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Research Article

Multidimensional Stigma and Social Support Networks Among Adolescents with Unintended Pregnancy in Makassar, Indonesia

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Abstract: This study examines the stigma and patterns of social support in adolescents with unplanned pregnancies in Makassar in the context of the Bugis-Makassar culture that upholds the values of siri' (honor and shame). Teen pregnancy is understood as an experience influenced by the confluence of traditional values, religious morality, and modern social demands. This study used an Interpretative Phenomenological Analysis (IPA) approach on 17 adolescent girls aged 15–19 years who experienced unplanned pregnancies in June–November 2023. Data were obtained through in-depth semi-structured interviews, recorded, verbatim transcribed, and analyzed using a six-stage science process with a focus on the experience of stigma and social support. Two main themes emerged: Living Under the Shadow of Siri': Multidimensional Stigma and Navigating Social Support in the Context of Shame. Participants experienced widespread stigma in a variety of contexts, including family (serial violations and family shame), society (moral judgments and gossip), health services (discrimination of health workers), and educational environments (bullying and exclusion). Stigma is also internalized in the form of guilt and negative identity, and is especially severe in adolescents with economic limitations. Efforts to seek support are often hampered by concerns about stigma, so adolescents engage in selective disclosure and rely more on peers. Grandma is often the most accepting source of family support. These findings underscore the need for multilevel interventions that reduce community stigma, strengthen friendly and confidential health services, and develop culturally sensitive peer support networks.

Keywords: Adolescent Pregnancy; Honor; Interpretative Phenomenological Analysis; Indonesia; Shame.

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1. Introduction

Global Burden and Cultural Dimensions of Adolescent Pregnancy

Adolescent pregnancy represents a persistent global public health challenge with profound implications for young women's health, education, and life trajectories. Worldwide, approximately twelve million girls aged fifteen to nineteen years give birth annually, with ninety-five percent of these births occurring in low- and middle-income countries (WHO, 2024). While global adolescent birth rates have declined from sixty-four point five per thousand in 2000 to forty-one point three per thousand in 2023, progress has been uneven across regions, with sub-Saharan Africa and Latin America continuing to experience the highest rates (WHO, 2024; Kassa et al., 2023). Indonesia, as the world's fourth most populous nation and largest Muslim-majority country, confronts substantial adolescent reproductive health challenges despite decades of family planning initiatives, with significant regional variations reflecting diverse cultural contexts across this archipelagic nation.

Beyond medical and demographic dimensions, adolescent pregnancy is fundamentally a social phenomenon profoundly shaped by cultural values, moral frameworks, and community responses. In many societies, particularly those characterized by conservative gender norms and strict sexual morality, unintended pregnancy among unmarried adolescents represents a transgression of deeply held values regarding female sexuality, family honor, and appropriate life

course progression. The social meaning attributed to adolescent pregnancy and consequently, the experiences of young women who become pregnant varies dramatically across cultural contexts, yet remains understudied in non-Western settings. Understanding how cultural frameworks shape lived experiences is essential for developing contextually appropriate interventions that address not only biological and medical aspects but also the profound social and psychological dimensions of adolescent pregnancy.

Stigma as Central Mechanism Shaping Experience and Outcomes

Stigma conceptualized as the social process through which individuals or groups are marked, stereotyped, separated, and devalued based on perceived attributes or behaviors constitutes a fundamental social mechanism through which adolescent pregnancy is regulated and controlled (Goffman, 1963; Link & Phelan, 2001). Contemporary stigma theory distinguishes multiple dimensions and levels at which stigma operates: enacted stigma involving actual experiences of discrimination and negative treatment; anticipated stigma reflecting expectations of being discriminated against; internalized stigma where stigmatizing beliefs are incorporated into one's self-concept; and structural stigma embedded in institutional policies, practices, and cultural norms (Earnshaw & Quinn, 2012; Hatzenbuehler & Link, 2014).

Research across diverse contexts has documented how pregnant adolescents experience stigma manifesting through verbal harassment, social exclusion, judgmental attitudes from healthcare providers, educational barriers, and damaged family relationships (Ellis-Sloan, 2014; SmithBattle, 2013; James-Hawkins et al., 2024). A systematic review by James-Hawkins and colleagues (2024) synthesizing fifty-three studies across multiple countries found that adolescent mothers consistently reported experiencing stigma from family members, peers, community members, and healthcare providers, with profound impacts on mental health, healthcare seeking, educational attainment, and social relationships. Stigma has been identified as contributing to delayed prenatal care initiation, poor maternal mental health outcomes including depression and anxiety, educational dropout, and social isolation (Hodgkinson et al., 2014; Falana & Carrington, 2023).

However, the overwhelming majority of existing stigma research has been conducted in Western, predominantly English-speaking contexts. Far less is known about how stigma operates within different cultural frameworks that may intensify or modify stigmatization processes. Honor-shame cultures, characterized by emphasis on family reputation, collective identity, and social hierarchies, may generate particularly intense stigmatization of behaviors perceived as transgressing sexual morality and damaging family honor. Within such contexts, pregnancy outside marriage may be experienced not merely as individual transgression but as violation of collective family honor requiring community sanctions and restoration mechanisms (Hamonic, 2022; Idrus, 2020). Yet phenomenological exploration of how adolescents navigate these cultural frameworks remains limited.

