Exploring Adolescent Ideas for Designing Reproductive Health Interventions to Prevent Early Marriage and Adolescent Pregnancy

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Abstract

Adolescence is a transitional phase filled with challenges, characterized by social development, attraction to the opposite sex, and vulnerability to risky behaviors. Adolescent pregnancy and early marriage remain global issues, including in Indonesia. Contributing factors include poverty, low levels of education, and inherited cultural practices. These lead to serious consequences such as school dropout, limited educational opportunities, and reduced quality of life, hindering the achievement of Indonesia Emas 2045. This study aims to explore adolescents' ideas and perspectives regarding existing policies and to design potential interventions. This research employed a qualitative, interpretative approach. The study involved 24 undergraduate students from the Public Health Study Program, Universitas Jambi. Data were collected through Focus Group Discussions (FGDs) and in-depth interviews and were analyzed using a manual thematic analysis approach. This process involved an in-depth analysis of patterns to identify key themes that represent adolescents' ideas and innovations regarding reproductive health services. The research findings identified a significant knowledge gap regarding the availability of adolescent-specific reproductive health services (RHS) at universities and health facilities. In fact, 20 out of 24 participants were not sufficiently aware of reproductive health services or counseling specifically targeting them. Informants also reported relatively good communication with their parents, particularly with mothers, while community figures were identified as playing important roles. This study contributes to global reproductive health policy by strengthening the integration between public health centers and campus-based counseling units. Lecturers and students jointly manage these units to provide safe, trusted, and sustainable access to services for adolescents.

Keywords: Adolescent Pregnancy, Early Marriage, Preventive Intervention, Reproductive Health, Youth Involvement

INTRODUCTION

Throughout their life stages, adolescents will go through a critical and challenging period. At this time, adolescents are expected to become independent as they transition from childhood to adulthood. Attraction to the opposite sex, development of social skills, learning behaviors that will become the basis for future decision-making, and the possibility of exposure to behaviors that deviate from life norms, such as drug use, free sex, pregnancy, and early marriage, are all possible (WHO, 2021). Adolescent pregnancy is a pregnancy that occurs under the age of 18, regardless of marital status, while early marriage is a marriage under the age of 18. An adolescent can enter into an early marriage without a preceding pregnancy. Most adolescent pregnancies and early marriages are caused by poverty, low levels of education, and

customs or cultures that are passed down through generations (UNICEF, 2025). Berkman et al. argue that health issues do not originate solely within the individual but are also influenced by interactions between individuals and their social environment. At the individual layer, this includes knowledge gaps regarding adolescent reproductive health facilities. The interpersonal layer examines the influence of the immediate social environment, such as communication patterns between adolescents and their parents or peers. Lastly, the community and institutional layer encompasses cultural norms, the roles of community leaders (RT) and traditional figures, and the availability of adolescent reproductive health services on campus and at public health centers (Puskesmas) and other health facilities(Berkman et al., 2014).

In 2019, the estimated number of adolescent pregnancies among 15-19-year-olds in low- and middle-income countries was 21 million each year, of which 50% were unintended, and an estimated 12 million births resulted from these pregnancies (WHO, 2024). Early marriage itself is a formal or informal marriage between children under the age of 18. Although the rate of early marriage has continued to decline in the last decade, marriage of children under 18 is widespread, with about 1 in 5 girls married during childhood worldwide (UNICEF, 2023). UNICEF reports that the global prevalence of child marriage has declined over the past decade, from 23% in 2015 to 19% in 2024. In East Asia and the Pacific, 1% of children are married before age 15, while 8% are married before age 18 (UNICEF, 2025). In Indonesia, 64.4% have been pregnant at the age of 10-19 years, and 12.8% of adolescents are currently pregnant in the same age range (SKI, 2023). Child marriage in Indonesia has also continued to decline in recent years, from 10.35% in 2021 to 6.92% in 2023.

