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Experiences of adolescent girls, families, and community leaders in maintaining reproductive health in tourist areas: a study qualitative

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ABSTRACT

Introduction: Adolescents living in tourist areas are exposed to permissive, high-risk environments that increase their vulnerability to reproductive health problems. This study explored the experiences of adolescent girls, their families, and community leaders in maintaining reproductive health in tourism-dependent settings.

Methods: A descriptive qualitative design was used with ten adolescent girls, eight family members, and two community leaders in an Indonesian tourist area. Participants were recruited through snowball sampling. Data were collected through in-depth interviews and field notes, audio-recorded, transcribed verbatim, and analyzed using Braun and Clarke's six-phase thematic analysis.

Results: The five themes of this research were (1) adolescents' experiences of navigating sexual invitations, harassment, and pressure within tourism-driven environments; (2) disrupted daily routines and shifting academic priorities influenced by nightlife-oriented social interactions; (3) multi-layered strategies adolescents used to preserve their physical, social, emotional, and spiritual well-being; (4) intersecting barriers arising from personal hesitation, sociocultural norms, and structural limitations in accessing reproductive health services; and (5) adolescents' aspirations for respectful, confidential, and youth-friendly reproductive health care that is accessible within tourism areas.

Conclusions: Adolescent girls in tourist areas face interconnected reproductive health challenges that are influenced by individual behaviors, peer interactions, community exposure, and limited access to supportive health services. Strengthening family communication, improving adolescent-friendly services, and designing culturally sensitive, multilevel interventions are essential to enhance reproductive health outcomes among adolescents in tourism settings.

Keywords: adolescent girls, community leaders, family, tourist areas, reproductive health

Introduction

Adolescents continue to face significant challenges in reproductive health driven by limited knowledge, early sexual debut, and uneven access to reliable information. These gaps contribute to rising risks such as unintended pregnancy, sexually transmitted infections, and psychosocial vulnerability (WHO, 2023). In many settings, conversations about puberty, sexuality, and bodily autonomy remain restricted, leaving adolescents to seek information from unverified sources that often reinforce misinformation (UNFPA 2022). As global data show increasing patterns of risk behaviors and persistent disparities in reproductive health literacy, addressing adolescent reproductive health is essential for strengthening long-term well-being and preventing avoidable health consequences (UNICEF, 2023; Chandra-Mouli et al., 2022).

Reproductive health is defined as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive system, its functions, and processes (WHO, 2022). One of the major contributors to the high rate of global maternal mortality is adolescent girls' reproductive health problems, such as the increasing prevalence of HIV transmission, sexually transmitted

infections (STIs), unintended pregnancies, unsafe abortions, and early marriages (WHO, 2023).

According to the 2020 Indonesia Demographic and Health Survey (IDHS), the abortion rate in Indonesia has reached 228 per 100,000 live births. Meanwhile, early marriage cases accounted for 10.18% of the total marriages and are expected to decline to 8.74% in 2024 and 6.94% in 2030 (BPS, 2020). WHO (2020) has reported that more than one million new cases of STIs occur every day globally. In Indonesia, data from 2022 show 3,272 cases of early-stage syphilis, 1,877 cases of gonorrhea, 920 cases of late-stage syphilis, 271 cases of trichomoniasis, and 254 cases of genital herpes (Ministry of Health, 2022).

Adolescent reproductive health problems are influenced by environmental factors (Amoadu et al., 2022). Adolescent girls who grow up in high-risk environments characterized by drug abuse, low religiosity, and exposure to violence are more likely to experience unintended pregnancies and contract sexually transmitted infections (Green et al., 2019). Risk-prone areas, such as tourist destinations, are locations with natural and cultural resources that are developed and managed to attract both local and international visitors. The tourist area investigated in this study is one of Indonesia's world-renowned destinations famous for its natural beauty and cultural heritage. Both natural and cultural attractions appeal to domestic and international tourists, as shown by the continuous increase in foreign visitor arrivals each year (Wullur et al., 2023).

Studies conducted in tourist regions have shown that adolescents' easy access to accommodations, the widespread consumption of alcohol in the community, and the availability of karaoke bars and cheap lodgings all contribute to adolescents' perception that risky sexual behavior is normal (Denty & Devy, 2022). This finding aligns with Prakasita et al. (2022), who stated that adolescents' perceptions of casual sex were influenced by their living environment. Adolescents who reside in tourist areas are accustomed to witnessing sexual activities and therefore view them as normal behaviors. Similarly, Lu et al. (2020) found that adolescent girls living in tourist destinations are at risk of contracting sexually transmitted infections due to risky behaviors, such as clubbing, nightlife participation, and multiple sexual partners. The presence of discos and nightclubs in tourist regions encourages adolescents to adopt a liberal lifestyle, including engaging in premarital sex and frequently changing sexual partners (Sagitarini, 2022; Yuliancella, 2015).