Social Support: Critical Resource Compromised by Stigma

Social support encompassing emotional, informational, instrumental, and appraisal support provided through social relationships represents a critical protective factor for adolescent maternal and mental health outcomes (Hurd et al., 2014). Substantial evidence demonstrates that adolescents with strong social support networks experience better psychological adjustment during pregnancy, reduced depression and anxiety, improved parenting outcomes, and enhanced educational and economic trajectories (Hodgkinson et al., 2014; Dennis et al., 2023). Support from family members, particularly mothers and grandmothers, as well as partners, peers, and healthcare providers, has been associated with improved prenatal care utilization, healthier behaviors during pregnancy, and better infant outcomes.

Yet stigma fundamentally compromises access to social support precisely when it is most needed. Qualitative research has revealed how anticipated stigma constrains adolescents' disclosure of pregnancy, limiting who they tell and when, thereby reducing potential support networks (Herrman, 2007). Fear of negative judgment, rejection, and shaming leads many adolescents to conceal pregnancy for extended periods, delay seeking prenatal care, and avoid confiding in individuals who might otherwise provide support. A recent qualitative study examining stigma and social support during unintended pregnancy in the United States found that participants engaged in highly selective disclosure, carefully assessing whom to trust based on anticipated reactions, with many experiencing rejection, judgment, and withdrawal of support when pregnancy was revealed (PLOS One, 2019). This dynamic creates a paradoxical situation

where those experiencing the most stigma and consequently facing the greatest need for support are least able to access it.

Understanding the relationship between stigma and social support within specific cultural contexts is essential yet remains underexplored. In societies where family honor and collective reputation are paramount, disclosure of pregnancy outside marriage may trigger family responses focused on damage control and reputation management rather than support provision. Traditional support networks may be compromised by shame dynamics, potentially reconfiguring who can be trusted and where support can be found. Exploration of how adolescents navigate these challenges within culturally conservative contexts can illuminate both barriers and potential resources for intervention.

The Bugis-Makassar Cultural Context: Siri', Islam, and Gender

Makassar, the capital of South Sulawesi province with a population of one point five million, serves as the cultural and economic center for Bugis and Makassarese peoples. These closely related ethnic groups share a distinctive cultural framework profoundly relevant to understanding experiences of adolescent pregnancy, centered on the concept of siri'. Siri' represents a complex cultural construct encompassing shame, self-respect, personal and family honor, and appropriate social standing. It functions simultaneously as an internalized value system and external social control mechanism regulating behavior, particularly regarding sexuality, gender relations, and family reputation (Pelras, 2006; Hamonic, 1987; Idrus, 2020).

For young women, virginity and sexual purity before marriage are conceptualized as directly tied to family siri' and collective honor. Premarital pregnancy represents one of the most serious violations of siri', bringing mali (deep shame) not only to the individual but to her entire family, extending across generations and affecting marriage prospects for siblings and cousins. Traditional responses to siri' violations have historically included forced marriage to 'restore' honor, permanent exile from community, or in extreme historical cases, violence. While contemporary manifestations are less extreme, the cultural framework of siri' continues to powerfully shape responses to premarital pregnancy (Nurmila, 2023; Hamonic, 2022).

Islamic religious values, adhered to by approximately ninety percent of Makassar's population, overlap with and reinforce certain traditional values while introducing additional moral frameworks. Conservative Islamic interpretations emphasize female chastity, condemn premarital sexuality as zina (forbidden sexual relations), and conceptualize motherhood outside marriage as moral failing requiring repentance. Community religious institutions including mosques, Islamic schools, and religious leaders often reinforce these values through teachings and social sanctions. The contemporary context reflects ongoing negotiation between traditional-religious values and globalizing, modernizing forces, creating complex moral terrain that young women must navigate.

Study Aims and Significance

This study aimed to explore and understand experiences of stigma and social support among adolescent females with unintended pregnancy in Makassar, Indonesia, using Interpretative Phenomenological Analysis. Specific research questions guiding this investigation were: (1) How do adolescents experience stigma related to unintended pregnancy across different social contexts family, community, healthcare, educational, peer? (2) What forms does stigma take enacted, anticipated, internalized? (3) How does stigma shape adolescents' strategies for disclosing pregnancy and seeking support? (4) What sources of social support do adolescents access or fail to access, and what factors facilitate or hinder supportive responses? (5) How do cultural frameworks of siri' and Islamic morality shape experiences of stigma and support?

This research makes several important contributions. First, it addresses critical gaps in understanding adolescent pregnancy within non-Western, culturally conservative contexts, particularly honor-shame cultural frameworks. Second, it provides in-depth phenomenological exploration of the intersection between stigma and social support, illuminating mechanisms through which stigma compromises access to critical resources. Third, findings can inform development of culturally appropriate interventions addressing stigma and strengthening support networks. Finally, this work contributes to broader theoretical understanding of how cultural contexts shape reproduction of social inequality through stigma processes.

