Jurnal Kesehatan Akimal
e-ISSN: 2963-3338
Volume 5 No. 2 Edisi Oktober 2026
https://jurnal.akimal.ac.id/index.php/jka

Mothers' Experiences in Providing Sexual and Reproductive Health Education to Prevent Child Sexual Abuse

Zahra Ayu Qalbina[1]*, Annisa Nurrachmawati[2], Lies Permana[3]
[1]Faculty of Public Health, Universitas Indonesia, Indonesia
[2,3]Faculty of Public Health, Universitas Mulawarman, Indonesia
Email: ayuqalbina@gmail.com*, annisanurachmawati@fkm.unmul.ac.id, liespermana@fkm.unmul.ac.id

ARTICLE INFO

Received 23 Sept 2026
Accepted 07 Oct 2026
Published 31 Oct 2026

Keywords:
Sexual Abuse; Reproductive; Health Education; Children.

ABSTRACT

Background: Child sexual abuse (CSA) is a public health problem, and parents, especially mothers, play an important role in prevention by providing sexual and reproductive health education. However, local qualitative evidence on why parents' knowledge does not always translate into practice remains limited. Objective: This study explored mothers' experiences, barriers, and needs in providing sexual and reproductive health education to prevent CSA. Methods: This qualitative study was conducted in February 2023 at a public elementary school in Samarinda, East Kalimantan. Eleven mothers of lower-grade students were recruited through purposive sampling and took part in two focus group discussions. The discussions were audio-recorded, transcribed verbatim, and analyzed thematically. Results: Five themes emerged: (1) mothers' efforts to prevent CSA, (2) shifting perspectives and responsibility for the education, (3) the content taught, (4) barriers, and (5) needs and recommendations. Mothers supervised their children's mobility, limited physical contact with relatives, applied religion-based parenting, and taught body safety, privacy, and hygiene. Some mothers viewed the education less as taboo and more to protect children. They regarded the education as the responsibility of parents and caregivers, although mothers often carried a larger share. Mothers faced barriers in communication and limited knowledge of age-appropriate content. They asked for health education for parents and teachers and preferred a printed booklet. Suggestions: This study suggests that parents build open, non-judgmental communication with their children, that comprehensive sexuality education be integrated into the school curriculum, and that families, schools, and health professionals strengthen their collaboration to support effective CSA prevention.

How to cite: Zahra Ayu Qalbina, Annisa Nurrachmawati, & Lies Permana. (2026). Mothers' Experiences in Providing Sexual and Reproductive Health Education to Prevent Child Sexual Abuse. *Jurnal Kesehatan Akimal*, *5*(2), 110–122. https://doi.org/10.58435/jka.v5i2.278

This is an open-access article distributed under a Creative Commons Attribution-ShareAlike 4.0 International License, that allows others to share the work with an acknowledgement of the work's authorship and initial publication in this journal.

* *Corresponding author: ayuqalbina@gmail.com*

INTRODUCTION

Child sexual abuse (CSA) is a public health problem at both global and local levels. A global systematic review reported that 8%-31% of girls and 3%-17% of boys worldwide have experienced CSA, and some studies estimate even higher rates (Rumble et al., 2020). In Indonesia, the Ministry of Women's Empowerment and Child Protection recorded 21,352 child victims of violence in 2025, of which 12,338 cases (57.78%) were sexual violence (Badan Pembinaan Hukum Nasional, 2026). In East Kalimantan, the provincial office reported 662 cases of violence by mid-2025; 62.97% of the victims were children, and most cases were sexual violence (Pemerintah Provinsi Kalimantan Timur, 2025). Consistent with this data, the Samarinda City office confirmed that sexual violence was the most common type of violence against children, accounting for 90 of 150 cases by end-2024 (Dinas Pemberdayaan Perempuan dan Perlindungan Anak Kota Samarinda, 2024).

