Kesmas

Volume 17
Issue 3 *August*

Article 8

8-31-2022

Perspectives on Reproductive Health Education among Javanese Parents

Bagoes Widjanarko
Department of Health Promotion and Behavioral Science, Faculty of Public Health, Universitas Diponegoro, Semarang, Indonesia, bagoes62@gmail.com

Ratih Indraswari
Department of Health Promotion and Behavioral Science, Faculty of Public Health, Universitas Diponegoro, Semarang, Indonesia, ratih.indraswari@gmail.com

Aditya Kusumawati
Department of Health Promotion and Behavioral Science, Faculty of Public Health, Universitas Diponegoro, Semarang, Indonesia, aditya.kusumawati@gmail.com

Novia Handayani
Department of Health Promotion and Behavioral Science, Faculty of Public Health, Universitas Diponegoro, Semarang, Indonesia, nv.is.novia@gmail.com

Recommended Citation

Widjanarko B , Indraswari R , Kusumawati A , et al. Perspectives on Reproductive Health Education among Javanese Parents. *Kesmas*. 2022; 17(3): 212-219
DOI: 10.21109/kesmas.v17i3.5893
Available at: https://scholarhub.ui.ac.id/kesmas/vol17/iss3/8

Widjanarko, *et al. Kesmas: Jurnal Kesehatan Masyarakat Nasional (National Public Health Journal)*. 2022; 17 (3): 212-219
DOI: 10.21109/kesmas.v17i3.5893

Kesmas: Jurnal Kesehatan Masyarakat Nasional (National Public Health Journal)

Perspectives on Reproductive Health Education among Javanese Parents

Bagoes Widjanarko, Ratih Indraswari*, Aditya Kusumawati, Novia Handayani

Department of Health Promotion and Behavioral Science, Faculty of Public Health, Universitas Diponegoro, Semarang, Indonesia

Abstract

This study aimed to investigate the perspectives of reproductive health education among Javanese parents of children aged 9-11 years. This cross-sectional study was conducted with 12,306 parents in Semarang City, Central Java Province, Indonesia, using a purposive sampling technique. Some parents agreed that reproductive health education at home was unnecessary (29.5%), taboo (45%), difficult (73.1%), and awkward (41.5%). Most parents (72.7%) were not transparent in providing reproductive health information to their children by using other terms to name the genitals, considering the politeness aspect. Good practices of providing reproductive health information are slightly more common in mothers (54.2%), unemployed parents (52.9%), those with a higher education level (69.5%), and those with a family income above the regional minimum wage (59.8%). As many as 76.9% of parents intensely monitor their children; however, 60.63% of parents have poor communications with their children. Parents believe that reproductive health information is essential for their children, but parents find the topic difficult with their children due to taboos and awkward feelings. Accordingly, the Indonesian Ministry of Health should empower parents to discuss reproductive health issues with their children openly.

Keywords: children, parents, reproductive health education

Introduction

Unwanted pregnancies among adolescents have become a health problem worldwide. Every year, approximately 16 million girls aged 15–19 years and 2.5 million girls under 16 years old in developing countries experience childbirth.[1] Additionally, the World Health Organization (WHO) also stated that three million adolescent girls aged 15–19 years in Asian countries undergo an abortion each year.[2] In developing countries, the abortion rate has increased by about 11%.[3] The increased risk of abortion is influenced by the incidence of unwanted pregnancies.[4] On average, 8% of abortions are performed on girls aged less than 19 years in Indonesia and are caused by unwanted pregnancies yearly.[5]

Based on data from the 2015 Global School-based Health Survey (GSHS), 5.26% of junior and senior high school students in Indonesia have engaged in sexual intercourse, and only 13% of them used condoms.[6] This corroborates data from the Indonesian Ministry of Health, which stated that the incidence of unwanted pregnancies in girls aged 15–19 years in Indonesia continues to increase. Data showed that unwanted pregnancies rose from 1.97% in 2013,[7] to 16.4% in 2017.[8] A pre-assessment by the Indonesian Planned Parenthood Association (IPPA)/*Perkumpulan Keluarga Berencana Indonesia* (PKBI) found that 40.6% of 64 adolescents with unwanted pregnancies in Central Java Province lived in urban areas. Consequently, most resided in Semarang, the capital city of Central Java Province.[9]