While a 6.9% prevalence places Indonesia in a slightly better position than the Asia-Pacific regional average, the challenges in Indonesia must remain a priority. The Ministry of Women's Empowerment and Child Protection stated that although child marriage continues to decline, other issues must be addressed immediately, such as unregistered marriages (perkawinan siri) and the culture of marrying off children to transfer responsibility from the parents (Kemenpppa, 2024). This indicates that despite the declining trend in child marriage rates in Indonesia, the risk of adolescent pregnancy remains high, as evidenced by national data showing that 12.8% of adolescents aged 10-19 are currently pregnant. Therefore, more profound interventions beyond regulatory changes are required to address the persistent root causes within society.

Seprina et al. reported that behaviors involving trying new things, such as kissing on the cheek, kissing on the lips, and touching breasts, have already been observed at the elementary school age (Seprina et al., 2019). If this risky behavior is not intervened in as early

as possible, the possibility of adolescent pregnancy and early marriage will be high. Research by Fitri et al. shows that pregnancies that occur during adolescence in Jambi Province cause them to drop out of school and be reluctant to continue their interrupted education. Many factors influence this, such as a lack of permission from the husband, financial limitations, and a shift in life focus to caring for and managing children, husbands, and families (Fitri et al., 2023). In another study, Fitri et al. also showed that 43.7% of parents had an approving attitude towards early marriage. Parents who believed in the community custom of marrying off their children early in Jambi City had a 3.62-fold higher risk of marrying off their daughters early (Fitri, Putra, Sitanggang, et al., 2024).

Adolescents who do not receive education about adolescent pregnancy and family life will certainly have an impact on the quality of life in the future (Fitri, Putra, Mekarisce, et al., 2024). The failure to equip adolescents with reproductive health and family life education is an absolute barrier to accelerating the "Indonesia Emas 2045" vision. This phenomenon not only triggers critical health issues, such as stunting and high Maternal Mortality Rates, but also perpetuates the cycle of intergenerational poverty. Furthermore, the lack of health literacy amidst the massive influx of digital information causes adolescents to lose direction when making crucial decisions for their future. In Indonesia, it is rare to find adolescents included in decision-making and policy-making, especially in adolescent health itself. This study attempts to explore in depth adolescents' ideas and notions, which are then formulated into an intervention design for adolescent pregnancy and early marriage. This research is a continuation of two basic studies that have been conducted on adolescent pregnancy and early marriage.

METHODS

This study employed a qualitative descriptive design rooted in an interpretative approach to systematically explore and contextualize the experiences, perspectives, and constructive innovations of young people regarding current reproductive health policies and interventions. Most qualitative research is interpretative and experience-based, as the main goal is to contextualize and understand people's experiences in the context of everyday life. The important thing about qualitative research is to develop inclusive practices and opportunities so that people can share opinions about health fields that may be important to them (Pitt et al., 2024).

The research was conducted from March to November 2025 at the Public Health Study Program, Universitas Jambi. The selection of students, specifically from the Public Health

Study Program, is based on several strategic considerations. First, as individuals who have recently transitioned from adolescence, they maintain a close emotional and social connection to peer dynamics, allowing them to deeply understand prevalent communication barriers, such as cultural taboos. Second, as future health professionals, they possess the technical competency and health literacy required to think systematically in designing solutions. Consequently, they are expected to provide intervention ideas that are both practical and applicable, distinguishing them from younger adolescents who may only be able to identify health problems without the capacity to formulate structured strategies.

The informants in this study were students from the 2023 cohort of the Public Health Study Program, Universitas Jambi. Informants were selected using a purposive sampling technique, with the inclusion criteria being students who had chosen their academic specialization. This selection was based on the consideration of their advanced health literacy and academic maturity, enabling them to provide critical perspectives and applicable intervention designs. A total of 24 informants were involved throughout the data collection process. Data were collected through two primary techniques: in-depth interviews with 12 informants to explore personal perspectives, and Focus Group Discussions (FGD) divided into two groups (six participants each) to observe group interaction dynamics.