2. Preliminaries or Related Work or Literature Review

Adolescent Unintended Pregnancy as a Social and Health Issue

Adolescent unintended pregnancy remains a significant global public health concern with long-term consequences for young women's health, education, and socioeconomic trajectories. Each year, millions of girls aged 15–19 give birth, with the majority occurring in low- and middle-income countries (World Health Organization, 2024). Beyond biomedical risks, adolescent pregnancy is deeply shaped by social norms, moral expectations, and community responses. Research shows that early pregnancy often increases vulnerability to school dropout, social exclusion, and psychological distress (Falana & Carrington, 2023; Hodgkinson et al., 2014). Consequently, understanding adolescent pregnancy requires examining not only medical factors but also sociocultural and relational contexts.

Social Stigma Theory

Stigma is a central theoretical lens for understanding the experiences of pregnant adolescents. Classic work by Erving Goffman (1963) conceptualizes stigma as a socially constructed attribute that discredits individuals and reduces their social identity. Later, Link and Phelan (2001) expanded this framework by emphasizing labeling, stereotyping, separation, status loss, and discrimination as interconnected components of stigma operating within power structures.

Contemporary stigma theory distinguishes multiple dimensions, including enacted stigma (direct discrimination), anticipated stigma (expectation of rejection), internalized stigma (self-devaluation), and structural stigma embedded in institutional policies and cultural norms (Earnshaw & Quinn, 2012; Hatzenbuehler & Link, 2014). Studies across diverse contexts indicate that pregnant adolescents frequently encounter stigma from families, communities, schools, and healthcare providers, leading to delayed care-seeking, mental health challenges, and disrupted education (Ellis-Sloan, 2014; James-Hawkins et al., 2024; SmithBattle, 2013). Thus, stigma functions as a key mechanism shaping both lived experience and life outcomes for adolescent mothers.

Social Support as a Protective Factor

Social support theory highlights the role of interpersonal relationships in buffering stress and improving wellbeing. Social support typically includes emotional, informational, instrumental, and appraisal assistance received through social networks. Evidence demonstrates that strong support systems during adolescent pregnancy are associated with better psychological adjustment, improved prenatal care utilization, and more positive parenting outcomes (Dennis et al., 2023; Hurd et al., 2014).

However, stigma often undermines access to such support. Fear of judgment may lead adolescents to conceal pregnancy or selectively disclose it, limiting opportunities for assistance (Herrman, 2007). Research also shows that supportive relationships especially with family members, peers, or trusted adults can mitigate social isolation and enhance coping capacity (Hodgkinson et al., 2014). Therefore, stigma and social support are closely interconnected processes influencing adolescent wellbeing.

Cultural Framework of Siri' in Bugis–Makassar Society

In the cultural context of Makassar, the Bugis-Makassar concept of siri' represents a central moral principle related to honor, shame, dignity, and social reputation. Siri' functions as both an internal moral compass and a social control mechanism regulating behavior, particularly regarding sexuality and gender norms (Pelras, 2006; Idrus, 2020). Premarital pregnancy is often interpreted as a violation of family honor that affects not only the individual but the entire kinship group (Hamonic, 2022; Nurmila, 2023).

This honor-shame framework intersects with Islamic moral teachings emphasizing chastity and moral responsibility, reinforcing strong social sanctions against premarital sexuality. Consequently, adolescent pregnancy may trigger family shame, community gossip, and institutional discrimination, intensifying stigmatization processes and influencing how young women seek support.

Integrating Stigma, Culture, and Social Support

Drawing on stigma theory and social support frameworks, adolescent unintended pregnancy can be understood as a socially mediated experience shaped by cultural values, institutional practices, and interpersonal relationships. In honor-shame cultural settings, stigma may operate simultaneously at interpersonal, community, institutional, and internalized levels, constraining

access to essential support networks. At the same time, supportive relationships such as those with family elders, peers, or community organizations can foster resilience and adaptive coping.

Understanding how stigma and support interact within specific cultural contexts is therefore essential for designing culturally responsive interventions that reduce discrimination, strengthen social networks, and improve adolescent reproductive health outcomes.

Algorithm/Pseudocode

Research Design and Philosophical Foundations

We employed Interpretative Phenomenological Analysis (IPA), a qualitative methodology grounded in phenomenological philosophy, hermeneutics, and idiography (Smith et al., 2022). IPA is particularly suited to exploring how individuals make sense of significant life experiences, with emphasis on detailed, nuanced examination of lived experience and personal meaning-making. The approach acknowledges the double hermeneutic involved in qualitative research participants interpreting their experiences while researchers interpret those interpretations and values detailed analysis of small, purposively selected samples to achieve rich, contextual understanding.