According to the Indonesia Demographic and Health Survey (IDHS)/*Survei Demografi dan Kesehatan Indonesia* (SDKI), the percentage of adolescents aged 15–19 years who had sexual intercourse for the first time increased from 59% in 2012 to 74% in 2017.[8] The GSHS shows that 27.35% of junior high and high school students in Indonesia have been sexually active before they turn 14 years old.[6] While, 6% of adolescents reported having sexual intercourse when they were 11–14 years old, the average age at the beginning of puberty or the transition from childhood to adolescence.[8] In addition, the age of menarche (first menstrual cycle) in Indonesia has declined to 11 days younger per year.[10]

Correspondence: Ratih Indraswari, Department of Health Promotion and Behavioral Science, Faculty of Public Health, Universitas Diponegoro, Prof. Soedharto SH Street, Tembalang, Semarang 50275, Indonesia, E-mail: ratih.indraswari@gmail.com, Phone: +62 24 7460 044*

Received : May 11, 2022
Accepted : August 27, 2022
Published: August 31, 2022

This indicates that adolescents in Indonesia might experience sexual intercourse for the first time at a younger age.

Sexual behavior is significantly related to access to pornography (p-value<0.001).[11] Access to magazines, books, pornographic films, and porn action causes adolescents to have sexual intercourse at an early age (13–15 years).[12] A previous study reported that 60.6% of adolescents accessed pornography at least once daily, mostly on their cellular phone (59.2%) at home. In fact, 1.2% of adolescents are exposed to pornography from 5-8 years old by their parents' cellular phones.[11] Parental supervision and communications with children influence adolescents' risk of sexual behavior.[13] About 50% of parents did not monitor the activities of their children, and 63% provided free internet access without supervising their children's online activities.[11]

Low parental involvement and supervision likely affect adolescents at risk of sexual behavior. The adolescent reproductive health indicator in the 2017 IDHS showed that peers (57.5%) and mothers (45.2%) likeliest have opportunities to address reproductive health issues with their adolescent daughters.[14] However, some parents refuse to discuss reproductive health because they worry about its effects on their children's behavior. Parents feel that one day the child will learn about the topic independently from teachers at school.[15] A study stated that even teachers feel awkward and embarrassed when they address reproductive health issues with students in class.[16]

Based on the background above, risky premarital sex behavior is critical to prevent and should be done as early as possible, at least when the children enter puberty. Children should have acquired sufficient knowledge of reproductive health at prepubertal age, and parents are responsible for educating their children in preparing for puberty. Still, based on the data mentioned above, it can be seen that parents in Central Java Province are reluctant to share information on reproductive health because the Javanese culture considers it taboo.[17] Using this background on reproductive health education, this study aimed to describe the perspective of reproductive health education among Javanese parents of children aged 9–11 years.

Method

This study employed an explanatory study method with a cross-sectional approach. The population of this study was parents of students at grades 4–6 of elementary schools (aged 9-11 years) in Semarang City, Central Java Province, Indonesia, whose number is uncertain. With purposive technique sampling, this study's final sample comprised 12,306 respondents who met the criteria (parents of students in grades 4–6 (aged 9-11 years) of elementary schools in Semarang City) and completed the entire survey.

The survey was conducted online (e.g., mobile-based data collection) in March 2021 because it was impossible to conduct face-to-face interviews during the large-scale social distancing (LSSR)/*Pembatasan Sosial Berskala Besar* (PSBB) since the beginning of the coronavirus disease 2019 (COVID-19) pandemic. All public elementary schools in Semarang City (327 schools) were visited to obtain verbal informed consent from principals and teachers. Subsequently, teachers from each school's fourth, fifth, and sixth grades were assisted to collect online data from parents by sharing a Google Forms questionnaire link via the class WhatsApp Group between the teacher and parents. The teacher explained the purpose of the survey and encouraged parents to complete the questionnaire. On the first page of the questionnaire form, detailed information on the purpose of the study and informed consent statements were provided. Parents could continue to fill out the form after agreeing to be respondents in the study. The questionnaire responses from all parents were received through the Google Forms system.

The variables in this study were parents' characteristics (age, sex, education level, occupation, and family income), parents' attitudes to reproductive health education for children, parental monitoring of children's activity, parent-child communication, and parents' practices in providing reproductive health education to their children. Age was categorized as adolescent for respondents aged under 26 years, adult for respondents aged 26–45 years, and elderly for respondents older than 45 years. Sex was determined biologically, meaning a female was the mother or a male was the father. Formal education levels were no education, completed elementary school, junior high school, high school, Diploma III, Bachelor's, and Master's degrees. The categories of respondents' occupations were unemployed, civil servant/government official/police/army, private employee, entrepreneur, farmer, fisherman, labor/maid, and others. Family income was categorized by the regional minimum wage (IDR 2,810,025).