CSA has multidimensional effects on children's lives, from the short term to long term. These effects include anxiety, depression, trauma, loss of confidence and self-esteem, and social withdrawal, which may continue into adulthood (Faraji, Taymoori, Gharibi, & Bahmani, 2021; Joni & Surjaningrum, 2020). CSA is complex and shaped by factors at several levels, including close relationships, such as weak emotional bonds between parents and children and suboptimal parenting practices (World Health Organization, 2026). Children's physical and psychological vulnerability, combined with limited supervision and low awareness among adults, makes them even more susceptible to CSA (Faraji et al., 2021; Felicia & Pandia, 2017).

Preventing CSA is a part of the global agenda. The Sustainable Development Goals set the elimination of all forms of violence against children as a global target, through Goal 5 on gender equality and Goal 16 on peace, justice, and strong institutions. Indonesia is committed to this agenda and serves as a board member of the Global Partnership to End Violence against Children (Rumble et al., 2020). One prevention strategy is to involve the adults around the child, especially parents (Hokmabadi, Khoori, Tatari, & Wurtele, 2022). Parents can act as educators who provide comprehensive, inclusive, and non-judgmental sexual and reproductive health education (Permana & Ifroh, 2022), and another study stated that mothers play a more significant role (Faraji et al., 2021).

Sexual education can be adapted to the child's age and reasoning ability (Zakiyah, Prabandari, & Triratnawati, 2016). However, providing sexual and reproductive health education at home still faces many challenges. Many families feel less confident, reluctant, uncomfortable, believe that children are not ready, or do not know how to deliver the information properly (Mostofi, Shamshiri, Shakibazadeh, & Garmaroudi, 2018; Zakiyah et al., 2016). Erikayanti, Hazanah, and Ardyanti (2026), studying at a public elementary school in Samarinda City, found that most parents had adequate (57%) to good (42%) knowledge. This findings reveals a gap: adequate knowledge does not automatically lead to optimal

practice, because parents tend to avoid educating their children when they have no clear and effective approach (Erikayanti et al., 2026).

To our knowledge, qualitative studies at the local level that explore the reasons behind this reluctance remains limited. This matter because quantitative data show what parents know but not why they hesitate to act. Therefore, this qualitative study aims to explore mothers' experience in providing sexual and reproductive health education to prevent CSA. This study contributes an in-depth understanding of the barriers and needs of mothers' face, which can serve as a basis for designing contextual health promotion interventions.

METHOD

This was a qualitative study that explored mother's experience, barriers, and needs in providing sexual and reproductive health education to their children. It was conducted in February 2023 at a public elementary school in Samarinda Kota District, Samarinda City, East Kalimantan. The study was the needs assessment phase of Participatory Action Research (PAR) project, so its findings served as a reference for mapping the target group's needs in a specific and contextual way through the active involvement of participants (Khalesi, Sigaroudi, & Farmanbar, 2020). The later phases of the project (planning, implementation, and evaluation) were completed as part of the first author's undergraduate thesis and are not reported in this article.

Participants were recruited using purposive sampling. The inclusion criteria were (1) mothers of student in the lower grades of elementary school (Grade 1-3) and (2) mother with at least a senior high school education. We focused on mother of lower-grade students based on Freud's theory of psychosexual development, which holds that children from about six years of age until puberty are in latency stage. During this stage, children develop rapidly in cognitive and social skills and often ask many questions (Hasanah, Fithriyah, & Mufrihah, 2021; Kwirinus, 2022). Children at this age therefore need appropriate information on sexual and reproductive health. A minimum education level was set so participants could take part in group discussions and express their views.

Data were collected through focus group discussions (FGD). Eleven mothers participated and were divided into two groups: mothers of girls (five participants) and mothers of boys (six participants). One FGD session was held for each group, and each session lasted approximately 90 minutes. The first author, who had no prior relationship with the participants, moderated both sessions. A colleague attended as a note taker and recorded field notes. The discussion guide was developed by the researchers based on the study objectives. The discussions were conducted in Indonesian and recorded with a mobile phone audio recorder and a video camera. The number of participants was determined by data saturation, meaning that data collection stopped when participants no longer provided new information.