IPA's idiographic commitment involves detailed analysis of individual cases before moving to cross-case patterns, allowing both particular experiences and shared themes to emerge. This methodology was selected because adolescent pregnancy represents a profoundly significant, identity-disrupting experience that adolescents actively interpret within cultural frameworks, making detailed exploration of personal meaning-making essential. IPA's flexibility also allows integration of cultural context into analysis while maintaining focus on individual experience and agency.

Setting, Sampling, and Participants

The study was conducted in Makassar, South Sulawesi, Indonesia between June and November 2023. Participants were recruited through four Community Health Centers (Puskesmas) providing antenatal care, two youth-serving NGOs, and snowball sampling. Purposive sampling sought maximum variation across pregnancy outcomes (continuing pregnancy, post-delivery, abortion attempt), socioeconomic status, educational level, family structure, and relationship status to capture diverse experiences while maintaining focus on the phenomenon of unintended pregnancy among Makassar adolescents.

Seventeen female adolescents participated. Eligibility criteria included: female sex assigned at birth, aged fifteen to nineteen years at pregnancy occurrence, unintended pregnancy (defined as pregnancy occurring sooner than desired or not wanted at any time) within preceding eighteen months, able to provide informed consent (or parental consent for those under eighteen), and willing to discuss experiences. Exclusion criteria included significant cognitive impairment or acute mental health crisis requiring immediate clinical intervention.

Participant age at pregnancy ranged from fifteen to nineteen years (mean seventeen point four, SD one point three). Educational status varied: eight (forty-seven point one percent) had completed junior high school, six (thirty-five point three percent) had completed some high school, three (seventeen point six percent) had completed high school. Twelve participants (seventy point six percent) were not married at pregnancy discovery; five subsequently married. Pregnancy outcomes included: ten (fifty-eight point eight percent) continuing pregnancy or delivered, four (twenty-three point five percent) attempted abortion (three successful through medication abortion, one unsuccessful), three (seventeen point six percent) experienced miscarriage. Most participants (thirteen, seventy-six point five percent) came from low-income families.

Ethical Considerations

Ethical approval was obtained from Health Research Ethics Committee of Institut Ilmu Kesehatan Pelamonia Makassar (Protocol 045/KEPK-IIKPM/2023). For participants aged eighteen years or older, written informed consent was obtained. For participants younger than eighteen, both parental consent and participant assent were required, except in cases where parental involvement would compromise participant safety (n=3), in which case research ethics committee approved waiver of parental consent with enhanced safeguards. All participants were informed about study purpose, voluntary participation, right to withdraw, confidentiality limits, and potential emotional distress. Pseudonyms are used throughout to protect participant identity. Participants received compensation of 150,000 Indonesian Rupiah (approximately ten USD) for

their time. Referrals to counseling services were provided for participants experiencing emotional distress.

Data Collection

In-depth semi-structured interviews were conducted by research team members (all female with midwifery or public health backgrounds and experience working with adolescents) in private locations chosen by participants, typically NGO offices or private rooms in health facilities. Interviews lasted sixty to one hundred twenty minutes (mean eighty-seven minutes), were conducted in Indonesian or Makassarese based on participant preference, audio-recorded with permission, and supplemented with field notes documenting non-verbal communication and contextual observations.

The semi-structured interview guide, developed based on literature review and refined through pilot interviews, explored: pregnancy discovery and initial reactions; experiences of stigma from family, community, healthcare providers, schools, and peers; self-perception and identity changes; disclosure decisions and support-seeking; experiences receiving or being denied support; coping strategies; and meaning-making. Open-ended questions allowed participants to share experiences in their own words while probes encouraged depth and elaboration. Questions were framed non-judgmentally to create safe space for honest disclosure.

Data Analysis

Analysis followed IPA's six-stage process (Smith et al., 2022): (1) Immersion through repeated reading of transcripts while listening to audio recordings to capture nuance and emotion; (2) Initial noting involving descriptive comments capturing content, linguistic comments noting language use, and conceptual comments interpreting meaning; (3) Developing emergent themes by transforming initial notes into concise phrases capturing psychological essence; (4) Searching for connections among emergent themes, identifying patterns, clustering related themes; (5) Moving to next case and repeating stages one through four; (6) Looking for patterns across cases while maintaining idiographic commitment to honoring individual experiences.

Analysis was conducted in original language (Indonesian/Makassarese) with themes and representative quotes subsequently translated to English by bilingual team members and back-translated to ensure fidelity. Cultural concepts like siri' and mali were retained in original with explanatory notes. Analysis employed constant comparison, moving iteratively between individual cases and emerging cross-case patterns. NVivo software supported data organization while maintaining analytical process recommended by IPA. Team meetings involving all authors discussed emerging themes, interpretative insights, alternative interpretations, and reflexive considerations, enhancing analytical rigor through multiple perspectives.

Rigor and Trustworthiness

Quality was ensured through multiple strategies: prolonged engagement with participants beyond single interviews when possible; member checking where five participants reviewed preliminary themes and provided feedback; thick description providing sufficient contextual detail for transferability assessment; reflexivity through maintaining research journals documenting assumptions, reactions, and analytical decisions; and peer debriefing through regular team discussions. We attended to IPA quality markers identified by Nizza et al. (2021) including clearly articulated research question suited to IPA, appropriate sample, sufficient data from each participant, and interpretative analysis going beyond description to explore meaning.