The parents' attitude variable consisted of five questions on the permission to date and parents' opinions on delivering reproductive health information to children due to taboo feelings, awkwardness, the necessity of providing information, and the necessity of monitoring children's interactions with friends. The attitude was scored 1 for each more permissive answer and 0 for each less permissive answer. The total score for attitude was 10. An attitude score of 5 or less was categorized as less permissive, and a score of 6 or more was classified as permissive.

The parental monitoring of children's daily activity

was measured by six questions: children's permission to go outside the home, knowing children's friends, time limitations for children playing outside the house, asking children to give detailed explanations if they broke the rules, knowing how children spend money, and knowing the sites or applications accessed or used by children from a cellular phone/laptop. The monitoring was scored 1 for a "yes" and 0 for each "no." The total score for monitoring was 6. A monitoring score of 3 or less was categorized as weak monitoring, and a score of 4 or more was classified as strong monitoring.

A standardized Parent-Child Interaction Questionnaire (PACHIQ),[18] was used to measure parent-child communication. This questionnaire consisted of 28 questions on parents' communications with their children in everyday situations. Communication was scored 1 for a "no" and 0 for each "yes." The total score for communication was 28. A communication score of 19 or less was categorized as bad, and a score of 20 or more was classified as good.

The parents' practice variable in providing reproductive health education to their children consisted of six questions about knowing the pubertal status of children, the content of reproductive health information (organs and functions, menstruation/nocturnal emission, physical changes after puberty, and pregnancy), limiting children's relationships with opposite-sex friends, using slang terms in naming genitals, encountering difficulties in discussions, and parents' responses to children's questions (no response/changing the topic, scolding, and giving an honest or hazy explanation). The practice was scored 1 for each good practice answer and 0 for each bad practice answer. The total score for all practices was 10. A practice score of 5 or less was categorized as bad, and a score of 6 or more was classified as good. Univariate analysis was used on the data to determine the frequency of each variable distribution, performed with the software package used for the analysis of statistical data.

Results

There were 34.6% of fathers and 65.4% of mothers participating in this study (Table 1). Most respondents were adults (26–45 years old), employed, completed senior high school, and earned a family income higher than the regional minimum wage (IDR 2,810,025).

Table 2 shows parents' attitudes toward reproductive health education for their children. Parents thought reproductive health education at home was unnecessary and perceived it taboo. Some parents perceived discussing reproductive health issues with children as awkward and considered monitoring children's daily interactions with friends unimportant. Most parents limit their children's friendships with the opposite sex. Nevertheless, a few parents permitted their children to start dating at age 9-11 years, considering the child's maturity.

Most parents admitted that children always ask for permission to leave the house. Parents knew their children's friends, how they spent pocket money, and what their children access via cellular phone/laptop. Most parents give children a time limit to play outside the house and ask for a more detailed explanation if children come home after that time limit (Table 3).

Based on Table 4, most parents often feel dissatisfied with their children and admit that children often disobey the rules in their house. Some parents did not listen to

Table 1. Respondent's Characteristic (n = 12,306)

Variable	Category	n	%
Age	Adolescent	5	0.04
	Adult	9,717	78.96
	Elderly	2,584	21
Sex	Male (father)	4,260	34.6
	Female (mother)	8,046	65.4
Education level	No education	99	0.8
	Elementary school	1,187	9.6
	Junior high school	1,964	16.0
	High school	6,506	52.9
	Diploma III degree	1,012	8.2
	Bachelor's degree	1,410	11.5
	Master's degree	128	1.0
Occupation	Unemployed	3,664	29.8
	Civil servant/police/army/government official	508	4.1
	Private employees	3,011	24.5
	Entrepreneur	2,094	17.0
	Farmer	35	0.3
	Fisherman	8	0.1
	Laborer/maid	1,610	13.1
	Other	1,376	11.2
Family income	<Minimum wage	8,712	70.8
	>Minimum wage	3,594	29.2

Table 2. Parents' Attitudes in Delivering Reproductive Health Information

Variable	n	%
Feeling unnecessary	3,625	29.5
Feeling taboo	5,543	45.0
Feeling awkward	5,112	41.5
Feeling unimportant to monitor children's interactions with friends	771	6.3
Giving dating permission	1,685	13.7