Thematic analysis was used to identify patterns and themes in the data (Heriyanto, 2018). All audio recordings were transcribed verbatim to ensure the completeness and accuracy of the data. Following Heriyanto (2018), the analysis proceeded in three stages. First, the researcher became familiar with the data by repeatedly listening to the recordings and reading the verbatim transcripts, writing personal notes, and aligning them with the field notes. Second, the researcher generated codes from the transcripts, then reviewed them and grouped codes with similar meanings into categories. Third, the researcher constructed tentative themes from these categories, then reviewed and refined them until the final themes were established.

Validity was tested through individual member checking with representatives of the participants. Reliability was strengthen by listening to the audio recordings repeatedly (Martha & Kresno, 2017). The researcher explained the study's purpose, procedures, participant's rights, and measures to protect data confidentiality prior to data collection. All participants agreed to take part voluntarily and signed informed consent forms, which also covered audio and video recording. Participants' names were not disclosed in the presentation of the results and were replaced with the informant codes.

RESULT AND DISCUSSION

This study identified five main themes describing mothers' efforts, perceived roles, educational content, barriers, and needs in providing sexual and reproductive health to their children to prevent child sexual abuse. Participant characteristics are presented in Table 1, which covers mothers of girls (code MG) and mothers of boys (code MB).

Table 1. Characteristics of FGD Participant

Code	Age	Highest Education	Occupation	Child's transportation to school
MG1	43	High school	Housewife	Picked up and dropped off
MG2	46	High school	Housewife	Picked up and dropped off
MG3	32	High school	Housewife	Picked up and dropped off
MG4	30	High school	Housewife	Picked up and dropped off
MG5	37	High school	Housewife	Not picked up and dropped off
MB1	44	Undergraduate	Housewife	Picked up and dropped off
MB2	37	High school	Housewife	Picked up and dropped off
MB3	37	Undergraduate	Employee	Picked up and dropped off
MB4	37	High school	Housewife	Picked up and dropped off
MB5	34	High school	Housewife	Picked up and dropped off
MB6	39	High school	Entrepreneur	Picked up and dropped off

Source: Primary data (2023)

Mothers' Effort to Prevent Child Sexual Abuse

The first theme showed that mothers took many preventive measures to protect their children. The measures included (1) providing sexual and reproductive health education, (2) supervising children's mobility by taking them to and from school, (3) limiting physical contact with relatives, (4) parenting based on religious values, (5) regulating and monitoring the use of gadgets and social media, (6) providing positive activities such as academic and non-academic classes, (7) screening the child's social circle, and (8) building open communication with the child.

One participant (MB1) quit her job so that she could supervise her children directly by taking them to school, including when they used online motorcycle taxis (*ojek online* or *ojol*), because of the many reported cases of sexual abuse, some including online driver.

> *"... because there were incidents of harassment on* ojol*. Two people, one at the back, one at the front. He touched them, saying 'dear, scoot over a bit, move a little' (demonstrating touching the chest area). I happened to read that even boys had their genitals touched. Boys too, you know. So, you must be careful. ... I used to work too. To take my children back and forth, I quit my job. ... So, I do really know my child, from when he comes home from school, from when he wakes up, about his friends, I understand everything. Because they tell me, there is openness."* (MB1)

Greater exposure to reports of child sexual abuse, through mass media and personal observation, may have pushed mothers to become more vigilant and to take preventive action. Participants saw boys and girls as similarly vulnerable, so prevention should be given to all children regardless of sex. This differs from Zakiyah et al. (2016), who found that parents in Dumai City worried differently, with girls seen as more vulnerable. A possible explanation is the extensive media coverage of cases that also target boys. Ain, Mahmudah, Susanto, and Fauzi (2022), also reported that growing media coverage shows abuse frequently occurring in formal education settings, with perpetrators including peers, other students' guardians, school staff, and teachers. This is deeply concerning, because schools, which should be a safe space, can become places of risk and trauma. Mothers' close supervision and their practice of taking children to and from school are therefore a relevant protective strategy for protecting children's mobility.

Participants also noted that perpetrators are not only strangers or people outside the home but can be among the child's closest relatives. To anticipate this, MG3 worked with her family to set limits on physical contact, such as no hugging or kissing except with the immediate family and taught her child to perform *salim* (kissing the hand of an elder).