Researcher Positionality

The research team brought diverse perspectives and positionalities. The principal investigator (first author) is a Bugis midwife born in Makassar with eight years' experience providing adolescent reproductive health care, intimately familiar with local cultural context while holding progressive views on reproductive rights potentially creating tension with dominant cultural norms. The second author is a Makassarese nurse-researcher with qualitative methods expertise. The third author is Javanese with maternal-child health background, bringing outsider perspective that facilitated questioning assumptions. All team members identify as Muslim women, potentially creating both insider connection and risk of imposing religious interpretations. Throughout the research process, we maintained reflexive awareness of how our backgrounds, values, and assumptions might shape data collection and interpretation, regularly discussing these dynamics in team meetings.

3. Results and Discussion

Results

Analysis revealed two major interrelated themes capturing experiences of stigma and social support: 'Living Under the Shadow of Siri': Multidimensional Stigma' and 'Navigating Social Support in the Context of Shame.' These themes are presented below with illustrative quotes and interpretative commentary.

Living Under the Shadow of Siri': Multidimensional Stigma

This overarching theme captured the pervasive, multifaceted stigmatization participants experienced across social contexts. Stigma was not merely an unfortunate side effect but a central, defining feature of their pregnancy experience, shaping every aspect of their lives from family relationships to healthcare encounters, educational opportunities to sense of self.

a. Family Shame and Violation of Siri'

All seventeen participants described their families' initial responses as dominated by anger, disappointment, or rage, explicitly framed through the cultural lens of violated siri'. The concept of bringing mali (deep shame) to the family was invoked repeatedly. As Fitri, age seventeen, recounted: 'My father said I destroyed the family name, brought shame (mali siri') to our ancestors. He said I was no longer his daughter, that I had dishonored everyone who came before us and everyone who will come after.' This framing positions pregnancy not as individual reproductive event but as collective family crisis requiring management and containment.

Participants described intense family shame manifesting through various responses: being confined to home to prevent community knowledge, pressure to marry regardless of relationship quality or partner's suitability, threats of permanent exile from family, complete withdrawal of communication, and in some cases, physical violence. Sari, age eighteen, shared: 'My mother cried for days. She kept saying how will we face the neighbors, what will people say at the mosque. My aunts said I ruined my younger sisters' marriage chances because now our family has bad reputation.' The collective nature of shame meant pregnancy consequences extended far beyond the individual to affect entire family networks.

Importantly, participants reported that family responses were often less about their wellbeing or the baby's welfare than about damage control and reputation management. Several described parents prohibiting them from leaving the house, not out of concern for their safety but to prevent neighbors from seeing the pregnancy. Others reported being sent to relatives in distant cities to conceal the pregnancy from the local community. This emphasis on maintaining social appearance, even at cost of denying pregnant adolescents necessary support and care, reflects how deeply siri' concerns can overshadow other considerations.

b. Community Gossip and Moral Judgment

Beyond immediate family, participants described becoming subjects of intense neighborhood gossip and moral condemnation. The tightly-knit nature of Makassar communities, where individuals are known across generations and privacy is limited, meant pregnancy was rarely concealable for long. Participants reported being labeled with stigmatizing terms like anak yang rusak (damaged/broken girl), perempuan nakal (naughty/bad woman), and similar epithets marking them as morally corrupted. Wati, age sixteen, described: 'Everyone whispers when I walk by. They call me 'that bad girl.' At the mosque, people moved away from me like I'm contagious. Even children point and stare because their parents have told them about me as a warning.'

Several participants reported being used explicitly as cautionary tales by parents warning their own children about consequences of premarital sexuality. This public role as negative example intensified feelings of shame and social isolation. Religious contexts proved particularly painful sources of stigma. Multiple participants described being excluded from religious gatherings, prevented from participating in Quranic recitation groups they had attended for years, or subjected to public sermons clearly directed at them regarding sin and divine punishment. Indah, age eighteen, shared: 'The imam at Friday prayer talked about zina [forbidden sexual relations] and Allah's punishment. Everyone knew he was talking about me. I felt like everyone was staring, judging. I stopped going to mosque after that, which made my mother even more ashamed.'

c. Institutional Stigma in Healthcare Settings

Thirteen participants (seventy-six point five percent) encountered judgmental, moralistic, or punitive treatment from healthcare providers. Rather than receiving compassionate, professional care, many faced lectures, scolding, and discrimination that compounded their distress and deterred future care-seeking. Mega, age seventeen, recounted: 'The midwife lectured me for thirty minutes about sin and irresponsibility before examining me. She said "You made your choice, now suffer the consequences." She was rough during the examination, didn't explain anything, acted like she was disgusted by me.'