The increasing prevalence of HIV/AIDS and STIs in tourist areas is also associated with free sexual lifestyles, heterosexual and homosexual relationships, and tattoo practices (Handayani et al., 2022; Bali Health Office, 2021). Septarini et al. (2019) found that the high rate of early pregnancy in tourist areas was influenced by negative peer pressure. Furthermore, exposure to foreign tourists has a significant impact on local sexual behavior, contributing to the rising prevalence of STIs (Dewi, 2023). Similarly, Dovis et al. (2017) found that adolescents living near areas with concentrated sex trade activities are psychologically affected and at a higher risk of infection.

Tourism areas, while contributing positively to the economy by creating employment opportunities and increasing foreign exchange earnings, also pose serious challenges to adolescent reproductive health, especially for young women. Poorly managed reproductive health problems can have both physical and psychological consequences. Physically, adolescents are at a risk of contracting STIs, early marriage, pregnancy, and unsafe abortion. Social and psychological effects include loss of self-esteem, guilt, lack of family support, depression, drug abuse, suicidal ideation, and academic expulsion (Teferi Mengistu et al., 2022; Risniawan & Handayani, 2021).

Several studies have attempted to address adolescent reproductive health (RH) issues. For instance, providing sexual health education on STIs, HIV, and pregnancy has proven effective in reducing early pregnancy and increasing condom use among adolescents (Bahar et al., 2023). Another study by Djuwitaningsih and Setyowati (2017) showed that interactive health education using the Djuwita mobile application effectively improves young women's attitudes, interests, and self-awareness in managing their reproductive health. However, these efforts have not yet yielded optimal results in reducing adolescent reproductive health problems in Indonesia.

Based on these issues, this study aims to explore in depth the experiences of adolescent girls, their families, and community leaders living in tourist areas in Indonesia regarding how they maintain their reproductive health. The findings of this study are expected to provide valuable insights for the development of appropriate and effective interventions to improve reproductive health in this vulnerable population.

Materials and Methods

This study employed a descriptive qualitative design to explore how adolescent girls, their families, and community leaders in a tourism-dependent setting understood and maintained reproductive health. This design was selected because it enables naturalistic descriptions of behaviors, values, social interactions, and contextual influences without imposing theoretical interpretations, which aligns with the purpose of descriptive qualitative inquiry in health research (Bradshaw et al., 2017; Colorafi & Evans, 2016). One-on-one in-depth interviews were used to elicit detailed accounts of participants lived experiences, as interviews are well established for capturing nuanced perspectives

in qualitative health studies (Sandelowski, 2000). This study was conducted in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) to ensure methodological transparency and rigor (Tong et al., 2007).

The research was conducted in a well-known tourist destination in Indonesia, with the location withheld to protect confidentiality. Twenty participants were recruited: ten adolescent girls, eight family members, and two community leaders. Adolescents were recruited using snowball sampling based on the criteria that required them to be female, aged 10–19 years according to WHO classification, residents of the tourist area, unmarried, and able to communicate in Indonesian. Family members aged 24 years and older who lived in the same household were included, while community leaders were selected based on a minimum residency of ten years, as verified through identification documents. Two adolescents chose not to involve their parents, resulting in fewer family participants; however, the inclusion of three participant groups provided complementary perspectives that deepened their understanding of reproductive health experiences in the tourism context.

As the primary instrument of the study, the researcher engaged empathetically with the participants and acknowledged that meanings were co-constructed within social interactions. Reality was understood as multiple and context-dependent and shaped by the participants' perceptions and circumstances. Reflexive engagement allowed the researcher to recognize and bracket personal assumptions, particularly given the prior professional experience of working with adolescents.

Data were collected through in-depth interviews, field notes, and audio recording. The questions used were as follows. For adolescent girls, the interviews explored how they perceived the influence of the tourism environment on their daily lives by asking, *"How does living in a tourist area influence your daily activities?"* Participants were also invited to describe their reproductive health experiences through questions such as *"What situations have you encountered related to reproductive health or safety?"* To understand their coping strategies, they were asked, *"What do you do to maintain your reproductive health?"* Additionally, barriers were explored with the question, *"What challenges make it difficult for you to stay healthy?"* and service expectations were examined through, *"What kind of reproductive health services do you need or expect?"*

For family members, interviews examined their perspectives and support roles using questions such as *"What reproductive health issues do you observe among adolescents in this community?"* and *"How do you support your daughter's reproductive health?"* Communication and supervision challenges were explored through, *"What difficulties do you face when discussing reproductive health with your daughter?"* Finally, expectations for services were addressed by asking, *"What types of programs or services would better support your family?"*

For community leaders, the guide focused on broader community and structural issues, beginning with, *"What reproductive health issues are commonly observed among adolescents in this tourist setting?"* Existing support efforts were examined through, *"What initiatives currently support adolescent wellbeing here?"* Barriers were explored by asking, *"What community or institutional constraints limit adolescents' access to health services?"* and recommendations were elicited through, *"What improvements are needed to strengthen reproductive health support for adolescents?"*

Interview guides were developed with academic supervisors to ensure alignment with study objectives. Field notes captured non-verbal cues, environmental conditions, and contextual information relevant to interpretation. The interviews were conducted in locations chosen by the participants to ensure comfort and privacy, including their homes and quiet semi-public spaces where confidentiality could be maintained. Interviews lasted 30–45 minutes and were conducted in participants' homes or private locations, such as cafés, ensuring privacy and minimal disturbance. All interviews were conducted face-to-face, after obtaining verbal and written consent from the participants. The researcher met each participant two to three times: initially to build rapport and explain the study, subsequently to conduct interviews, and finally to verify the findings through member checking.