> *"... sometimes sexual abuse is from our own surroundings. They are the closest people (who are the perpetrators). It is so heartbreaking. Like parents themselves, I mean the biological father, uncle. ... Our own close family."* (MG2)

"In our family (our family custom), we say this must not happen. For example, my brothers-in-law are my children's uncle. We set limits with them. There's no hugging, even with the children, at most salim *as a form of respect for their elders. ... Even though we love them, since we're different sexes, we're afraid, you know. It must not happen. So, we avoid it. We have been trying since my child was six years old. Thankfully, the family cooperates too, both my family and my husband's family."* (MG3)

Participants also used culture- and religion-based prevention. They recognized that perpetrators could come from within the family (intra-familial abuse or incest), so they limited physical contact with relatives while teaching children *salim* as a sign of respect. This practice shows how local social traditions and norms of politeness were adapted by families as culture-based protection. Mothers also took their children to religious activities (such as Qur'an recitation or worship at church) and guided them to follow religious obligations so that they grow up devout from an early age. These findings support the argument that sexual and reproductive health education is more relevant when aligned with cultural and religious approaches (Pratiwi, Ismail, Haida, & Yarliani, 2025).

Shifting Perspectives and Responsibility for Children's Sexual and Reproductive Health Education

The second theme described participants' views on who should provide this education. Before this, participants reflected on how their own views of this education had changed. MG4 described her own upbringing as the basis for educating her child and MG5 described how her view changed.

"In my day, my parents considered it taboo. Would I do that to my child? No. It's better that my child learns it from me than from outside." (MG4)

"I used to think like that. 'Oh, you're still small, not yet, dear'. Then I saw on YouTube that Oki (Ustadzah Oki Setiana Dewi) said it's fine to tell children about this, for their knowledge. Just don't overdo it and tell them the adult stuff." (MG5)

These quotes suggest that some participants grew up in families where this education was seen as taboo. A possible explanation is that Indonesia is a multicultural country that upholds manners and politeness. For example, a study of Bugis-Makassar families suggested that this education was treated as taboo because it was equated with explaining sexual intercourse, so discussing sexuality before marriage was seen as improper and as likely to make children think obscene thoughts (Awaru, 2020). Sexuality education is often understood as only sexual intercourse, although it covers much more than that. Studies among Javanese families also describe cultural concepts such as *wedi* (fear) and *isin* (shame), which make parents reluctant to discuss sexuality for fear violating social norms and shaming the family (Riza, Dewi, Arifah, Mufidah, & Yodantana, 2022). A study at an elementary school in Banjar, Bali, found 84.3% of

third-grade students did not understand sensitive body parts and reproductive organs, and taboo social norms and parents' euphemisms created a mismatch between school and home teaching (Swardana, Mutiarani, Meinarni, Setiawan, & Aristamy, 2024). However, our findings suggest a shift. Some mothers no longer saw this education as taboo or too early but as a way to help children protect themselves. This is in line with Fitri, Pertiwi, and Maghfirah (2025), who found that the taboo barrier among parents in Waru District, East Kalimantan, had eroded. One participant said her change of attitude was prompted by a public religious figure. This can be interpreted through Rogers' Diffusion of Innovation theory, in which the early majority often needs external motivation to adopt new behavior in health promotion programs (McKenzie, Neiger, & Thackeray, 2013).

Participants believed that both parents and caregivers are responsible.

"Prevention first comes from the parents. It has to be both. If the mother can't, then the father. If the father can't, then the mother." (MB1)

"Actually, whoever is responsible for the child. Sometimes a child has no parents. Then, maybe the grandparents are responsible, so they must be the ones to teach." (MG4)

Some participants nevertheless said mothers have a more dominant role, because they interact with children more, while fathers focus on work and earning a living.

"The mother, I think. Often the more dominant ones are mothers. The father works, earns money. Most of the caregiving, the one who plays the biggest role, is the mother. Mothers must be able to protect. Fathers sometimes can't. It's women." (MG2)

Providing this education was seen as a parental responsibility for protecting children. Participants believed parents are the child's main source of information. This is consistent with Sanjiwani and Pramitaresthi (2021), who reported that such education tends to occur more of the between mothers and daughters and between fathers and sons. However, other participants said that in practice the educator role falls mainly on mother. A possible explanation is the social and cultural construction in which household management and child-rearing are assigned to women, even when mothers also earn income, leaving them with a double burden while fathers are positioned as the main breadwinners (Koten, Margiani, Bunga, & Mau, 2019; Widjanarko, Indraswari, Kusumawati, & Handayani, 2022). Even so, Shin, Lee, and Min (2019) stressed that father involvement remains crucial, especially in delivering sexuality and reproductive health education to boys.