This sample size was determined based on the principle of data saturation in relatively homogenous groups. Recent methodological literature underscores that in-depth interviews combined with focus groups typically achieve code and thematic saturation within a range of 9 to 16 interviews and 2 to 3 Focus Group Discussions (FGDs) when exploring shared sociocultural phenomena among a homogenous cohort (Donkoh, 2023; Meydan & Akkaş, 2024). Accordingly, the data collection framework consisting of 12 in-depth interviews and 2 FGDs (comprising 6 participants each) adequately fulfilled these contemporary international standards. Data collection was concluded when the research team observed that no new conceptual codes, insights, or structural themes emerged during the manual thematic analysis.

The research instrument utilized was a semi-structured interview guide. Data were analyzed using manual thematic analysis. To ensure the rigor and trustworthiness of the findings, methodological triangulation was systematically applied by cross-verifying and integrating the data collected from the 12 in-depth interviews and the 2 Focus Group Discussions (FGDs), aligned with recent qualitative validation frameworks. Individual insights regarding personal barriers and sensitive reproductive health experiences obtained from the interviews were contextualized and compared against the collective norms, shared consensus, and social dynamics observed during the FGD sessions. This comparative analysis allowed the

research team to reconcile conflicting narratives and validate the consistency of the identified themes, thereby significantly enhancing the credibility of the study. Furthermore, to address transferability, the convergence of these two distinct data collection methods provided a rich, thick description of the adolescents' viewpoints within their academic environment. By providing this detailed contextual data alongside explicit descriptions of the homogenous participant characteristics, other researchers can evaluate the applicability and relevance of these intervention models to similar higher education or public health settings. Ethical considerations were addressed through an ethical clearance certificate from Poltekkes Jambi, number LB.02.06./2/1982/2025. Informed consent was obtained before the study, where informants were provided with comprehensive explanations regarding the research, data confidentiality, and their right to withdraw from the study at any time.

The researchers' roles as lecturers at Universitas Jambi significantly influenced the students' openness. Despite the hierarchical position (lecturer-student), the established academic rapport created a comfortable atmosphere. The researchers positioned themselves as facilitators and discussion partners, encouraging informants to provide honest and critical responses as part of their contribution to the study. This approach minimized awkwardness and enhanced the quality of the data obtained during the interview process.

RESULT

Service Bureaucracy Structural Hurdles in Adolescent Healthcare Access

Many informants said they did not know about the existence of adolescent reproductive health services at the university level. They only knew about the existence of a sexual violence protection unit. This shows that services focused on adolescent reproductive health have not been effectively reached by the adolescents themselves.

> *"Not much. In junior high and early high school, there was no counseling. Only in the 12th grade of high school, through biology lessons, the teacher explained a little about reproduction."* – APD.
> *"What I know about is the sexual violence protection, PKS that one."* – UJ
> *"It seems there isn't one. But there is a contact person for reporting sexual violence or harassment."* – RA.

The limitation of reproductive health services at the university level makes informants feel the need for reproductive health services on campus. They argue that these reproductive health services are an important safe space for consultation, sharing complaints, and expressing "unek-unek" (pent-up feelings) about reproductive health issues that are often considered taboo or awkward to talk about with friends or family. To increase the effectiveness of using reproductive health services, they proposed several innovations, such as providing anonymous

counseling services to maintain privacy, establishing easily accessible "counseling corners," and utilizing social media for promotion and dissemination of information relevant to adolescent communication styles. Continuous collaboration between the campus and puskesmas is also seen as a strategic solution to improve the quality and reach of services.

