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Dekan Fakultas Psikologi Universitas Katolik Soegijapranata Semarang memberikan tugas kepada :

Nama	:	**Damasia Linggarjati Novi, S.Psi., MA**
Status	:	Staf Dosen Fakultas Psikologi Universitas Soegijapranata Semarang
NPP	:	**058.1.2001.241**
Tugas	:	Presentasi artikel dengan judul : Health Literacy of Psychology Student of Soegijapranata Catholic University, Semarang
Hari	:	Selasa
Tanggal	:	14 November 2017
Tempat	:	Universitas Malaya Malaysia
Lain – lain	:	Harap melaksanakan tugas dengan sebaik-baiknya dan penuh tanggung jawab serta memberikan laporan setelah selesai melaksanakan tugas.

Demikian surat tugas ini dibuat untuk dapat dipergunakan sebagaimana mestinya.

Semarang, 9 November 2017

Dekan,

Dr. M. Sih Setija Utami, M.Kes

NPP : 058.1.1990.068

9th AHLA International Health Literacy Conference 2017
Centre for Population Health (CePH)
Department of Social and Preventive Medicine
Faculty of Medicine
University of Malaya
14/11/17

Telah melaksanakan Tugas
Mengetahui :

( )

UNIVERSITY OF MALAYA
Department of Social and Preventive Medicine

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Centre for Population Health

A·H·L·A
Asian Health Literacy Association

THE 5th AHLA INTERNATIONAL HEALTH LITERACY CONFERENCE

Certificate of Participation

Presented to

Damasia Linggarjati Novi

for participating at the

5th AHLA International Health Literacy Conference 2017
Health Literacy & Population Health

held from **12th - 14th November 2017** at
University of Malaya, Kuala Lumpur, Malaysia

hosted by
Centre for Population Health (CePH),
Department of Social and Preventive Medicine,
Faculty of Medicine, University of Malaya,
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Partnership with:

Roche MSD HPB

Health Literacy of Psychology Students of Soegijapranata Catholic University in Semarang, Indonesia

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Background

1. The main academic interest of undergraduate program of Psychology Faculty of Soegijapranata Catholic University, Semarang, Indonesia is Health Psychology.
2. Since 1993, we have been teaching the students about health behaviour and promoting healthy life styles. But, we never studied health literacy of our students.
3. We found the *Health Literacy Measure for Adolescent* (HELMA) in Shahla Ghanbari, Ali Ramezankhani, Ali Montazeri, Yadollah Mehrabi (2016). Health Literacy Measure for Adolescents (HELMA): Development and Psychometric Properties. *PLoS ONE, 11(2)*, 1-12. e0149202. doi:10.1371/journal.pone.0149202

Purpose of Study

1. To do adaptation the measurement of Health Literacy for adolescents (it will not be reported detail in this presentation)
2. To study the health literacy of the Psychology Faculty students related with sex, age, and batch.

Research Method

- It was quantitative Research.
- There were 664 students joined the research. They consisted of 156 male and 508 female students.
- They were students of batch 2012-2016; the age ranged from 17 to 23 years.
- Health literacy measurement was adapted from Health Literacy Measure for Adolescents (HELMA, Ghanbari et al, 2016)-> translated to Indonesian language, and retranslated to English language.

Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	156	23.5	23.5	23.5
	Female	508	76.5	76.5	100.0
	Total	664	100.0	100.0	

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	17	24	3.6	3.6	3.6
	18	130	19.6	19.6	23.2
	19	184	27.7	27.7	50.9
	20	162	24.4	24.4	75.3
	21	119	17.9	17.9	93.2
	22	40	6.0	6.0	99.2
	23	5	.8	.8	100.0
	Total	664	100.0	100.0	

Batch

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2012	25	3.8	3.8	3.8
	2013	134	20.2	20.2	23.9
	2014	188	28.3	28.3	52.3
	2015	155	23.3	23.3	75.6
	2016	162	24.4	24.4	100.0
	Total	664	100.0	100.0	

Results

1. About the scale

The Ghanbary's scale consists of eight factors: access, reading, understanding, appraisal, use, communication, self-efficacy, and numeracy.

Based on factor analysis, there were three factors :

a. understanding information about healthy life: "I can understand most things I hear about health".
b. effort to be healthy: "I try to choose foods without preservatives".
c. awareness about access to health information: "I am able to find more information on health".

Rotated Component Matrix[a]

	Component		
H_1		.495	
H_2			.538
H_3			.566
H_4			.543
H_5			.411
H_6			.465
H_7			.473
H_8			.532
H_9			.52-
H_10	.376		
H_11	.526		
H_12	.754		.335
H_13	.428		.322
H_14			.67
H_15	.5 5		
H_16	.530		
H_17	.639		
H_18	.626		
H_19	.6 1		
H_20	.5 7		
H_21	.452		
H_22	.7 1		.17
H_23	.67		.34
H_24	.448		
H_25	.456	.403	
H_26	.419	.369	
H_27	.451	.060	
H_28	.41	.017	
H_29	.041	.401	
H_30		.639	
H_31		.613	
H_32		.703	
H_33		.504	
H_34		.500	
H_35		.455	
H_36		.490	
H_37		.371	.358
H_38		.054	.40
H_39			.57
H_40		.387	.372
H_41		.367	.303

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 7 iterations.