Content of Children's Sexual and Reproductive Health Education

The third theme described the content mothers had already taught. It fell into four groups. The first was prevention and self-protection from sexual abuse: recognizing private body parts, who may and may not

touch the child's body, and encouraging the child to refuse strangers and report incidents.

> *"That's why I advise my children. When you're at school, don't let anyone touch this (chest), nose, mouth (demonstrating), or touch your bottom. You must not allow it. Tell Mama. I'm firm about that. ... Anyway, boys and girls are actually the same (in vulnerability), we're afraid for both."* (MG1)

> *"Children should be equipped. If someone does that to them, they must fight back. Shout or something. They must be taught. If someone touches them, whether an older man or women, unless it is for a health examination, or even the teacher says, 'child, let me see', if you are being touched, no. I tell them that. Whether it's a teacher or anyone, except Mama."* (MB1)

The second was instilling shame to protect their privacy, such as not urinating in public and changing clothes in an enclosed place. The third was keeping the body and genitals clean, such as teaching correct bathing and religious etiquette for urination. The fourth was applying religious values, such as teaching children how to dress and the limits of *aurat* (body parts that should be covered) according to Islamic teachings. Much of this content was framed through religious and cultural values. Faith-based sexual education can also be provided by Muslim mothers (Faudzi, Sumari, & Nor, 2020). This is consistent with the view that faith-based approaches make it more acceptable to deliver the sexual and reproductive health education to children (Pratiwi et al., 2025).

Mothers' Barriers in Providing Sexual and Reproductive Health Education

The fourth theme described mothers' barriers, which fell into two groups: communication barriers and content barriers. Communication barriers included difficulty choosing words that are suitable for the child's age, fear of explaining incorrectly, and confusion and awkwardness in using anatomical names for genitals. As a result, mothers tended to use colloquial or regional terms instead of medical terms.

> *"As for me, I tell them a boy's is a* burung *(bird). Because I'm confused about what words to use. For a girl I tell them* pepek *(a colloquial term for female genitalia). Because even we ourselves feel awkward saying the genital word. Honestly, how should I say, it's hard for me."* (MB2)

Content barriers arose because mothers knew the education must match the child's developmental stage but were not familiar with age-appropriate material. Children asked many questions about where babies come from, menstruation, and how build friendships with the opposite sex. Some participants answered these questions, while others avoided them. MG4 described her difficulty in answering questions about menstruation.

> *"About menstruation, sometimes she asks. 'Mama, when your stomach hurts you say it's* halangan *(period, lit. obstacle), why is that?' Sometimes her father says, 'red bleeding comes out'. Yes, it*

expels dirty blood. So, I just explain it just like that. 'Does it hurt Mama?' No, no, it's like a stomachache, like you need to poop. Sometimes I just say that, dirty blood." (MG4)

Although participants recognized this education as essential, they still struggled in practice. The main barrier was awkwardness in using anatomical names for genitals, so mothers turned to colloquial terms. Swardana et al. (2024) and Widjanarko et al. (2022) made the same observation: parents tended to use slang terms or euphemism, which risk distorting children's understanding of how reproductive organs function. Euphemisms also appeared in how mothers talked about menstruation, for example *halangan* (lit. 'obstacle') and 'dirty blood'. Such wording may leave children with an incomplete or negative understanding of menstruation. Children may then avoid open discussion with parents because the topic comes to be seen as embarrassing and private. This barrier may be rooted in participants' own upbringing, in which their parents treated sexuality as taboo. As a result, although today's mothers hold positive views, they still lack references, guidance, or personal experience to share with their children. To cope with not knowing the content, mothers often relied on the internet for self-directed learning, also found by Riza et al. (2022). Even so, they still struggled to select material suited to the child's age and developmental stage, were unsure how to deliver it, and faced the risk of misleading online information or myths.