Snowball sampling began with a seed participant identified with assistance from a community health worker at the local *Puskesmas*. Recruitment proceeded across three waves, with each participant referring to the next wave. Data collection continued until no new information was obtained in the final two interviews of each participant group, fulfilling an a posteriori saturation criterion, rather than relying on predetermined sample size expectations. To strengthen sampling transparency, the snowball sampling process was clearly documented. Recruitment began with a seed participant identified by a community health worker at local *Puskesmas*. From this starting point, the referrals continued through three waves (first-wave referrals from the seed participant, second-wave referrals from the first wave, and a final third wave). Data collection proceeded until a posteriori saturation was reached, defined as the point at which there were no new codes in the final two interviews within each participant group.

Data saturation was assessed using an *a posteriori* approach consistent with a qualitative descriptive methodology. The investigators began a preliminary analysis immediately after each interview, which included reading the transcripts, reviewing field notes, and generating initial codes. This iterative process

allowed the research team to identify when there was no new information or code available. Saturation was considered to have been reached when the final two interviews within each participant group (adolescent girls, family members, and community leaders) produced no additional codes or concepts beyond those already identified. At this point, the coding patterns demonstrated redundancy and no further variation in the data appeared during constant comparison across transcripts. This analytic monitoring occurred concurrently with data collection, enabling the investigators to recognize the point at which the interviews no longer contributed new thematic elements, and the research team discussed saturation collectively after each interview cycle to ensure that the judgment was consistent and credible. Because the analysis occurred in parallel with data collection, the investigators were able to determine saturation based on the observed thematic completeness rather than relying on a predetermined sample size.

Ethical approval was obtained from the Research Ethics Committee of the Faculty of Nursing, Universitas Indonesia (Approval No. KET-188/UN2.F12.D1.2.1/PPM.00.02/2023) along with permits from local government offices. Additional ethical safeguards have been implemented to address the involvement of minors. Adolescents under 18 years of age provided assent alongside parental consent, while participants aged 18–19 years provided independent informed consent. The researcher clearly explained the rights, risks, benefits, confidentiality protection, and voluntary nature of participation. To prevent emotional harm, a distress protocol was enacted: if an adolescent cried, fell silent, or showed distress, the interview was paused, and the participant was offered options to rest, resume, or stop entirely without consequences. Referral pathways to Puskesmas counselors were prepared for participants who required additional support. At the end of the interview series, the participants received a modest token of appreciation that was non-coercive. Ethical procedures were differentiated according to the participant's age. For adolescents under 18 years of age, the researcher obtained both parental consent and assent, while participants aged 18–19 years provided independent written informed consent. Special measures were implemented to ensure confidentiality during interviews occurring in semi-public settings such as cafés; the researcher selected secluded seating, ensured that no individuals were within listening distance, minimized background noise, and avoided venues with crowds. A distress protocol was applied to safeguard emotional well-being, and interviews were paused if participants displayed distress (e.g., crying, long silence, and signs of discomfort). Participants were given the option to rest, continue, or terminate the interview without penalties. When needed, the researcher facilitated referral to a Puskesmas counselor or a health worker. At the end of data collection, participants received a small, non-coercive token of appreciation that did not influence their decision to participate.

Data analysis followed Braun and Clarke's six-phase thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2019). The researcher first familiarized herself with the transcripts by reading them repeatedly while reviewing field notes and writing reflective memos. The initial codes were generated inductively on a line-by-line basis without applying any prior theoretical structure. The codes were then clustered to identify patterns and develop candidate themes. These themes were reviewed collaboratively by the research team to ensure internal coherence and alignment with the dataset. Themes were refined, combined, or separated as needed, and clear definitions and names were assigned to each theme to capture their central organizational ideas. The final analytic narrative was constructed using verbatim excerpts to maintain closeness to participants' voices. Analysis was conducted both within and across participant groups to illuminate convergent and divergent perspectives among adolescents, families, and community leaders (Ayres et al., 2003; Miles, Huberman, & Saldaña, 2014).

Rigor and trustworthiness are ensured through multiple systematically applied strategies. Credibility was strengthened through member checking and researcher triangulation across the coding and interpretive processes. The researcher applied continuous reflexivity, acknowledging a clear positionality statement: having prior professional experience in adolescent health, the researcher occupied a dual role as a partial insider on the topic, yet an outsider to the specific tourist-area community. This positionality required ongoing self-reflection to avoid imposing preconceptions and ensure that interpretations remained grounded in participants' narratives. Reflexive memos were written after each interview to document personal reactions, emerging assumptions, and potential bias.