"In my opinion, we should create a place... a place to let out pent-up feelings, to talk, because... talking about reproduction, it's not comfortable to talk about it with friends or anyone." – UJ.
"It's important. Because if there is a reproductive health service, there we don't just talk about diseases we've already experienced, we can also prevent them, we can... for example, I'm a woman, when I'm menstruating, for example, I have pain, sir, so we can ask for guidance and counseling there." – RA.
"...it would be more effective if it were anonymous, sir, because not everyone dares to talk." – ZE
"I don't think there is one... maybe we can make a counseling corner on campus, open to students and youth from the surrounding area." – SI.
"I don't really know, sir. Maybe the campus can become a promotional channel through social media regarding this matter." – AL.
"There could be a regular discussion forum between the campus and the puskesmas." - RA.

Informants' knowledge about the existence of reproductive health services in health facilities such as puskesmas or clinics is still relatively low. Some informants knew about these services at the puskesmas through posters, but many did not know at all or had only seen them briefly on social media. Youth programs like PIK-R from BKKBN (National Population and Family Planning Board) were also known by a small number of informants, but none of them or their friends had ever accessed these services directly. The main cause of this is the lack of massive socialization and promotion from the service providers.

"Outside of campus, I don't know, sir, if there are specific ones for reproductive health, but for general health... for PIK-R, sir, for adolescents, that exists..." – UJ.
"I've known about it at the puskesmas because there was a poster. However, the people around her and I have never tried to access the service." – RD.
"As far as I know, there are no specific adolescent reproductive health services at the puskesmas or clinics." – IMP.
"It seems lacking, the promotion is not strong enough." – ZE

The low utilization of reproductive health services by adolescents is not only due to a lack of information but also to internal barriers from the adolescents themselves. The most influential internal factor is the feeling of shame and fear of finding out about issues that are considered taboo and sensitive. In addition, there is a stigma regarding the quality of services in health facilities. Several informants mentioned services that were less friendly, slow, and bureaucratic as factors that made adolescents reluctant to use health services. The combination of internal barriers from the adolescents' side and service quality constraints from the health facilities creates a gap that makes these essential services difficult for adolescents to access.

"Because of a lack of information. Many are even afraid to find out." – MIA.
"Because of factors like shame, fear, and a lack of massive information." – RD.

"One of them is peer influence. Sometimes, some friends give negative opinions, like 'why go there,' which makes adolescents ashamed or hesitant to use it." – RI.
"In terms of distance, the puskesmas isn't far, but sometimes the service is unfriendly and slow." – ST.
"Sometimes access is difficult, like getting a referral letter, which takes quite a long time. But sometimes it runs efficiently, just for a few people." - RA.

The Taboo Barrier: Navigating Cultural and Parental Silences

Parental Communication Gaps

The openness of communication between adolescents and families regarding reproductive health shows some variations with patterns that tend to be influenced by gender. Some female informants felt quite comfortable and open to discussing this topic with their mothers. On the other hand, communication with fathers about reproductive health rarely occurred and was considered too sensitive. Meanwhile, male informants tended to feel that reproductive health was still "rather taboo" to talk about with parents.

"I have, sir, with my mother." – SE.
"For me, I'm quite open with my family, but with my mother." – RA.
"With my father, I'm not open because I feel embarrassed, and the topic is too sensitive." – RD.
"For me personally, sir... my family is quite open, but I've just never asked about things like that, maybe because I still feel awkward..." – ZE.
"Yes, I've never talked about reproduction with my parents, sir, that's why I feel it's still a bit taboo to talk about it with my parents..." - UJ.

Fear and negative responses from parents are one of the biggest barriers to open communication between adolescents and parents. The majority of informants said they were reluctant to talk because they were worried about judgment, being blamed, or being scolded by their parents. In addition, there were also experiences of seeing friends being judged by their parents when they shared, which made adolescents choose to be silent and closed off. Cultural factors that consider reproductive health topics taboo and concerns from parents that discussions about adolescent pregnancy and early marriage will trigger children's curiosity also become obstacles. To overcome this, informants suggested that parents be more open-minded, not immediately judgmental, and be good listeners so that children feel safe and comfortable initiating conversations.