Table 3. Parental Monitoring

Variable	n	%
Children always ask for permission to leave the house	9,804	79.67
I know who my children go out to play with	6,968	56.62
I give a time limit for children to play outside the house	8,709	70.80
I ask for a more detailed explanation (why, where, and with whom) if the child comes home late	11,739	95.39
I know how my children spend their money	8,936	72.61
I know what my child accesses via cellular phone/laptop	10,921	88.75

Table 4. Parent-Child Communication

Variable	n	%
When my child does not want to clean his room, I will not force him	7,366	59.86
My child often disobeys the rules in our house	9,378	76.21
I have difficulty speaking softly to my child	8,361	67.94
I cannot accept criticism from my child	3,486	28.35
I often feel dissatisfied with my child	9,799	79.65
When my child makes a mistake, (s)he can talk about it with me without fear of punishment	9,391	76.31
I accept my child's strengths and weaknesses as they are	10,389	84.42
I make decisions for my child without involving her/him	6,618	53.83
I do not need to remind my child about her/his homework	1,386	11.26
My child really trusts me	8,353	67.88
I make time to listen to my child	3,491	28.37
My child and I often fight	5,018	40.80
I give gifts (praises, goods, etc.) when the child does something for me	8,120	65.98
My child knows what I'm worried about	6,952	56.60
I like to hear my children when they tell stories	8,230	66.88
Actually, I do not really listen to my child's story	4,541	36.90
My child feels like a boss at home	5,192	42.19
I enjoy physical touch (hugs, kisses, etc.) with my child	8,634	70.16
I calm my child when he is facing problems	8,493	69.02
I hit my child if (s)he does not listen to me	349	2.84
I decide who can be my child's friend	3,801	30.89
I raise my voice (scream) if we disagree	5,022	40.81
I do not care if the child argues or does not do what I ask for	1,084	8.81
My child listens when I explain	9,240	75.09
I always cover my anger in front of children	2,076	16.87
I am proud of my child	9,109	74.02
I often praise my child	3,408	27.69
When my child is angry, I do not really understand what causes her/his anger	6,627	53.85

Table 5. Parent's Practice in Delivering Reproductive Health Information

Variable	n	%
Knowing children's puberty status	11,603	89.9
Reproductive health material that has been delivered:		
Reproductive organs and functions	2,611	21.2
Menstruation/nocturnal emission	3,391	27.6
Physical changes after puberty	5,347	43.5
Pregnancy	910	7.4
Never	5,461	44.4
Limiting children's relationships with opposite-sex friends	10.951	89.0
Using slang terms in naming genitals	8,943	72.7
Encountering difficulties in discussions	8,992	73.1
Parent's response to children's questions:		
No answer/changing the topic	736	6.0
Scolding children	136	1.1
Giving an honest explanation	10,442	84.9
Giving a hazy explanation	166	1.3
Others	826	6.7

their children and did not understand the reason for their children's anger. A few parents admit to hitting their children when they do not listen and find it difficult to speak softly to their children.

In Table 5, most parents knew their children's puberty status, such as menstruation for girls, a nocturnal emission for boys, or the pubescent phase. Almost half of the parents never provided information on reproductive health issues. Still, some parents provided reproductive health information on topics such as reproductive organs and their functions, menstruation, nocturnal emission, physical changes after puberty, and pregnancy. However, most parents substituted the names of genital organs when discussing reproductive health issues. Most parents encountered difficulties in bringing up reproductive health issues with their children, but parents

Table 6. Crosstab between Parent's Characteristic, Attitude, Parental Monitoring, and Parent-Child Communication toward Practices in Delivering Reproductive Health Information