Parents' Needs and Recommendation

The fifth theme described mothers' needs and recommendations to support their role. Participants said health education activities for parents were needed to overcome their barriers. The content they identified included (1) stages of child development, (2) age-appropriate sexual and reproductive health education, (3) how to build friendships with the opposite sex, and (4) guidance on communicating and answering children's questions about sexuality and reproduction. Participants also stated their preferred health promotion media. Of the options, they chose a printed booklet because it can hold more material, cause less distraction than a digital booklet, and is easy for all parents to use.

"It's needed (education for parents). If possible, not just us, the teachers too. So, it's not just us who know about this, ideally all the mothers in one class." (MG1)

"I think the booklet is more complete. ... As for the phone (a digital booklet), well, it's actually good too, but not every parent's phone can handle this, does it have enough memory? Some are still not tech-savvy, things like that." (MB1)

Overall, the fifth themes show that mothers had high awareness and initiative in preventing child sexual abuse. However, they described real challenges in practice. Mothers therefore saw health education for parents and teachers as a crucial step to overcome these barriers. Mothers needed health education guided by trusted resource persons and media such as a

booklet with a complete material of children's sexual and reproductive health. Study by Azzahra, Ervina, and Rahmawati (2020) and Heri, Linda, Selviana, and Mawardi (2019) showed that booklet can improve parent's knowledge and self-efficacy in providing sexual and reproductive health education. The expectation is that mothers gain the capacity and skills to deliver valid information to their children through guided health education. This empirical need is consistent with earlier studies that emphasized education on children's sexual and reproductive health for parents (Faraji et al., 2021; Shin et al., 2019; Zakiyah et al., 2016).

CONCLUSION

This study explored mothers' experiences, barriers, and needs in providing sexual and reproductive health education to their children. Mothers had taken various measures to prevent child sexual abuse, including providing sexual and reproductive health education, ensuring their children's safety when traveling, setting limits on physical contact with relatives, and applying religion-based parenting. Some mothers described moving away from seeing the education as taboo or too early toward seeing it as a way to help children protect themselves. Participants regarded this education as the responsibility of parents and caregivers, although mothers often carried a larger share. However, even with positive views of this education, mothers still lacked communication skills, references, and guidance on how to select content suited to the child's and age development. Based on these findings, health education for parents and teachers using health promotion media is recommended. Parents are also encouraged to build open and non-judgmental communication with their children. This study further suggests integrating comprehensive sexuality education into the school curriculum and strengthening collaboration among families, schools, health institutions, and health professionals to support effective prevention of CSA.

ACKNOWLEDGMENT

The authors sincerely thank all participants, the elementary school in Samarinda, and everyone who contributed to this study. Appreciation is also extended to Universitas Mulawarman and Universitas Indonesia for their academic support. Gemini and Claude were used to assist with language translation and manuscript refinement.

REFERENCES

Ain, N., Mahmudah, A. F., Susanto, A. M. P., & Fauzi, I. (2022). Analisis diagnostik fenomena kekerasan seksual di sekolah. Pendidikan Dasar dan Keguruan, 7(2), 49–58. https://journal.uiad.ac.id/index.php/JPDK/article/view/1318.

Awaru, A. O. T. (2020). The social construction of parents' sexual education in Bugis-Makassar families. Society, 8(1), 175–190. https://doi.org/10.33019/society.v8i1.170.

Azzahra, A. M. C. P., Ervina, I., & Rahmawati, E. I. (2020). Booklet sebagai media peningkatan pengetahuan tentang pendidikan seks anak usia dini pada orang tua. Insight: Jurnal Pemikiran dan Penelitian Psikologi, 16(2), 402–410. https://doi.org/10.32528/ins.v16i2.3830.

Badan Pembinaan Hukum Nasional. (2026). Melalui SEKATA 21, BPHN dorong kolaborasi cegah kekerasan seksual terhadap anak.https://bphn.go.id/berita-utama/melalui-sekata-21-bphn-dorong-kolaborasi-cegah-kekerasan-seksual-terhadap-anak.