"Maybe because, first, of the mother's response, because not all mothers will understand... they will think strange things, so they are too afraid of their mother's response and don't want to talk." – ZE
"Maybe they are afraid of their parents' response." – UJ
"There is a fear of being blamed, differences of opinion, or too large an age gap. That makes adolescents reluctant to be open." – MIA
"Because of feeling ashamed, afraid of being scolded, or because they only live with their father (single parent), so communication feels uncomfortable." – SFA

"In my opinion, parents have worries and fears about discussing that. They are afraid the child will just become curious." - RA

The Reactive Role of Community Leaders

Community figures, including traditional leaders like *Datuak*, religious leaders, teachers, and RT (neighborhood) leaders, have a very important role and influence in shaping the views of parents and the community on the issues of adolescent pregnancy and early marriage. In areas with very strong traditional and cultural ties, the voices and decisions of these figures are often heard and trusted more than the advice of professional health workers. For example, the *Datuak* in Minangkabau is the person sought when a nephew makes a mistake, and a *Datuak* in West Sumatra can immediately make a decision to perform a marriage if a (pre-marital) pregnancy occurs.

"In my opinion, community figures, because they are more trusted and also better known." – AL
"True, in my village, community figures are listened to more than health workers." - ST.
"In my place, the most influential figure is the Dato, because he is highly respected and esteemed in customs. If there is a case of adolescent pregnancy, usually the Dato immediately advises them to be married off quickly." – RI.
"I think in Minang, it's the 'datuak', ma'am, because... it will definitely be... if a nephew has a problem, the datuak will be sought." – AMA.
"Maybe it's the RT leader, ma'am." – KHR.

Although community figures have an important role, informants suggested that their role be more focused on being facilitators and supporters of health education programs. Rather than being the sole decision-makers, which is often reactive (like marrying off pregnant adolescents), they are expected to use their influence to bridge the community with professional health workers. The ideal role for these community figures is as mobilizers who encourage parents to actively participate in counseling or seek information from trusted sources. By being good facilitators, community figures can help ensure that reproductive health messages are well received by the community, making prevention efforts more effective.

"They should be listened to, sir... maybe the community figure should just be a facilitator, sir, like... getting information from doctors or health workers, like that, sir." – UJ.
"For me, it's still health workers. They are more expert, but it's better if they are supported by community figures so the message can be accepted." – NI.
"Create an education program that is easy to understand and can attract the attention of adolescents." – MIA
"In my opinion, there needs to be a special forum in the community, for example, the Dato or 'nini mama' gathering the young people to be given guidance on what is allowed and what is not allowed." – RI.
"Health workers also play an important role in providing counseling from the basics to more complex topics. Traditional leaders also have influence, for example, with social sanctions in the village so that adolescents do not repeat the same actions." – APD.

The Father's Shadow Patriarchal Influence and Authority.

Beyond immediate peer environments, the study illuminated a compelling theme conceptualized as "the father's shadow," which represents the combination of a profound communication gulf and an unyielding patriarchal authority within the household. While mothers are frequently viewed as the primary emotional confidantes for day-to-day interactions, fathers are consistently perceived as distant, rigid, and intimidating figures, rendering any proactive discussion on sexual and reproductive health virtually impossible.

> *"I communicate more with my mother, who often reminds me to be careful and not to cross the line. I am not open with my father because I feel embarrassed, and the topic is too sensitive."* – RD.

This paternal silence, however, does not imply a lack of involvement; it manifests as a powerful, absolute authority that dictates critical life transitions, particularly concerning family honor and early marriage. When risk behaviors or pre-marital relationships are discovered, the patriarchal head of the family often bypasses the adolescent's developmental readiness, enforcing early marriage as a non-negotiable cultural solution to conform to societal norms.

> *"So, I don't really know if parents are just following trends or what, but high school students are still quite young, you know. Yet, following what the neighbors do, they just get them married off. If they already have a boyfriend/girlfriend, they are immediately married off even though they are not ready yet."*– RD.