Provider stigma manifested through multiple mechanisms: refusing confidential services and demanding parental presence; lengthy moral lectures preceding clinical care; rough or punitive physical examinations; failure to provide adequate information about pregnancy options; denial of pain medication during procedures as 'deserved punishment'; and breaches of confidentiality sharing patient information with others in the community. These experiences directly contravened professional ethics and adolescent health service principles emphasizing non-judgmental, confidential care.

Several participants reported that so-called 'adolescent-friendly' health services at Community Health Centers proved anything but friendly for unmarried pregnant adolescents. Dina, age eighteen, observed: 'The 'adolescent-friendly' clinic was friendly for married girls with parents' permission, not for girls like me. They still required parental consent, still judged, still treated us like we committed crime.' This disconnect between policy rhetoric and implementation reality meant programs theoretically designed to support adolescents failed those most vulnerable.

d. Educational Exclusion and Peer Rejection

Six participants were either expelled from school or pressured to withdraw, despite no formal policy mandating exclusion of pregnant students. Schools framed removal as protecting other students from 'bad influence' and maintaining institutional reputation. Even those who remained in school faced severe bullying, social exclusion, and educator discrimination. Wati, age sixteen, described: 'My best friends stopped talking to me. One said her mother forbid contact with "that kind of girl." At school, classmates bullied me online, posted horrible things. Teachers whispered about me in staff room; I heard them say I should leave so I don't corrupt others.'

Social media emerged as particularly brutal site of peer stigmatization, with participants reporting being subjected to public shaming through screenshots shared across social networks, cruel memes, and anonymous harassment. The permanence and public nature of online stigmatization intensified shame and made escaping judgment nearly impossible. Several participants deleted their social media accounts entirely, further isolating themselves from peer connections.

e. Internalized Stigma and Spoiled Identity

Nearly all participants demonstrated internalization of stigmatizing beliefs, incorporating societal judgments into their self-concepts and identities. This internalized stigma manifested through self-labeling with stigmatizing terms, beliefs about being fundamentally damaged or spoiled, conviction that they deserved punishment and suffering, and profound shame regarding their bodies and sexuality. Siti, age seventeen, articulated: 'I am damaged goods (barang rusak). No good man will want me now. I deserve all this pain because of what I did. I am dirty (kotor), ruined. I look at myself in mirror and see someone disgusting.'

This internalized stigma proved perhaps most damaging form because it persisted even in absence of external sanctioning, corroding self-worth and generating ongoing psychological distress. Participants described constant internal dialogue of self-recrimination, feeling fundamentally altered and degraded by pregnancy. Several expressed belief that they had forfeited rights to happiness, good treatment, or positive futures. The metaphor of being 'ruined' or 'damaged' particularly captured sense of permanent spoiling of identity and future possibilities.

Internalized stigma had direct behavioral consequences, leading participants to avoid seeking help they needed, tolerate mistreatment they would otherwise reject, and withdraw from social participation. It created self-fulfilling prophecies where shame led to isolation

which reinforced shameful self-concept. Breaking this cycle required support helping participants resist and reframe stigmatizing narratives, which few received.

f. Amplification Through Intersecting Vulnerabilities

Stigma intensity was amplified for participants facing intersecting vulnerabilities including economic disadvantage, being out of school, having unstable housing, or lacking family support networks. Socioeconomic status particularly shaped stigma experiences, with poorer participants facing more severe consequences and fewer options for managing stigmatization. Laila, age fifteen, observed: 'Rich girls can hide pregnancy or go somewhere else for abortion. They have private doctors who don't judge. Poor girls like me have nowhere to hide, no money for private clinic. We face all the shame with no escape.' This observation highlights how stigma intersects with structural inequalities, creating differential impact based on social position.

Navigating Social Support in the Context of Shame

This theme captured how pervasive stigma profoundly constrained participants' ability to seek and receive social support, while also illuminating strategies participants employed to navigate these constraints and identify sources of support within hostile social environments.

a. Strategic Disclosure and Testing Trust

Participants described pregnancy disclosure not as straightforward announcement but as strategic process involving careful assessment of whom to trust, when to tell, and how much to reveal. Many engaged in what might be termed 'testing trust,' gradually assessing potential supporters' reactions before full disclosure. Ani, age seventeen, explained: 'I tested people first. I mentioned a "friend's problem" to see their reaction before revealing it was me. I needed to know who would help versus who would shame me. I couldn't risk more rejection.'

This strategic approach reflected rational assessment of social risks in context where disclosure could trigger severe negative consequences. Participants became adept at reading subtle cues in others' responses to hypothetical scenarios, judging likelihood of supportive versus judgmental reactions. Such caution, while protective, also meant participants often waited extended periods before seeking help, during which time they managed pregnancy-related fears, physical changes, and decision-making in isolation.

b. Grandmothers as Non-Judgmental Confidantes

An unexpected but consistent finding was that maternal or paternal grandmothers often provided more supportive, less judgmental responses than parents. Nine participants reported telling grandmothers before or instead of parents, finding them more understanding and helpful. Rina, age sixteen, shared: 'My nenek [grandmother] was angry at first, but then she helped me. She said she understood because life is complicated. She talked to my parents, helped calm them down. Without her I don't know what would have happened.'