Variable	Category	Bad Practice		Good Practice		Total	
		(n = 6,011)	%	(n = 6,295)	%	(n = 12,306)	%
Age	Adolescent	3	60.0	2	40.0	5	0.04
	Adult	4,765	49.0	4,952	51.0	9,717	78.96
	Elderly	1,243	48.1	1,341	51.9	2,584	21.1
Sex	Male (father)	2,324	54.6	1,936	45.4	4,260	34.6
	Female (mother)	3,687	45.8	4,359	54.2	8,046	65.4
Education level	No education	61	61.6	38	38.4	99	0.8
	Elementary school	664	55.9	523	44.1	1,187	9.6
	Junior school	1,109	56.5	855	43.5	1,964	16.0
	High school	3,291	50.6	3,215	49.4	6,506	52.9
	Diploma III degree	367	36.3	645	63.7	1,012	8.2
	Bachelor's degree	480	34.0	930	66.0	1,410	11.5
	Master's degree	39	30.5	89	69.5	128	1.0
Occupation	Unemployment	1,727	47.1	1,937	52.9	3,664	29.8
	Civil servant/police/army/government official	172	33.9	336	66.1	508	4.1
	Private employees	1,496	49.7	1,515	50.3	3,011	24.5
	Entrepreneur	1,031	49.2	1,063	50.8	2,094	17.0
	Farmer	25	71.4	10	28.6	35	0.3
	Fisherman	3	37.5	5	62.5	8	0.1
	Laborer/maid	912	56.6	698	43.4	1,610	13.1
	Other	645	46.9	731	53.1	1,376	11.2
Family income	<Minimum wage	4,568	52.4	4,144	47.6	8,712	70.8
	>Minimum wage	1,443	40.2	2,151	59.8	3,594	29.2
Feeling unnecessary	Agree	2,384	65.8	1,241	34.2	3,625	29.5
	Disagree	3,627	41.8	5,054	58.2	8,681	70.5
Feeling taboo	Agree	3,596	64.9	1,947	35.1	5,543	45.0
	Disagree	2,415	35.7	4,348	64.3	6,763	55.0
Feeling awkward	Agree	3,374	66.0	1,738	34.0	5,112	41.5
	Disagree	2,637	36.7	4,557	63.3	7,194	58.5
Feeling it is unimportant to monitor children's interactions with friends	Agree	441	57.2	330	42.8	771	6.3
	Disagree	5,570	48.3	5,965	51.7	11,535	93.7
Giving dating permission	Agree	983	58.3	702	41.7	1,685	13.7
	Disagree	5,028	47.3	5,593	52.7	10,621	86.3
Parental monitoring	Weak	2,280	80.20	563	19.80	2,843	23.10
	Strong	3,731	39.43	5,732	60.57	9,463	76.90
Parent-child communication	Poor	5,302	71.06	2,159	28.94	7,461	60.63
	Good	709	14.63	4,136	85.37	4,845	39.37

likely addressed reproductive health issues honestly when the children asked. In addition, a few parents changed the topic, and some scolded the children or gave a hazy explanation when responding to the children's questions.

Good practices in productive health discussions were slightly more common in females/mothers than in males/fathers (Table 6). Parents with higher education levels provide better reproductive health information to their children than the lower ones. On average, unemployed parents provided reproductive health information slightly better than parents working as private employees, entrepreneurs, farmers, and laborers/maids. Delivering good reproductive health information was mainly found in parents with family incomes above the minimum wage. Parents with low socioeconomic levels tended to have poor practices in conveying reproductive health information to their children. Parents perceived reproductive health education as necessary to monitor children's friendships and restricted their children's dating.

Discussion

Most respondents were adults, and a productive age was crucial for improving cognitive and social abilities, meaning that age influenced the level of knowledge. The older a person is, the more mature they think and act regarding problems.[19] This study reported no relationship between age and parental education on reproductive health, though parents aged <26 years had worse attitudes to reproductive health education at home than older parents (adult and elderly). Besides, influencing a cognitive perspective, age also relates to beliefs. Mature individuals will be trusted more than immature ones. Maturity also affects comprehension and mindsets. As people age, their mindsets and knowledge also develop.

There is no report about a decline in intellectual ability, problem-solving, and verbal ability at this age.[20] Hence, parents at a productive age should be able to be good health communicators for their children.

This study involved more female participants/mothers than males/fathers. In the Javanese ethnic group, mothers typically handle household- and child-related affairs. Most Javanese women also encounter the double burden of caring for family and raising money to sustain the family.[21] One-third of parents were unemployed, and most parents had a family income under the regional minimum wage. The patriarchal culture reduces women's equal opportunities to obtain a better education and income than men.[21] Men are the breadwinners for the family, while women focus more on household chores and childbearing.

Consequently, mothers have more responsibility for their children's reproductive health issues than fathers. In the Javanese tradition, mothers monitor their children's growth, such as their weight and height.[21] Children's understanding of and self-efficacy in reproductive health tends to be neglected. Prosperous parents provide health information better than the unprosperous ones due to the sufficiency of family time.