The pervasive nature of this theme is further underscored by the rigid, unchanging mindsets of the older paternal generation. Informants expressed a sense of helplessness when attempting to challenge or modernize these traditional parental attitudes toward youth autonomy and health promotion.

> *"When parents are already set in their ways like that, it will be very difficult to change them. Take my own parents, for example, even when I criticize their negative attitudes, they still cannot change to this day. So, what we can do is bridge the generation that is already set; they can no longer be forced, but we must carefully protect this upcoming generation that is about to grow..."* – ZN.

Table1. Adolescent-Led Innovations for Reproductive Health Interventions

Innovation Category	Proposed Program Forms	Objectives & Targets	Supporting Data (Research Findings)
Digital Education & Engagement	Creative campaigns via TikTok and Instagram featuring short educational videos and infographics.	To provide valid yet relatable information to dismantle cultural taboos on social media.	Informants proposed digital platforms due to their extensive reach among peer groups.
Anonymous Counseling Support	WhatsApp Hotline services or digital "suggestion boxes" that ensure full anonymity.	To eliminate the fear of judgment and maintain identity confidentiality for adolescents seeking advice.	Many informants expressed shame or fear if their identity were revealed when inquiring about reproductive health.

Innovation Category	Proposed Program Forms	Objectives & Targets	Supporting Data (Research Findings)
Campus Counseling Corner	Establishment of a comfortable, informal physical "Counseling Corner" within the university environment.	To serve as a bridge between students and clinical services (Public Health Centers/Campus Clinics).	Findings showed that 20 out of 24 informants were unaware of specific adolescent services on campus.
Peer Led Advocacy	Training students as "Peer Educators" or mobilizers for educational materials.	To reduce communication awkwardness, adolescents are more open to discussing issues with their peers.	Informants (Public Health students) expressed willingness to serve as material designers and program mobilizers.
Collaborative Integration	An integrated referral model collaboratively managed by Lecturers and Students.	To ensure program sustainability and the validity of medical information under expert supervision.	Proposals to integrate campus counseling units with formal health facilities (Public Health Centers/Puskesmas).

DISCUSSION

Service Bureaucracy Structural Hurdles in Adolescent Healthcare Access

The low utilization of reproductive health services for adolescents in nearby health facilities is caused by a combination of a lack of promotion of health services and internal barriers from the adolescents themselves, such as feelings of shame and fear. Negative perceptions of service quality, such as unfriendly health workers and convoluted services, also become obstacles for adolescents to utilize existing reproductive health facilities. Research by Batek et al. shows that confidentiality, cost, and judgmental attitudes from health service providers are the three main barriers experienced by adolescents (Batek et al., 2024). Other research by Obiezu et al. emphasizes that health facilities must implement adolescent-friendly service standards that include guarantees of privacy and health workers trained to handle complaints expressed by adolescents (Obiezu-Umeh et al., 2021).

The lack of health services that focus on adolescent reproductive health in schools and universities in Indonesia deserves special attention. Many informants said reproductive health services at the high school and university levels help students protect against the risk of unplanned pregnancy, early pregnancy, and transmission of sexually transmitted infections. The existence of this reproductive health service can be used as a safe and confidential counseling place for students to ask questions or overcome anxiety related to the body and relationships with the opposite sex and with fellow friends. Ultimately, students are able to make healthy and responsible decisions for their own reproductive health.