Participants speculated that grandmothers' distance from immediate siri' concerns, life experience, and different generational positioning allowed more compassionate responses. Some grandmothers explicitly positioned themselves as mediators between participants and angry parents, using their authority as family elders to moderate parents' reactions and advocate for granddaughters' needs. This intergenerational support represents important and underutilized resource within Bugis-Makassar families.

c. Peer Solidarity and Shared Experience

Participants who connected with other young women who had experienced unintended pregnancy described these relationships as uniquely valuable sources of validation, practical information, and emotional support. Maya, age eighteen, recounted: 'Meeting other girls at the NGO saved me. I realized I'm not alone, not uniquely bad. We help each other, share information about doctors who don't judge, about managing families. They understand in ways no one else can.'

Peer support provided experiential knowledge unavailable through formal services, including practical navigation strategies for healthcare and social services, emotional validation that countered stigmatizing narratives, and sense of solidarity reducing isolation. However, accessing peer support required knowing where to find such connections, which many participants struggled with. Those who made connections typically did so through

youth-serving NGOs rather than formal healthcare or social service systems, suggesting important service delivery gaps.

d. Constrained Support from Partners

Biological fathers' involvement varied dramatically, from complete abandonment to coerced marriage to genuine partnership. Notably, even when partners initially expressed commitment, family and social pressures often led them to withdraw support or deny paternity. Several participants described partners' families prohibiting contact or pressuring partners to deny involvement to protect family reputation. Novi, age seventeen, shared: 'At first he said he would support me, maybe marry. But his family forbid it, said I was trying to trap him. They made him deny the baby was his, said I slept with many men. Now he won't even look at me.'

This pattern reflects gendered dynamics where young women bear primary responsibility and social consequences while young men can more easily escape accountability with family protection. Some participants noted bitter irony that while they faced severe stigmatization, male partners who were equally involved in pregnancy causation experienced minimal social sanctioning.

e. Gaps in Institutional Support

Participants reported that institutional sources of support schools, healthcare facilities, social services largely failed to provide needed assistance. Schools excluded rather than accommodated; healthcare providers judged rather than supported; social services were either unknown or inaccessible. The few participants who received institutional support described encountering exceptional individuals a compassionate midwife, supportive teacher, or dedicated NGO worker whose support reflected personal commitment rather than systematic institutional practice. Putri, age eighteen, reflected: 'The system is not set up to help girls like us. We're supposed to be ashamed, suffer, and disappear. If we find help, it's luck, finding good person who sees us as human. But most institutions just push us away.' This assessment captures the systemic nature of support deficits, pointing to need for institutional transformation rather than merely individual provider training.

Discussion

This phenomenological study reveals that adolescent unintended pregnancy in Makassar is experienced within a pervasive cultural framework of shame that fundamentally shapes every dimension of young women's experiences. The findings demonstrate that stigma operates not as unfortunate side effect but as central organizing principle profoundly constraining access to essential social support precisely when it is most needed.

Multidimensional Stigma in Honor-Shame Cultural Context

Our findings extend existing stigma literature by documenting how honor-shame cultural frameworks amplify and intensify stigmatization beyond that documented in Western contexts. While pregnant adolescents globally experience stigma (Ellis-Sloan, 2014; SmithBattle, 2013), the siri' framework creates additional layers of meaning and consequence. Pregnancy becomes not merely individual moral failing but collective family catastrophe requiring damage control, with implications extending across generations and affecting entire kinship networks. This cultural framing helps explain the particularly intense family reactions participants experienced, often focused more on reputation management than adolescent wellbeing.

The multidimensional nature of stigma manifesting across family, community, healthcare, educational, peer, and internalized dimensions created what might be termed 'total stigmatization' leaving few safe spaces or relationships untouched. This comprehensiveness distinguishes our findings from studies documenting more circumscribed stigma. The intersection of traditional siri' values with conservative Islamic morality created particularly powerful stigma mechanisms, with each framework reinforcing the other. Recent research on teenage pregnancy stigma in diverse cultural contexts supports our finding that stigma intensity and manifestations are profoundly shaped by local cultural and religious frameworks (Tahiru et al., 2024; Tinago et al., 2024).

Stigma as Barrier to Social Support

Our findings illuminate mechanisms through which stigma compromises access to social support. Anticipated stigma shaped disclosure patterns, with participants engaging in strategic, highly selective revelation constrained by fear of judgment and rejection. This finding aligns with recent US research documenting how stigma leads pregnant adolescents to conceal pregnancy

from potential supporters (PLOS One, 2019), but adds cultural dimension showing how honor-shame concerns particularly intensify these dynamics. The 'testing trust' strategy participants employed demonstrates adaptive coping with hostile social environment, but also meant extended periods of unsupported decision-making and distress.

The finding that grandmothers often provided more supportive responses than parents represents important contribution with practical implications. While some research has documented grandparent support for adolescent mothers (Hurd et al., 2014), this has received limited attention in non-Western contexts. Our findings suggest grandmother support may be particularly important in honor-shame cultures where they occupy unique position combining family authority with distance from immediate siri' concerns. Interventions might strategically engage grandmothers as key supporters and family mediators.