More than half of the parents in this study had graduated from high school. Education level is important in honing skills to create educated humans expected to meet educational goals. Education makes a major contribution to human interaction with the environment.[22] The skills and knowledge acquired at school help advocate for health communication. Community education affects perceptions and conceptual abilities to deliver and receive messages and information. It will also affect the arrangement of thoughts and feelings about responses or feedback given to a communicator or communicant.[22] People with higher education may communicate better in terms of content and attitudes. Human behavior as the result of learning reflects changes due to environmental influences.[23] Therefore, this study reported that parents with higher education levels provide better reproductive health education to their children at home.

Most parents knew the puberty status of their children and limited their children's relationships with opposite-sex friends. In addition, 13.7% of mothers permitted dating early (aged 9-11 years) because it was considered normal, and 6.3% thought monitoring children's friendships was unnecessary. Monitoring, one of the parental roles, could be accomplished by checking children's activities and maintaining positive ones. Children who lack parental monitoring might feel and act freer as their parents do not supply well-defined rules. Several previous studies have also proved that the lack of parental monitoring results in accessing pornography and risky sexual behavior among their children.[11,24,25] Parents who do not supervise and control children tend to make children more daring to violate social norms.[24] Parents play a role in controlling, educating, reminding, and advising children that they display indications of risky behavior.

Children's activities can be monitored by checking their social media use and establishing a good bonding and communication between parents and children. According to Lawrence Green, a person's behavior is influenced by factors that encourage or strengthen the occurrence of the behavior,[26] including the attitudes and behaviors of parents toward children depicted by parental monitoring and parent-child communication. This is due to the psychological control of adolescents, according to which their parents know their whereabouts and activities outside the house. Adolescents having good relationships with their parents (good communication, supervised, and monitored by their parents) affect the psychological control of adolescents when they are outside the house without parental supervision. However, most parents felt the need to convey reproductive health information to their children, though they faced difficulties starting discussions and considered it taboo or awkward. This corroborates other studies stating that parents feel embarrassed and unconfident when discussing reproductive health issues.[27,28] Most parents consider reproductive health an adult, private affair, and taboo.[29] In fact, many parents immediately refused to participate in this study after learning the research topic. Correspondingly, children will seek reproductive health information without parental control and may obtain misleading information or even engage in sexual intercourse.

Previous study found that parents mostly did not receive reproductive health education when they were young. Hence, parents step back from reproductive health education, and children might be curious to experiment with reproduction.[27] Parents often do not properly answer children's questions about reproductive health. Some parents may change the topic, give no response, or even scold the child for asking about that topic. This kind of response makes children misinterpret the message and stimulates them to seek information from other sources that might not be valid.

Almost half of the parents had never provided reproductive health education to understand their children's beliefs. As much as 84.9% avoided providing health information honestly to help their children understand, but 72.7% of parents used slang terms when referring to genitals. In Javanese, the male genitalia (penis) are called the *manuk* (bird) or *titit*. Using a word substitution strategy sometimes does not enable children to understand the fundamental concept of the reproduct-

ive organ, and they only grasp a similar understanding of the content.[30] This attempts to translate taboo terms with other words or phrases.[31] Therefore, children likely avoid the topic when discussing reproductive health with their parents.

Reproductive health education should be addressed early to reduce adolescent pregnancies. Some studies indicate that early reproductive health education helps parents talk to children.[30] Educational supplies carried out as early as possible can prevent adolescents from falling into the massive health risk behaviors encountered as teenagers. A conversation about reproductive health has a positive impact on avoiding adolescent pregnancies.[32] Poor parental communication and a lack of skills and confidence are linked to poor reproductive health among adolescents. The more educated parents are, the more quickly they discuss reproductive health issues with their children. Parents should be able to follow the development of their children by assessing their children's needs. As the closest person to children, parents should always try to improve their communication skills and learn information on adolescent reproductive health, so that they can provide valid information to their children. Therefore, parents will be children's close friends, whom children can trust to provide correct reproductive health information.

Strengths and Limitations

To participate in this online survey, the respondents relied heavily on the availability of the internet access. Some limitations in this study must also be acknowledged concerning online data collection. This condition caused the authors be unable to know the actual situation of respondents when answering the survey. To overcome it, the authors eliminated not only respondents answering the form more than once, but also the completeness of the answers and the suitability of respondents' responses based on favorable and unfavorable questions when cleaning data. The authors suggested further studies to investigate parents' communication skills and explore the obstacles to discussing reproductive health matters with children through in-depth and face-to-face qualitative study.

Many studies report on parents' communication skills in discussing reproductive health information with adolescents. However, this study revealed parents' perspectives in delivering reproductive health information to their children aged 9–11 years, which has not been explored in previous studies. This study also involved many samples to gather more accurate information.