Dependability and confirmability were enhanced through a detailed audit trial that recorded the methodological and analytic decisions. This analytic decision trial documented how initial codes were merged, split, renamed, or discarded across iterative cycles of analysis. For example, early codes such as "peer influence" and "environmental exposure" were initially placed together but later separated after analytic discussions revealed distinct conceptual boundaries. All analytic adjustments were logged systematically using Word and Excel files to maintain the transparency and traceability of the theme-development process.

Negative or deviant cases were intentionally incorporated to refine and strengthen the thematic structures. One adolescent participant, for instance, described feeling entirely safe in the tourist area and

reported no reproductive health concerns, which contrasted with the dominant patterns in the dataset. Instead of being excluded, this deviant case was examined to test the robustness of the emerging themes and illustrate the variability in lived experiences, thereby increasing the credibility of the findings. Transferability was supported through rich contextual descriptions of participants and socio-cultural characteristics unique to the tourism environment, enabling readers to assess the applicability of the findings to other settings.

Data and material availability

Data credibility was achieved by frequently clarifying the data analysis results with participants and extending the time spent with participants. Data transferability was achieved by maximizing sample variation including variations in age, parity, and delivery type. The reliability of the study was achieved by correctly interpreting the results and following agreed-upon steps, so that readers could agree with the conclusions of the authors. The findings were confirmed by conducting a pilot audit and using an ideal sampling technique to obtain sample variation, namely, purposive sampling (Asadi et al., 2022; Polit & Beck, 2010). The trustworthiness, reliability, and credibility of the results were enhanced through member checking, audit trail completion, and investigator triangulation strategies (Carter et al., 2014). The member-checking process involved face-to-face group discussions to confirm the results and interpretations generated during the first analysis phase with several adolescent girls and their parents involved in the study. All of our analytical decisions were traced back through an audit trail consisting of a series of Word and Excel documents. This process was repeated to ensure the accuracy and validity of our findings. Furthermore, our analytical strategy incorporated perspectives from different researchers to ensure convergence of the final interpretations. Data were validated by confirming several statements with specific participants. The validity of the research data was ensured by directly contacting the participants and discussing them with the research team and experts.

Results

The adolescent participants in this study were female adolescents aged 16-19 years. Five participants experienced menarche at age 12, four at age 14, and one at age 13. Five participants were still in high school, four were freshmen, and one was employed. One participant was employed, three were college students, two were college students and employed, two were female students, and one also worked. Five participants' fathers were entrepreneurs and five others worked in the private sector. Seven participating mothers were private-sector employees and three were housewives. Seven participants lived with their parents, one participant lived alone, one participant lived with her uncle, and one participant lived with her parents, grandparents, and an aunt and uncle (a list of participants is in Table 1).

Eight participants were interviewed with their parents with backgrounds in private sector work and trading, while only two were community leaders. A list of the characteristics of parents and community leaders is presented in Tables 2 and 3.

The results of the research analysis identified five themes consisting of interrelated categories derived from keywords from interviews with young women, families, and community leaders, as shown in table 4.

Thematic results

Theme one: Navigating Sexual Invitations, Harassment, and Pressure in a Tourism-Driven Environment

All participants stated that tourist areas influence teenagers to engage in high-risk sexual behaviors, such as casual sex, dating with the same sex, wearing revealing clothing, going to clubs, looking for dates on dating apps, coming home late at night, and not sleeping at home. Examples of participant statements are as follows.

"...like dating people in general. Yes, it's normal to have casual sex... Yes. If the former is just casual love, then... if the latter... as you wish. And it's very common, uh, casual sex. Sex. Here... Especially in my circle..." (p. 4).

"...If I drink, I've tried alcohol. But that's mixed with Coca-Cola too..." (P. 3) (P. 7).

"... This 17-year-old is pregnant and she can have a natural birth (P10) (P2) (P3).

Table 1. Characteristics of female adolescent participants

Code	Age	Long Stay in the Tourist Area	Menarche	Living in the same house with family
P1	17	17	12	Parents Grandfather Brother and Aunt
P2	17	17	12	Father's brother
P3	19	19	14	Parents
P4	19	19	14	alone
P5	16	16	12	Parents
P6	19	19	14	Parents
P7	17	17	12	Parents
P8	19	19	12	Parents
P9	18	18	13	Parents
P10	18	18	14	Parents

Table 2. Characteristics of parent participants

Code	Male/ Female	Age	Education Level	Work	Length of Stay in the Tourist Area/Year
Pr1	Male	52	Junior high school	Private sector employee	52
Pr2	Male	56	Secondary school	Private sector employee	56
Pr3	Female	48	Junior high school	Housewives	48
Pr4	Female	53	Junior high school	Housewives	53
Pr5	Female	46	Secondary school	Housewives	46
Pr6	Female	54	Junior high school	Housewives	54
Pr7	Female	56	Junior high school	Housewives	56
Pr8	Female	51	Junior high school	Housewives	51

Table 3. Characteristics of community leader participants

Code	Male/ Female	Age	Education Level	Work	Length of Stay in the Tourist Area/Year
CL1	Male	57	Bachelor	Civil Servant (Village Staff)	57
CL2	Male	52	Bachelor	Civil Servants (traditional leaders)	51

Four out of ten participants stated that adolescent girls living in their areas had experienced sexual harassment, including being teased by men and subjected to verbal abuse. The participants' statements are as follows:

"... Seduced by a man. If, for example, the negative is if you are wearing revealing clothes." (P5).