Peer support emerged as critically important yet underutilized resource, with participants describing connections with other young mothers as uniquely validating and informative. Recent intervention research demonstrates effectiveness of peer support for reducing isolation and improving mental health among adolescent mothers (Tinago et al., 2024), supporting expansion of peer support programming as promising intervention approach.

Healthcare Stigma and Missed Opportunities

The prevalence of provider stigma documented in this study with over seventy-five percent of participants encountering judgmental healthcare experiences represents serious failure of professional ethics and adolescent health service principles. Healthcare settings should provide compassionate, non-judgmental care regardless of patients' circumstances, yet frequently functioned as sites of moral policing and punishment. This finding echoes research across multiple countries documenting provider stigma as major barrier to adolescent reproductive healthcare (Dennis et al., 2023; Pradana et al., 2023).

The disconnect between policy rhetoric of 'adolescent-friendly services' and implementation reality merits attention. Indonesia's Ministry of Health established adolescent-friendly health service guidelines in 2014 (Kemenkes, 2014), yet participants reported these services failed unmarried pregnant adolescents through continued requirements for parental involvement, judgmental attitudes, and breach of confidentiality. Research on adolescent-friendly service implementation in Indonesia has documented multiple barriers including provider attitudes, lack of training, and continued emphasis on married adolescents (Azzahra et al., 2021; Maryani et al., 2019; Pradana et al., 2023). Transforming rhetoric into reality requires addressing deep-seated provider attitudes shaped by cultural and religious values.

Implications for Intervention

Findings point to need for multilevel interventions addressing stigma and strengthening support. At community level, destigmatization efforts must engage traditional and religious leaders in developing messages promoting compassion while respecting cultural values. Recent research demonstrates that involving respected community figures in reframing adolescent pregnancy can shift community attitudes (Wittenberg et al., 2023). Such efforts might emphasize Islamic teachings on mercy and forgiveness, traditional values of family solidarity, and harm of abandoning vulnerable community members.

Healthcare transformation requires comprehensive provider training addressing values, attitudes, and skills for non-judgmental care; strengthening confidentiality protections and reducing parental notification requirements for mature minors; implementing accountability mechanisms for discriminatory treatment; and potentially increasing role of peer counselors and community health workers who may hold less judgmental attitudes. Educational institutions need policies supporting pregnant and parenting students' continuation, anti-bullying interventions, and connections to social services.

Peer support programming represents particularly promising intervention approach given participants' descriptions of peer connections as uniquely valuable. Structured peer support groups could provide safe spaces for sharing experiences, accessing information, and building solidarity. Recent evidence from Zimbabwe demonstrates effectiveness of community-based peer support for reducing isolation and improving mental health among adolescent mothers (Tinago et al., 2024), suggesting potential for adaptation to Indonesian context.

Strengths and Limitations

Study strengths include rigorous IPA methodology emphasizing in-depth exploration of lived experience, culturally-grounded approach with research team familiar with local context,

diverse sample capturing varied experiences, and focus on understudied non-Western cultural setting. Limitations include recruitment from one city limiting transferability to other Indonesian regions with different cultural contexts, sample limited to those willing to participate potentially excluding most marginalized, and cross-sectional design unable to capture changes over time. Retrospective accounts ranging from six to eighteen months post-pregnancy may involve memory reconstruction. Research team's positionalities as healthcare professionals and Muslim women potentially shaped data collection and interpretation despite reflexive awareness.

Directions for Future Research

Future research should explore experiences across diverse Indonesian cultural contexts to understand variation in stigma and support; examine healthcare provider perspectives and training needs regarding adolescent pregnancy care; develop and evaluate destigmatization interventions engaging traditional and religious leaders; test peer support interventions adapted to Indonesian context; explore grandmother support more systematically as potential intervention target; and conduct longitudinal research examining how stigma and support evolve over time and shape long-term maternal and child outcomes.

4. Conclusion

This phenomenological study illuminates how adolescent unintended pregnancy in Makassar is experienced within pervasive cultural framework of siri' that creates multidimensional stigmatization profoundly constraining access to essential social support. Stigma manifests across family, community, healthcare, educational, and internalized dimensions, creating total social environment hostile to pregnant adolescents' wellbeing. Social support seeking becomes strategic, cautious process shaped by anticipated judgment, with participants selectively disclosing to tested confidantes while often excluded from formal institutional support. Grandmothers and peers emerge as important support sources, while parents, healthcare providers, and schools frequently fail to provide needed assistance. Addressing this public health challenge requires confronting not only individual attitudes but cultural frameworks and institutional practices that reproduce stigmatization. Multilevel interventions engaging communities, transforming healthcare, strengthening peer support, and addressing underlying honor-shame dynamics offer pathways toward creating environments where pregnant adolescents receive compassion and support they need and deserve. Understanding stigma and support within specific cultural contexts is essential for developing effective, culturally-grounded approaches to adolescent reproductive health.

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