Conclusion

Most parents believe that reproductive health information is important for their children, but they find it difficult to facilitate this topic with their children due to taboos and awkward feelings. Parents tend to avoid direct talk about reproductive health by replacing original terms with slang to reduce taboo words. Parents who allow their children to date should equip them with adequate health information to avoid risky health behaviors. The Indonesian Ministry of Health should empower parents to discuss reproductive health issues with their children openly. Hence, children will have trustworthy sources of information in the family circle.

Abbreviations

WHO: World Health Organization; GSHS: Global School-based Health Survey; IPPA: the Indonesian Planned Parenthood Association; PKBI: *Perkumpulan Keluarga Berencana Indonesia*; IDHS: Indonesia Demographic and Health Survey; SDKI: *Survei Demografi dan Kesehatan Indonesia*; LSSR: Large-Scale Social Distancing; PSBB: *Pembatasan Sosial Berskala Besar*; COVID-19: Coronavirus Disease 2019; IDR: Indonesian Rupiah; PACHIQ: The Parent-Child Interaction Questionnaire.

Ethics Approval and Consent to Participate

The study was approved by the Ethics Committee of the Faculty of Public Health, Universitas Diponegoro (Approval ID: 158/EA/KEPK-FKM/2021).

Competing Interest

The authors declare that no significant competing financial, professional, or personal interests might have affected the performance or presentation of the work described in this manuscript.

Availability of Data and Materials

The data supporting this study's findings are available upon reasonable request from the corresponding author. The data are not publicly available as they contain information that could compromise the privacy of the research participants.

Authors' Contribution

BW and RI conceived the study concept. RI conducted the methodology and data analysis and wrote and edited the manuscript. NH and AK collected data and wrote the original draft. All authors discussed the final results and contributed to the final manuscript.

Acknowledgment

The authors would like to thank the respondents and schools participating in this study. The authors also thank all colleagues and students who provided help while conducting this study.

References

1. Ajayi AI, Odunga SA, Oduor C, Ouedraogo R, Ushie BA, Wado YD. "I was tricked": understanding reasons for unintended pregnancy among sexually active adolescent girls. Reprod Health. 2021; 18 (1): 19.