".. A man who threatens like if you don't want to, it's done like this, it's done, like that, it's very detrimental to the woman I feel...Men have different fetishes, right, if the fetish is out of the norm, it can also interfere with the physical body, the mentality of women, especially...' (P10).

Three out of ten participants reported that there were adolescent girls in their communities who had experienced sexually transmitted diseases. As conveyed by the participants, as follows:

"... My close friend was there because he was playing too freely or changing partners as well. What disease does he have, what disease is it, what is syphilis ... This is a venereal disease, right," (P8) (P10).

This condition is further exacerbated by parental permissiveness toward risky sexual behaviors. For example, during interviews with families, it was revealed that some parents held permissive attitudes toward premarital sex and early pregnancy. Specifically, five out of eight parents indicated that they allowed their adolescent daughters to engage in sexual activity before marriage, provided that they used condoms. Meanwhile, three out of eight parents stated that they would accept their daughters becoming pregnant as long as there was a clear intention to marry the partner involved. The following are examples of the participants' parent statements:

If you are sure you are going to marry that person, you may be pregnant. If you are not sure about marrying that person, do not" (P4).

Usually my son takes his girlfriend to sleep here... I am calmer.. rather than sleeping outside .." (Pr1) (Pr2).

'Here it is normal for young people to get pregnant before marriage, because it is better to get pregnant before marriage than after marriage and they cannot get pregnant, so they will get divorced' (Pr5) (Pr7).

All community leaders stated that the lack of parental and environmental support for adolescents in maintaining reproductive health contributes to the persistent increase in cases of sexually transmitted diseases, making it difficult to effectively reduce their prevalence.

"... There is no direction from their parents to check or at least come to the posyandu, especially in tourist areas, it is the most marginal, even though the village has come there, only many fishermen focus on looking for fish to earn money" (CL1) (CL2).

"... Indeed, we usually do it when there is activity, but adolescent control here is indeed low" (CL1) (CL2).

Theme two: Disrupted Routines and Shifting Priorities in School and Learning.

Four out of ten participants stated that living in a tourist area contributed to adolescents neglecting their school responsibilities, becoming lazy to study, and experiencing difficulty concentrating on their lessons, which ultimately led to a decline in academic performance. The participants' statements are as follows:

"...Tomorrow schools will be disrupted and school responsibilities will not be carried out. So it makes us lazy to learn." (P2).

*"...His appearance will definitely decline in school... used to be diligent in doing such things ... Getting a top 10 score in a class is classically smart. Now it has changed as the value decreases. forgot to do a task. lazy like that" (*P3).

This finding is consistent with the statements of all community leaders, who observed that young women's awareness of the importance of maintaining health is relatively low. They noted that many young women prioritize earning extra income and spending time in entertainment venues to attend to their reproductive health.

Table 4. Theme coding tree

Quotes (Verbatim)	Initial Codes	Subthemes	Themes
"Sometimes my friends invite me to drink at the tourist spots, and then they have sex with their partners without even thinking about using any protection." (P3)	alcohol use; peer pressure; unprotected sex	Alcohol-related unsafe encounters	Theme 1: Navigating Sexual Invitations, Harassment, and Pressure in a Tourism-Driven Environment
"When I pass through the nightclub area, strangers often touch me." (P5)	unwanted touching; harassment in nightlife	Sexual harassment in crowded spots	
"Foreign guys usually ask me to go to a hotel… I'm scared, but my friends say it's normal." (P7)	pressure from tourists; unsafe expectations	Sexual pressure and exploitation	
"Young girls are often teased or flirted with by male tourists." (CL1)	catcalling; unsafe environment	Street harassment	
"My friends often switch partners when hanging out in the beach area." (P4)	casual sex; partner change; peer influence	Casual sexual exposure	
"I go to cafés with my friends at night, and then I'm sleepy at school the next day." (P6)	nightlife participation; poor sleep; low concentration	Disrupted study routines	Theme 2: Disrupted Routines and Shifting Priorities in School and Learning
"Her grades dropped because she spends more time hanging out in tourist areas." (Pr4)	decreased academic achievement	Academic decline	
"I often skip school because I meet my friends at the beach club." (P8)	truancy; peer distraction	School disengagement	
"I always remember to use a condom when I'm in a relationship." (P9)	condom use; protective practices	Safe sexual practices	Theme 3: Multi-Layered Strategies to Preserve Well-Being in Challenging Social Environments
"When I'm scared, I pray and remember my parents' advice." (P2)	spiritual coping; moral reminder	Spiritual coping and moral regulation	
"I join HIV education sessions from the health center staff." (P10)	health education; HIV awareness	Health literacy improvement	
"I feel embarrassed going to the health center because I'm afraid of running into neighbors." (P8)	embarrassment; stigma fear	Personal emotional barriers	Theme 4: Barriers Emerging from Personal Hesitation, Social Norms, and Structural Constraints
"The health center is very far, so I feel reluctant to go there." (P1)	limited access; distance barrier	Geographic/systemic access barriers	
"In our family, talking about sex is considered taboo." (Pr2)	cultural norms; communication taboo	Sociocultural constraints	
"I actually feel completely safe living here; I'm not afraid of anything." (P5 – deviant case)	contradictory perception; safety feeling	Deviant/negative case	
"I want the health staff to be friendly and not judgmental." (P10)	need for friendly care	Non-judgmental attitudes	Theme 5: Aspirations for Respectful, Youth-Friendly, and Accessible Reproductive Health Services
"It would be better if the health center had a special room for adolescents." (P7)	need for privacy; youth-friendly space	Privacy in clinical settings	
"Health workers should explain things slowly and not scare us." (Pr1)	communication clarity; respectful interaction	Effective communication	