2. Between male and female students

a. There was no significant difference between male and female students on understanding information about healthy life (t=-0.302, p=0.763, $Mean_m$ =63.31, SD_m = 10.19; $Mean_f$ =63.57; SD_f=8.986) neither on effort to be healthy (t=-1.268, p=0.205; $Mean_m$ = 39.65, SD_m =8.079; $Mean_f$ =40.51; SD_f=7.188).

b. But there was significant difference between male and female students on awareness about access to health information (t=-4.108, p= 0.000; $Mean_m$ =40.17, SD_m = 6.377; $Mean_f$ = 42.30; SD_f=5.443), which male score was lower than female score.

Report

Sex		Fak1und	Fak2eff	Fak3access
Male	Mean	3.52	3.30	3.65
	N	156	156	156
	Std. Deviation	.566	.673	.580
Female	Mean	3.53	3.38	3.85
	N	508	508	508
	Std. Deviation	.499	.599	.495
Total	Mean	3.53	3.36	3.80
	N	664	664	664
	Std. Deviation	.515	.618	.522

3. Based on the batches (2012-2016)

a. there was no significant difference among batches on understanding information about healthy life (F=1.307, p=0.266).
b. There was significant difference among the batches on effort to be healthy (F=3.273, p= 0.011), (the highest was batch 2014, and the lowest was batch 2012)
c. There was significant difference among the batches on awareness about access to health information (F=4.638, p=0.001). (the highest was batch 2014, and the lowest was batch 2016).
d. There was no significant correlation between batches and understanding information about healthy life (r = -0.017, p=0.663), neither was correlation between batches and effort to be healthy (r=0.008, p=0.883)
e. There was significant correlation between batches and awareness about access to health information (r =- 0.100, p=0.01). The earlier batches had the higher score on awareness about access to health information

Report

Batch		Fak1und	Fak2eff	Fak3access
2012	Mean	3.48	3.20	3.76
	N	25	25	25
	Std. Deviation	.420	.565	.514
2013	Mean	3.50	3.27	3.81
	N	134	134	134
	Std. Deviation	.466	.562	.518
2014	Mean	3.58	3.47	3.90
	N	188	188	188
	Std. Deviation	.551	.563	.472
2015	Mean	3.56	3.40	3.82
	N	155	155	155
	Std. Deviation	.470	.656	.542
2016	Mean	3.47	3.29	3.66
	N	162	162	162
	Std. Deviation	.561	.672	.540
Total	Mean	3.53	3.36	3.80
	N	664	664	664
	Std. Deviation	.515	.618	.522

Correlations

		Batch	Fak1und	Fak2eff	Fak3access
Batch	Pearson Correlation	1	-.017	.008	-.100**
	Sig. (2-tailed)		.663	.837	.010
	N	664	664	664	664
Fak1und	Pearson Correlation	-.017	1	.587**	.550**
	Sig. (2-tailed)	.663		.000	.000
	N	664	664	664	664
Fak2eff	Pearson Correlation	.008	.587**	1	.522**
	Sig. (2-tailed)	.837	.000		.000
	N	664	664	664	664
Fak3access	Pearson Correlation	-.100**	.550**	.522**	1
	Sig. (2-tailed)	.010	.000	.000	
	N	664	664	664	664

**. Correlation is significant at the 0.01 level (2-tailed).

4. There was no significant correlation between age and each of the factors.

Correlations

		Age	Fak1und	Fak2eff	Fak3access
Age	Pearson Correlation	1	.000	-.017	.050
	Sig. (2-tailed)		.997	.656	.199
	N	664	664	664	664
Fak1und	Pearson Correlation	.000	1	.587**	.550**
	Sig. (2-tailed)	.997		.000	.000
	N	664	664	664	664
Fak2eff	Pearson Correlation	-.017	.587**	1	.522**
	Sig. (2-tailed)	.656	.000		.000
	N	664	664	664	664
Fak3access	Pearson Correlation	.050	.550**	.522**	1
	Sig. (2-tailed)	.199	.000	.000	
	N	664	664	664	664

**. Correlation is significant at the 0.01 level (2-tailed).

5. Comparing between each factor

a. There were significant differences between score of understanding information about healthy life and that of awareness about access to health information (t=-14.214; p=0.000) and that of effort to be healthy (t=8.329, p= 0.000).
b. There was significant difference between score of awareness about access to health information and that of effort to be healthy (t= -20.158, p= 0.000).
c. The research results showed that the top rank of the student score was the awareness about access to health information (mean=3.80, SD= 0.522). The second was the understanding information about healthy life (mean = 3.53; SD=0,515), and the last one was the effort to be healthy (mean =3.36; SD= 6.18;).

	Mean	SD
Understanding information about healthy life	3.53	0.515
Effort to be healthy	3.36	0.618
Awareness about access to health information	3.80	0.552

Conclusion

1. There were three main factors of the adapted HELMA.
2. There was significant difference between male and female students on awareness about access to health information, and female students had higher score than male students did.
3. Among batches:
   a. There was significant difference among the batches on effort to be healthy (the highest was batch 2014, and the lowest was batch 2012)
   b. There was significant difference among the batches on awareness about access to health information (the highest was batch 2014, and the lowest was batch 2016).
   c. There was significant correlation between batches and awareness about access to health information ($r = -0.100$, $p=0.01$). The earlier batches had the higher score on awareness about access to health information

4. There was no significant correlation between age and each of the factors.
5. The score of the students of awareness about access to health information was the highest, followed by score of the understanding information about healthy life, and the lowest one was the effort to be healthy.

Thank You