials/procedures) was not systematically evaluated, and there was no medium- to long-term follow-up; therefore, the sustainability of changes in attitudes and skills remains uncertain.

The development recommendations emphasize improving the quality and accessibility of the program through various strategic measures: (1) expanding coverage to several locations (several

studios/schools) with a quasi-experimental design using comparison groups to strengthen causal inference; (2) adapting materials based on age groups (7–10; 11–14 years) and gender/cultural sensitivities, as well as collaborative design with teachers and parents to align with local norms; (3) improving M&E by using tailored self-efficacy/knowledge tools that have been tested for reliability and validity, monitoring facilitator fidelity, and conducting follow-ups every 3 to 6 months to see if changes are sustained; (4) Add parent components (such as tip cards and short classes) and referral services (such as community health centers and psychosocial services) to protection SOPs; (5) Create a scalability toolkit (modules, game boards, monitoring and evaluation sheets, communication materials) and digital micro-learning to facilitate replication at lower cost, accompanied by simple cost analysis; (6) Strengthen facilitators by providing regular training, peer supervision, and memoranda of understanding (MoUs) between education and health to ensure policies are adopted and sustained at the school or center level.

The combination of interactive lectures and educational “snakes and ladders” games in an informal setting is an effective way to teach migrant workers' children (aged 7 to 14) about reproductive health and help them feel more confident

about it. The mechanism of change operates through active learning that explains cause-and-effect relationships, supported by a safe learning environment, the integration of religious values and social norms, and the exemplary behavior of facilitators, thereby empowering participants to adopt protective behaviors and reject risky offers. These results provide a practical foundation for schools and centers to institutionalize routine reinforcement, counseling corners, and youth-friendly referral collaborations, with age-appropriate and culturally sensitive modifications to the materials. To ensure lasting impact and strengthen causal inference, it is important to design evaluations (multi-site, 3–6 month follow-up, standardized measurement tools) and monitor how well they are implemented. This low-cost, replicable game-based model can be used as a means to protect and promote reproductive health in migrant communities if there is consistent governance and partnerships between education and health.

### Conclusions

The El Shaddai Guidance Center's interactive lecture program and educational “snakes and ladders” game help migrant workers' children (aged 7 to 14) further understand basic reproductive health, such as the changes that occur during puberty and their rights over their bodies. This

intervention also successfully provided education and practical skills such as risk recognition, refusal skills, decision-making, and child-friendly service referral pathways that are relevant for the prevention of teenage pregnancy, sexual violence, and sexually transmitted infections. In addition, the results show that participants' self-confidence and self-efficacy increased: they were able to recognize protective behaviors, refuse risky invitations, and make their own plans to stay healthy. The program's objectives were achieved, and this model can be applied in similar situations with long-term success (regular sessions, counseling corners, parental involvement) and light monitoring to ensure consistent impact.

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