The following is a statement from a community leader:

"*If there are activities, usually from the health center, sometimes there are people who come to the village for posyandu activities, they are lazy and do not want to come*" (CL1) (CL2).

"They have been carried away by foreign cultures because of their daily behavior, so they are teenagers who are busy with their activities to make money" (CL1) (Cl 2).

Theme three: Multi-Layered Strategies to Preserve Well-Being in Challenging Social Environments.

All participants stated that their efforts to maintain reproductive health included maintaining the physical health of the reproductive system by ensuring nutritious food intake, practicing proper hygiene of reproductive organs, and undergoing regular health check-ups. For example, the participant's statement was as follows:

".... First, diet is important..."(P7) (P1).

"... Maintain cleanliness, for example, if you urinate again, it must be dry first, if you urinate again. Then every 3 or 4 hours the bearings should be replaced..."(P1)(P2).

".... Check Our Reproductive Health"(P6) (P7) (P9).

Four out of ten participants stated that efforts made to maintain their reproductive health were to maintain social and environmental health, such as choosing positive friends. As conveyed by the participants, as follows:

"... The way to take care of it may have to be from the environment first, find a healthy environment..." (P1) (P2) (P8).

"...If I choose a place where I will hang out, then friends are very important, right, the environment is also like that, that's how I take care of it" (P1) (P2) (P7).

Five out of ten participants stated that their efforts to maintain reproductive health involved nurturing their spiritual well-being, which included regular religious worship, reflecting on advice from parents, family, and friends, maintaining a positive mindset, and engaging in

constructive and positive activities. Examples of participant statements are as follows:

"Praying diligently is the main thing for us to be strong, if we run out of faith, always remember the counsel of our parents... Parents should always remind us to try our best to maintain their trust" (P1).

All participants stated that they received social support from their parents, family, friends, and teachers at school to maintain their reproductive health. As conveyed by the participants, as follows:

"From my parents and also from my family ... Yes, he said that if you are dating, you should be able to really take care of yourself" (P5) (P1).

"At most we only communicate with who are you close to or dating? If the guy is not nice, usually my close friends will tell me that. We take care of each other" (P2) (P3) (P7).

*"Can get materials such as education as well. It's like getting a PPT that will be explained like that with the teacher. For example, about sexually transmitted diseases. It's like we're making a poster. pasted like that..." (*P5) (P8).

Eight out of ten participants stated that they received support from health workers to maintain their reproductive health through activities at school. The participants' statements are as follows:

"... The health center explains common diseases such as HIV/AIDS, there are also examinations, asking the doctor if there are complaints. Then when HIV/AIDS education is done, most people ask what vaginal discharge is, then the doctor will explain it" (P1) (P3) (P4)).

Interviews with parents revealed that their efforts to maintain adolescent reproductive health included preparing traditional herbal drinks and communicating with their daughters. Two parents reported drinking turmeric, tamarind, and betel nuts as a means to support their daughters' reproductive health. The remaining six parents emphasized the importance of communicating openly with their adolescent daughters as their primary method of support. The following are the participants' statements.

*"... I made a recipe for herbal medicine from my mother first. like turmeric, sour sometimes I make betel stew" (*P1) (P3*).*

"If I prefer to talk to them, make my children like friends and open up to each other" (Pr2) (Pr4) (Pr5).

On the other hand, parents reported that a lack of knowledge, limited control, and feelings of shame and discomfort in discussing reproductive health with their children contributed to the inadequate maintenance of adolescent reproductive health. Three out of eight parents stated that they struggled to provide information about their reproductive health because of insufficient knowledge. Additionally, five parents expressed that they felt awkward and uneasy when initiating conversations related to the sexual and reproductive organs. Moreover, five parents acknowledged having limited time to supervise their adolescents' activities, which further hindered their ability to support their children's reproductive health. The following are the participant's parent statements:

'It's not *easy to get kids to discuss sex issues like this... I feel ashamed of my son and I also feel awkward*".' (Pr3) (Pr5) (Pr6)

"I also didn't get any information from my mother, so when I told my daughter, I didn't know much " (Pr1) (P2r) (Pr7).