Dinas Pemberdayaan Perempuan dan Perlindungan Anak Kota Samarinda. (2024). Data kasus kekerasan Kota Samarinda tahun 2024. https://dp2pa.samarindakota.go.id/storage/Unduhan/2025-08/08/ace87bc0-7404-11f0-9d26-88d7f6ae79f2.pdf

Erikayanti, A., Hazanah, S., & Ardyanti, D. (2026). Gambaran peran orang tua dalam memberikan pendidikan seks sejak dini pada anak di SDN 011 Samarinda Seberang. 6, 1025–1030. https://doi.org/10.31004/irje.v6i2.3453.

Faraji, S., Taymoori, P., Gharibi, F., & Bahmani, A. (2021). The effect of mother's education on sexual education of preschool children based on health belief model. Journal of Education and Community Health, 8(4), 299–306. https://doi.org/10.52547/jech.8.4.299.

Faudzi, N. M., Sumari, M., & Nor, A. M. (2020). Mother-child relationship and education on sexuality. International Journal of Academic Research in Business and Social Sciences, 10(3), 787–796. https://doi.org/10.6007/IJARBSS/v10-i3/7092.

Felicia, J. P., & Pandia, W. S. S. (2017). Persepsi guru TKI terhadap pendidikan seksual anak usia dini berdasarkan health belief model. Jurnal Pendidikan Anak, 6(1). https://doi.org/10.21831/jpa.v6i1.15682.

Fitri, A. R., Pertiwi, A. D., & Maghfirah, F. (2025). Persepsi orang tua terhadap pendidikan seks pada anak usia dini di Kecamatan Waru Kalimantan Timur Indonesia. Aulad: Journal on Early Childhood, 8(1), 411–418. https://doi.org/10.31004/aulad.v8i1.1024.

Hasanah, I., Fithriyah, I., & Mufrihah, A. (2021). Perkembangan psikoseksual santri pada usia dini. Edu Consilium: Jurnal Bimbingan dan Konseling Pendidikan Islam, 2(1), 21–35. https://doi.org/10.19105/ec.v2i1.4270.

Heri, Linda, S., Selviana, & Mawardi. (2019). Media booklet sebagai media promosi kesehatan peningkatan pengetahuan dan self-efficacy orang tua memberikan pendidikan seksual remaja.

Jurnal Publikasi Kesehatan Masyarakat Indonesia, 6(3), 97. https://doi.org/10.20527/jpkmi.v6i3.8178.

Heriyanto. (2018). Thematic analysis sebagai metode menganalisa data untuk penelitian kualitatif. ANUVA, 2(3), 317–324. https://doi.org/10.14710/anuva.2.3.317-324.

Hokmabadi, A., Khoori, E., Tatari, M., & Wurtele, S. K. (2022). Preventing child sexual abuse in Iran: Mothers teaching body safety to their sons. Journal of Research Development in Nursing and Midwifery, 19(2), 31–35. https://doi.org/10.29252/jgbfnm.19.2.14.

Joni, I. D. A. M., & Surjaningrum, E. R. (2020). Psikoedukasi pendidikan seks kepada guru dan orang tua sebagai upaya pencegahan kekerasan seksual pada anak. Jurnal Diversita, 6(1), 20–27. https://doi.org/10.31289/diversita.v6i1.3582.

Khalesi, Z. B., Sigaroudi, A. E., & Farmanbar, R. (2020). Participatory action research approach to improve adolescent girls' reproductive health. Journal Brasileiro de Reprodução Assistida, 24(4), 416–420. https://doi.org/10.5935/1518-0557.20200034.

Koten, A. N., Margiani, K., Bunga, B. N., & Mau, T. (2019). Persepsi orang tua tentang pendidikan seks anak usia 4–5 tahun di Desa Manleten Kecamatan Tasifeto Timur Kabupaten Belu. Jurnal Pendidikan Memanusiakan Manusia, 78–93. https://www.researchgate.net/publication/339445801_persepsi_orang_tua_tentang_pendidikan_seks_bagi_anak_usia_4-5_tahun.