The underutilization of reproductive health services at health facilities, such as community health centers (*puskesmas*) or Youth Information and Counseling Centers (PIK-R), stems from

a combination of external and internal factors. From the provider's side, promotion and socialization efforts are considered insufficiently widespread, failing to effectively reach the adolescent population. Internally, adolescents face psychological barriers, including embarrassment and fear of discussing taboo issues, which are compounded by negative perceptions and gossip from peers. These obstacles are exacerbated by a negative perception of service quality, characterized by staff who are perceived as unfriendly, slow, and bureaucratic. Complex administrative procedures, lack of strict confidentiality guarantees, and judgmental or moralistic attitudes from healthcare providers often deter adolescents from seeking consultation or early intervention services. This structural avoidance highlights how heavily institutional environment and provider behavior influence youth healthcare-seeking patterns (Kusumaningrum et al., 2025; Nmadu et al., 2020). Holtman et al. state that judgmental and unfriendly staff attitudes are a primary barrier, alongside shame and fears regarding privacy guarantees (Holtman et al., 2024). Similarly, Reilly & Ebersole also found that adolescents' concerns about privacy violations hinder them from accessing health services (Reilly & Ebersole, 2024).

The research findings reinforce the Health Belief Model (HBM), particularly regarding the “Perceived Barriers” dimension. Although informants demonstrate an awareness of the risks associated with pregnancy (perceived severity), the psychosocial barriers, such as shame and the fear of stigma at public health centers, far outweigh the perceived benefits. This indicates that physical access to health services alone is insufficient if psychological barriers and service bureaucracies remain unaddressed. Reproductive health services at the school and university level are just as important as those in health facilities, such as community health centers (*Puskesmas*) or clinics. Reproductive health services at the educational level act as the frontline for promotional and preventive efforts regarding adolescent reproductive health, covering issues like teen pregnancy, early marriage, and menstruation. In contrast, at the *Puskesmas* or clinic level, these services function as clinical and curative services. Both are part of one interconnected system, working continuously in the prevention of teen pregnancy and early marriage.

The Taboo Barrier: Navigating Cultural and Parental Silences

Parental Communication Gaps

Communication about reproductive health between adolescents and parents varies and is influenced by gender. Female informants were more open to talking with their mothers, while male informants felt the topics of adolescent pregnancy and early marriage were taboo to discuss with parents. The dominant barrier stems from adolescents' fear of negative responses

from parents, such as being judged or scolded. This is in line with previous studies indicating that open discussion about sexuality between parents and children remains limited due to prevailing stigmas (Chaparro Buitrago et al., 2025; Mohd. Tohit & Haque, 2024). Furthermore, cultural barriers in developing regions often transform familial spaces into zones of silence rather than education, leaving adolescents to rely on unverified peer information (Joseph et al., 2024). Melese et al. found that parents often feel uncomfortable and lack the skills to discuss reproductive health issues, which creates a communication barrier between parents and children (Melese et al., 2024). Millanzi et al. stated that open and supportive communication from parents is highly influential on safe sexual behavior in adolescents (Millanzi et al., 2023).

This needs to be emphasized so that parents can be more open and not judgmental of the stories shared by their children. If parents are close-minded and judgmental, their children will never see them as a safe space. They will seek answers to their curiosity from inaccurate and dangerous sources. This open-minded attitude does not mean parents are approving (of wrong behavior); it ensures that parents become the primary source of education before problems occur. The main point is that if a child has already found themselves in trouble or made a mistake, it is this open-mindedness that makes adolescents brave enough to come and seek solutions with their parents, rather than hiding it and making fatal decisions such as eloping or even unsafe abortions.

The Reactive Role of Community Leaders

In a community context that is closely tied to culture, community figures play a very influential role and are often listened to more than professional health workers, especially in making decisions to marry off adolescents who are pregnant out of wedlock. Informants suggested that the role of community figures should change to that of facilitators who bridge adolescents with health services. Abdi et al. (2020) showed that the involvement of community and religious leaders as community gatekeepers is very important for the success of health programs (Abdi et al., 2020). Bonevski et al. (2014) stated that health interventions originating from local leaders or community figures should not be the main determinant of a decision, but rather supporters and promoters of the program (Bonevski et al., 2014).