I leave early and go home in the afternoon and sometimes in the evening, so I can't fully monitor my son. My husband also has a full business in the City, so we can't keep an eye on him " (Pr2) (Pr3) (Pr4).

Theme four: Barriers Emerging from Personal Hesitation, Social Norms, and Structural Constraints.

Nine out of ten participants stated that the obstacles adolescents face in maintaining their reproductive health primarily stem from low self-awareness, lack of knowledge about reproductive health, and feelings of shame and fear. One additional participant noted that the barrier was the absence of open discussions or communication regarding reproductive health checkups. The following is an example of a participant statement.

"The obstacles come from myself. The thought of checking reproductive health awareness does not exist. Yes, as long as we feel healthy. Why check it, that's what he thinks." (P. 4).

"... Similarly, if I wanted to check his shyness, I was worried. fear... fear.. Maybe I won't be healthy later. Like that..." (P5).

"... I really don't know any information about reproductive health, so I'm confused and I also want to ask and consult a health professional" (P2) (P3) (P7).

Seven out of ten participants reported that the primary obstacles in maintaining their reproductive health were rooted in the sociocultural norms of the community, which normalized premarital pregnancy and were influenced by traditional beliefs that emphasize the importance of producing offspring as part of ancestral cultural expectations. The following is an example of a participant statement.

"*If my environment has never been discussed or discussed like that, yes, ma'am. Moreover, reproductive health... It's like a stupid time. Since there is such a thing here, it's normal. so that people don't care"* (P4) (P2) (P7).

Five out of ten participants stated that the obstacle faced by adolescents in maintaining their reproductive health is the distance from home to health services. The participant's statement is as follows:

*"Then there are also distance constraints. If the place is far away, I think twice, so I'll check to find the officer." (*P2) (P3).

Theme five: Aspirations for Respectful, Youth-Friendly, and Accessible Reproductive Health Services.

Five out of ten participants expressed that their expectations for reproductive health services included having nurses who were friendly, empathetic, and understanding of adolescent circumstances. They emphasized the importance of nurses being patient, open, communicative, respectful of privacy, and capable of building emotional connections, such as offering comforting gestures like a hug. Additionally, the participants expected nurses to avoid rude behavior and refrain from making negative or judgmental remarks. The following is an example of a participant statement.

"The important thing is to be friendly, so as not to be awkward, especially for teenagers today, when you talk about ..., it's also a bit sensitive, nowadays teenagers don't have anything to remember, so yes, try to be friendly..." (P1) (P. 8) (P. 9).

All participants stated that adolescents' expectations for reproductive health services include the implementation of reproductive health services through counseling, education, and examinations by health workers in tourist areas. The following is an example of a participant statement.

".... Someone hugged us, immediately jumped onto the field. whether to provide counseling or examination... Because no one is here yet." (P. 3) (P. 4).

Community leaders stated that limited support from health centers and local government authorities poses a significant obstacle for health workers to improve the reproductive health of adolescent girls. All community leaders emphasized that the absence of regular screening and health check-ups, combined with insufficient institutional support to address reproductive health issues, represents a major barrier that remains difficult to overcome. The following are statements from the community leaders:

"Here there are no reproductive health checks, most health centers are carried out in the village only for weighing" (CL1) (CL2*).*

"..reproductive health itself has not received serious attention from the government and our health office"(CL1) (CL2).

Nevertheless, some parents made efforts to communicate with their daughters, as reported by six of the eight parent participants. The following is an example of a participant's parent statement.

"*If I prefer to talk to them, treat my children like friends and be open with each other."* (Pr2) (Pr4).

Discussions

The findings of this study revealed that adolescent girls living in tourist destinations face multilayered vulnerabilities affecting their reproductive health, encompassing exposure to risky sexual behaviors, sexual harassment, sexually transmitted infections, and declines in academic performance. These vulnerabilities arise through the dynamic interaction of individual, interpersonal, community, organizational, and broader socio-cultural factors, which can be understood comprehensively through the Social Ecological Model (SEM) (Bronfenbrenner, 1977; Golden & Earp, 2012). At the individual level, adolescents described heightened exposure to casual sexual encounters, harassment, and unsafe interactions that stem from the nature of the tourism environment surrounding their communities. These experiences are consistent with previous research indicating that the presence of nightlife venues, entertainment clubs, bars, and other tourism-related establishments elevates the risk of violence, exploitation, and impulsive sexual decision-making among youths (WHO, 2023; Cañada & Guereña, 2022). Similar evidence from global studies underscores that tourist destinations often create sexualized environments that contribute to early sexual initiation and low perceived reproductive health risks among adolescents, particularly when reproductive health literacy is limited (UNFPA, 2022; UNICEF, 2023; Alcaide et al., 2020).