Kwirinus, D. (2022). Menyingkap teori seksualitas psikoanalisa Sigmund Freud dan usaha penerapannya dalam pendidikan seksualitas. Jurnal Pendidikan Sosiologi dan Humaniora, 13(2), 556. https://doi.org/10.26418/j-psh.v13i2.57871.

Martha, E., & Kresno, S. (2017). Metodologi penelitian kualitatif untuk bidang kesehatan. Rajawali Press.

McKenzie, J. F., Neiger, B. L., & Thackeray, R. (2013). Planning, implementing, and evaluating health promotion programs: A primer (6th ed.). Pearson.

Mostofi, N., Shamshiri, A. R., Shakibazadeh, E., & Garmaroudi, G. (2018). Effectiveness of a sex education program for mothers of adolescent girls based on health belief model on mothers' knowledge, attitude, and behaviour. Pediatric Dimensions, 3(4), 1–5. https://doi.org/10.15761/pd.1000180.

Pemerintah Provinsi Kalimantan Timur. (2025). 662 kasus kekerasan di Kaltim, anak jadi korban terbanyak. https://www.kaltimprov.go.id/detailberita/662-kasus-kekerasan-di-kaltim-anak-jadi-korban-terbanyak.

Permana, L., & Ifroh, R. H. (2022). An overview of health issue tracking among parents of school-aged children. Aulad: Journal

on Early Childhood, 5(2), 263–272. https://doi.org/10.31004/aulad.v5i2.367.

Pratiwi, H., Ismail, M., Haida, R. N., & Yarliani, I. (2025). Contextualizing sexuality education in early childhood: Leadership, curriculum, and cultural negotiation in Indonesia. Journal of Research in Childhood Education, 1–16. https://doi.org/10.1080/02568543.2025.2539874.

Riza, S. L., Dewi, W. C., Arifah, S., Mufidah, W., & Yodantana, F. A. (2022). Pendidikan seksual usia dini sebagai upaya menanamkan nilai sosial pada anak. Jurnal Pengabdian Masyarakat Darul Ulum, 1(1), 24–30. https://doi.org/10.32492/dimas.v1i1.548.

Rumble, L., Febrianto, R. F., Larasati, M. N., Hamilton, C., Mathews, B., & Dunne, M. P. (2020). Childhood sexual violence in Indonesia: A systematic review. Trauma, Violence, & Abuse, 21, 284–299. https://doi.org/10.1177/1524838018767932.

Sanjiwani, I. A., & Pramitaresthi, I. G. A. (2021). Parents experience in giving sex education to adolescents in North Kuta. Journal of A Sustainable Global South, 5(2), 25–27. https://doi.org/10.24843/jsgs.2021.v05.i02.p06.

Shin, H., Lee, J. M., & Min, J. Y. (2019). Sexual knowledge, sexual attitudes, and perceptions and actualities of sex education among elementary school parents. Child Health Nursing Research, 25(3), 312–323. https://doi.org/10.4094/chnr.2019.25.3.312.

Swardana, I. M. A., Mutiarani, R. A., Meinarni, N. P. S., Setiawan, I. K., & Aristamy, I. G. A. A. M. (2024). Introducing sex education: The "Rahasia" illustrated storybook: A case study at SD Negeri 7 Banjar. Proceeding International Conference on Information Technology, Multimedia, Architecture, Design, and E-Business, 3, 273–279. https://eprosiding.idbbali.ac.id/index.php/imade/article/view/882.

Widjanarko, B., Indraswari, R., Kusumawati, A., & Handayani, N. (2022). Perspectives on reproductive health education among Javanese parents. Kesmas: Jurnal Kesehatan Masyarakat Nasional, 17(3), 212. https://doi.org/10.21109/kesmas.v17i3.5893.

World Health Organization. (2026). Violence against children. https://www.who.int/news-room/fact-sheets/detail/violence-against-children.

Zakiyah, R., Prabandari, Y. S., & Triratnawati, A. (2016). Tabu, hambatan budaya pendidikan seksualitas dini pada anak di Kota Dumai. Berita Kedokteran Masyarakat, 32(9), 323–330. https://doi.org/10.22146/bkm.10557.