2. Bearak J, Popinchalk A, Alkema L, Sedgh G. Global, Regional, and subregional trends in unintended pregnancy and its outcomes from 1990 to 2014: estimates from a Bayesian Hierarchical model. Lancet Glob Heal. 2018; 6 (4): e380–9.
3. Ganatra B, Gerdts C, Rossier C, Johnson BR Jr, Tunçalp Ö, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. Lancet. 2017; 390 (10110): 2372–81.
4. Singh S, Shekhar C, Acharya R, Moore AM, Stillman M, Pradhan MR, et al. The incidence of abortion and unintended pregnancy in India, 2015. Lancet Glob Heal. 2018; 6 (1): 111–20.
5. Ocviyanti D, Dorothea M. Aborsi di Indonesia. J Indones Med Assoc. 2018; 68 (6): 213–5.
6. Pusat Penelitian dan Pengembangan Upaya Kesehatan Masyarakat. Perilaku berisiko kesehatan pada pelajar SMP dan SMA di Indonesia. Pusat Penelitian dan Pengembangan Upaya Kesehatan Masyarakat; 2016.
7. Kementerian Kesehatan Republik Indonesia. Situasi kesehatan reproduksi remaja. Jakarta; Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia; 2015.
8. Badan Kependudukan dan Keluarga Berencana Nasional. Survei Demografi dan kesehatan Indonesia 2017: Buku Remaja. Jakarta; Badan Kependudukan dan Keluarga Berencana Nasional; 2018.
9. Sasongko AJ. Tingginya kehamilan remaja tuntut PKBI Jateng susun program kerja 2015-2018. PKBI Daerah Jawa Tengah; 2019.
10. Wahab A, Wilopo SA, Hakimi M, Ismail D. Declining age at menarche in Indonesia: a systematic review and meta-analysis. Int J Adolesc Med Health. 2018; 32 (6).
11. Gayatri S, Shaluhiyah Z, Indraswari R. Faktor-faktor yang berhubungan dengan frekuensi akses pornografi dan dampaknya terhadap perilaku seksual pada remaja di Kota Bogor. J Kesehat Masy. 2020; 8 (3): 410–9.
12. Wulandari S. Perilaku seksual pranikah berisiko terhadap kehamilan tidak diinginkan pada remaja SMKN Tandun Kabupaten Rokan Hulu. J Matern Neonatal. 2016; 4 (1): 74–84.
13. Wanufika I, Sumarni S, Ismail D. Komunikasi orang tua tentang seksualitas terhadap perilaku seksual pranikah remaja. Ber Kedokt Masy. 2017; 33 (10): 495–500.
14. Badan Kependudukan dan Keluarga Berencana Nasional. Survei demografi dan kesehatan Indonesia 2017: kesehatan reproduksi remaja (indikator utama). Jakarta: Badan Kependudukan Keluarga Berencana Nasional; 2018.
15. Rusady IK, Shaluhiyah Z, Husodo BT. Analisis kebutuhan pendidikan kesehatan reproduksi pada diswa SMP di wilayah Kecamatan Pedurungan Semarang. J Kesehat Masy. 2017; 5 (5): 1010–20.
16. Mohammad-Esmaeil M, Rejaei L, Jonidi AJ, Ardalan G, Dorouzi J, Rezaei N, et al. Priorities in health education needs of youth based on needs assessment and stakeholder involvement, in areas covered by the Health Departments of Iran University of Medical Sciences. J Educ Community Heal. 2016; 3: 51–7.
17. Indraswari R, Shaluhiyah Z, Widjanarko B, Suryoputro A. Factors of mothers' hesitation in discussing reproductive health. Int J Public Heal Sci. 2021; 10 (4): 801–6.
18. Lange A, Blonk R, Wiers RW. Assessment: the parent-child interaction questionnaire, PACHIQ. Clin Psychol Psychother. 1998; 5(3): 187–98.
19. Fischer AL, O'Rourke N, Thornton WL. Age differences in cognitive and affective theory of mind: concurrent contributions of neurocognitive performance, sex, and pulse pressure. J Gerontol B Psychol Sci Soc Sci. 2017; 72 (1): 71–81.
20. Correia R, Barroso J, Nieto A. Age-related cognitive changes: the importance of modulating factors. J Geriatr Med Gerontol. 2018; 4 (2): 1–10.
21. Sigiro AN. Care Economy and the burden of housewives' work in Indonesia. J Peremp. 2018; 23 (4): 249.
22. Navickienė V, Sederevičiūtė-Pačiauskienė Ž, Valantinaitė I, Žilinskaitė-Vytienė V. The relationship between communication and education through the creative personality of the teacher. Creat Stud. 2019; 12 (1): 49–60.
23. Obaki SO. Impact of classroom environment on children's social behavior. Int J Educ Pract. 2017; 5 (1): 1–7.
24. Dávila SPE, Champion JD, Monsiváis MGM, Tovar M, Arias MLF. Mexican adolescents' self-reports of parental monitoring and sexual communication for prevention of sexual risk behavior. J Pediatr Nurs. 2017; 35: 83–9.
25. Handayani S. Faktor-faktor yang mempengaruhi kejadian kehamilan tidak diinginkan pada remaja di Kelurahan Balecatur Gampingan Sleman Yogyakarta. J Kesehat Samudra Ilmu. 2016; 7 (1).
26. Green LW, Kreuter MW. Health promotion: planning an educational and environmental approach. 2nd ed. CA: Mayfield; 1991.
27. Shin H, Lee JM, Min JY. Sexual knowledge, sexual attitudes, and perceptions and actualities of sex education among elementary school parents. Child Heal Nurs Res. 2019; 25 (3): 312–23.
28. Robinson KH, Smith E, Davies C. Responsibilities, tensions and ways forward: parents' perspectives on children's sexuality education. Sex Educ. 2017; 17 (3): 333–47.
29. Runcan R, Bahnaru A. Sex education revisited: school-based sex education. Analele Univ din Craiova. 2019; 18 (1): 1–7.
30. Khoshsaligheh M, Ameeri S, Mehdizadkhani M. A Socio-cultural study of taboo rendition in Persian fansubbing: an issue of resistance. Lang Intercult Commun. 2018; 18 (6): 663–80.
31. Robati FZNN, Zand F. Translation of taboos: the absolutely true diary of a part-time Indian. Int J Appl Linguist English Lit. 2018; 7 (3): 35–40.
32. Azira N, Abdullah FB, Muda SM, Zain NM. The role of parents in providing sexuality education to their children. Makara J Heal Res. 2020; 24 (3): 157–63.