Interpersonal factors contributed to these patterns. Many adolescents reported a decline in academic achievement as they spent more time socializing with peers, visiting clubs, or participating in tourism-related activities than focusing on their educational responsibilities. This is consistent with studies showing that early sexual experience, unintended pregnancies, and social pressures can negatively influence school performance and motivation (UNESCO, 2021; Mmari et al., 2021). Peer influence plays a substantial role in shaping adolescent choices, especially when peer groups frequently engage in nightlife or leisure activities that are common in tourism areas. While peer interactions may increase risk, family communication and support can act as protective factors that influence healthier decision-making, although such support may be inconsistently available in the tourism context (Widman et al., 2023; Markham et al., 2020).

At the community level, the tourism environment acts as a structural factor that shapes adolescents' exposure to risks and opportunities. The influx of local and international visitors, combined with economic activities tied to nightlife and entertainment, expands adolescents' interactions with diverse individuals, and increases the likelihood of unsafe encounters. International evidence shows that tourist areas can become hotspots for the sexual exploitation, harassment, and trafficking of minors (UNODC, 2023; ECPAT International, 2022). Despite these challenges, some adolescents have attempted to maintain their reproductive health by using condoms, recalling parental advice, and participating in health education programs provided by local health workers. These efforts are consistent with findings from other studies that highlight the importance of informational and emotional support in enabling adolescents to adopt safer sexual practices (Chandra-Mouli et al., 2022; WHO, 2023).

Societal and cultural factors also influence adolescents' reproductive health behaviors and challenges. The study found that low awareness of reproductive health, negative beliefs about sexuality, and deeply embedded patriarchal norms contributed to adolescents' barriers to accessing and utilizing reproductive health services. Cultural expectations surrounding female sexuality, traditional gender roles, and religious interpretations have been shown to restrict adolescents' autonomy and informed decision making. Similarly, previous research indicates that in some tourist regions, early marriage, premarital pregnancy, and

permissive attitudes toward adolescent sexual activity become normalized due to distorted social dynamics influenced by tourism, thereby exacerbating the risks for adolescent girls (UNFPA, 2022; Guttmacher Institute, 2023; Greene et al., 2020).

Furthermore, adolescents have reported significant challenges when attempting to access formal health services. Distance to health facilities, conflicting schedules with school hours, and negative interactions with healthcare providers, such as judgmental attitudes, lack of confidentiality, and unfriendly communication, discouraged adolescents from seeking reproductive health care. These findings are consistent with the broader literature demonstrating that non-judgmental, confidential, and youth-friendly reproductive health services are essential for improving adolescents' service utilization (WHO, 2022; WHO, 2023; Kågesten et al., 2021). The reluctance of adolescents to visit health facilities ultimately contributes to delayed care seeking, limited STI screening, and inadequate sexual health counseling (CDC, 2024).

Taken together, these results highlight the need for interventions across multiple ecological levels. Improving reproductive health literacy and decision making at the individual level must be supported by strengthened family communication and peer-based education at the interpersonal level. At the community level, expanding youth-friendly educational programs and ensuring safe public spaces within tourism environments can help to reduce exposure to harmful situations. Organizationally, health facilities must enhance adolescent-friendly services by training staff to adopt empathetic, confidential, and nonjudgmental approaches. At the societal level, policies regulating adolescent protection in tourist zones and culturally sensitive reproductive health education should be prioritized. These recommendations align with global guidelines by the WHO, UNICEF, and CDC, which emphasize multi-level strategies to address adolescent reproductive health in high-risk environments (WHO, 2023; UNICEF, 2023; CDC, 2024).

The findings of this study further indicate the importance of involving multiple stakeholders in future research, including traditional leaders, governmental institutions, and tourism industry actors, to better understand the structural determinants that influence adolescent reproductive health. Future studies should also explore intervention-based or digital approaches, such as mobile health applications, as promising strategies for delivering reproductive health information more effectively to adolescents living in tourism-dependent communities.

In this study, several participants requested that the interviews be conducted at home; therefore, the author could not directly observe the family support provided to adolescent girls, which could affect the depth of understanding of the support provided by the family in maintaining adolescent reproductive health.

Conclusion

This study showed that adolescent girls living in tourist areas face significant reproductive health vulnerabilities shaped by individual behaviors, peer influence, community exposure, limited access to youth-friendly services, and broader cultural norms. The tourism environment increases the risk of unsafe sexual experiences, harassment, and academic disruption, whereas structural and social constraints hinder their ability to seek appropriate care. Although adolescents use various strategies to protect themselves, such efforts remain insufficient without broader systemic support. Strengthening reproductive health programs requires multilevel interventions aligned with the Social Ecological Model, including improving adolescents' knowledge, enhancing family and peer support, ensuring safe community environments, and providing non-judgmental and confidential health services. Future initiatives should involve community and governmental stakeholders and explore innovative approaches, such as digital health education, to better support adolescents in tourism-dependent settings.

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Authors' contributions

Setyowati contributed to the conception and design of the study, data acquisition, and data analysis; provided input on revisions to the final draft; and provided final approval of the version to be published. Siti Rahmawati contributed to the conception and design of the study, data acquisition, and data analysis, and wrote the first and final revised drafts of the manuscript. Tri Budiati provided input and guidance during the proposal development, research, and data analysis process.

Declaration of Interest

There are no conflicts of interest to declare.

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