The role of community leaders in this study carries an influence that establishes them as key, highly respected figures and the primary point of reference when problems arise in their community (Culhane-Pera et al., 2021). However, this significant influence is often reactive rather than facilitative. In this capacity, they could leverage their influence to bridge the community, particularly parents, with accurate health information sources, such as doctors or community health centers. The involvement of community leaders as supporters of educational

programs or as initiators of discussion forums for young people is considered crucial so that prevention messages can be well-received by the community.

The Father's Shadow Patriarchal Influence and Authority.

The Father's shadow critically exposes the hidden yet dominating undercurrent of patriarchal authority that heavily dictates adolescent autonomy and reproductive health outcomes. While mothers are generally positioned as closer emotional confidantes with whom youth share day-to-day worries, the ultimate decision-making power, particularly concerning early marriage approval or responding to pre-marital crises, rests absolutely with the father as the traditional head of the family. The concept of the "shadow" represents a distant paternal figure who rarely engages in proactive, open discussions regarding sexual health due to deeply ingrained cultural taboos, yet wields an absolute veto power that can completely overrule the adolescent's developmental readiness and future aspirations (Karki et al., 2025; Kusumaningrum et al., 2025). This rigid patriarchal structure creates a hazardous communication void within the household when families are built on top-down communication without proactive emotional support, adolescents become highly vulnerable to hidden behavioral risks and isolated within their personal crises (Kim et al., 2026).

Therefore, as highlighted by contemporary public health frameworks, transforming family dynamics and introducing adaptive parenting interventions that explicitly engage fathers are vital strategies to overcome these cultural silences and build a resilient structural foundation for adolescent protection (Chaparro Buitrago et al., 2025). This study also identifies the "Father's Shadow" as a significant interpersonal barrier. Historically, reproductive health interventions have tended to overlook the role of fathers. The findings suggest the need for communication strategies that involve fathers not merely as breadwinners and decision makers, but as protectors of their children's future and as safe, supportive figures for open dialogue. Engaging fathers in health education can dismantle the long-standing stigma and taboos often encountered in communication among family members.

This study acknowledges several limitations that should be considered when interpreting the findings. First, the participant cohort was restricted to undergraduate students from a single public health study program in Universitas Jambi. Consequently, the experiences and ideas captured may reflect a higher level of health literacy compared to the broader, more diverse adolescent population in rural or out-of-school settings. Second, while methodological triangulation between in-depth interviews and focus groups was rigorously maintained, the sensitive and culturally stigmatized nature of reproductive health topics may still induce social desirability bias among some informants during group dynamics. Based on these limitations,

several recommendations for future research are proposed. Future studies should expand the sampling framework to include heterogeneous adolescent demographics, such as out-of-school youth, married adolescents, and those living in remote rural areas, to enhance the transferability of the intervention models. Additionally, longitudinal qualitative inquiries or mixed method designs could be employed to evaluate the long-term feasibility and operational impact of implementing the proposed youth-friendly services and paternal engagement frameworks within local communities.

CONCLUSION

This study concludes that adolescents face multi-layered structural and cultural challenges when navigating reproductive health interventions and early marriage prevention. These challenges are characterized by rigid administrative barriers within institutional frameworks ("Service Bureaucracy"), social taboos within families ("The Taboo Barrier"), and deep-seated paternal dominance ("The Father's Shadow"). While young people possess constructive ideas for peer-driven innovations, their utilization of formal public health facilities is severely hampered by complex procedures and perceived non-youth-friendly services. Based on these findings, specific policy and operational recommendations are proposed. First, public health authorities and Puskesmas management must systematically implement youth-friendly service training for healthcare providers. This training should explicitly focus on developing non-judgmental communication skills, ensuring strict ethical confidentiality guarantees, and eliminating moralistic biases during adolescent consultations to break down the "Service Bureaucracy" barrier. Second, academic institutions should design integrated peer counseling networks on campus to provide accessible, confidential first-line support. Lastly, future intervention models must actively engage paternal figures through tailored community parenting programs to transition the traditional patriarchal structure into a proactive, emotionally supportive family environment.

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