SINTHOP: Media Kajian Pendidikan, Agama, Sosial dan Budaya
Volume 4, Issue 2, July-December 2025
E-ISSN: 2986-8475 | DOI: 10.69548/sinthop.v4.i2.50.220-228

THE IMPLEMENTATION OF CONTRACEPTIVE LEGALIZATION AND ITS MORAL IMPLICATIONS FOR MUSLIM ADOLESCENTS IN RURAL INDONESIA

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Abstract

Population growth remains a critical issue for Indonesia, leading to the government's implementation of the Family Planning (*Keluarga Berencana*) program, which promotes contraceptive use to control fertility and improve reproductive health. In rural Muslim communities such as Sukarapih Village, Bekasi, the program encounters moral and cultural resistance shaped by religious interpretation and social norms. This study examines how the government's contraceptive policy is implemented and morally negotiated within this religiously conservative context, focusing on its influence on adolescent understanding and behavior. Using a qualitative descriptive design, the research was conducted from March to May 2024 through eighteen in-depth interviews and two focus group discussions with religious leaders, midwives, parents, and adolescents. Thematic analysis identified five key patterns: knowledge and misconceptions, religious gatekeeping, service delivery, family supervision, and peer influence. Findings reveal that contraceptive policy implementation operates through moral negotiation among health institutions, families, and religious authorities. While health workers adapt counseling to emphasize health protection, religious leaders and parents maintain control over adolescents' moral development. Contraceptive access thus functions as both a public health initiative and a moral discourse shaped by community values. The study concludes that policy success depends not only on service provision but also on alignment with religious and ethical frameworks. Culturally sensitive approaches that integrate Islamic moral principles, family engagement, and adolescent education can strengthen both reproductive health outcomes and moral integrity in Muslim-majority rural settings.

Keywords: *Contraceptive Policy, Adolescent Morality, Islamic Ethics, Reproductive Health, Rural Indonesia*

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A. Introduction

Population growth has become one of the most pressing challenges for the Indonesian government, prompting the implementation of various policies, including the legalization and distribution of contraceptive devices under the Family Planning (*Keluarga Berencana* or KB) program. This policy aims to control population growth

while promoting public awareness of reproductive health. According to the Indonesia Demographic and Health Survey (IDHS, 2017), contraceptive prevalence among married women reached 63 percent, yet unmet needs for family planning remain at 10 percent, reflecting persistent disparities in access (BKKBN, BPS, Kemenkes, & ICF, 2018). The World Health Organization (2024) similarly reports that more than 214 million women in developing countries who wish to avoid pregnancy are not using modern contraceptive methods, underscoring ongoing challenges in access and acceptability. Despite such efforts, in rural areas with strong religious values, such as Sukarapih Village in Tambelang District, Bekasi, the policy often encounters cultural resistance and moral contestation.

In predominantly Muslim communities, religious norms strongly influence perceptions and acceptance of contraceptives. While the government emphasizes health and demographic benefits, many community members interpret contraceptive use through Islamic teachings, resulting in differing opinions and occasional rejection. Studies across Muslim-majority settings, including Indonesia and Pakistan, show that family planning policies are often negotiated within moral and religious frameworks rather than purely medical or demographic rationales (Ataullahjan & Routray, 2019; Jones, 2005). In such contexts, religious leaders function as moral gatekeepers who can either facilitate or hinder policy acceptance, depending on their interpretations of Islamic law. This dynamic creates a complex interplay between public health objectives and moral authority, shaping how reproductive health policies are understood and practiced in daily life.

Adolescents represent a particularly sensitive demographic group affected by these policies. On one hand, the availability of contraceptives and reproductive health education can enhance awareness and reduce health risks. On the other hand, misinterpretations or misuse may influence adolescents' moral development, raising concerns among parents, religious leaders, and educators. Evidence from national and regional surveys indicates that unmet needs for family planning are especially high among adolescents and women in rural or conservative communities (BKKBN et al., 2018; Blanc, Curtis, & Croft, 1995). Although access to reproductive health services has expanded, stigma, misinformation, and moral anxiety persist, constraining young people's ability to make informed decisions (Yusuf, 2014; Ataullahjan & Routray, 2019). In many Muslim contexts, community elders and religious authorities equate contraceptive access for unmarried youth with permissiveness, which reinforces sociocultural taboos surrounding sexuality.

Over the past decade, research in Indonesia and Southeast Asia has increasingly examined how Islamic ethics and policy implementation intersect in shaping reproductive behavior. Studies in Malaysia, Indonesia, and other ASEAN countries demonstrate that programs framed within religious discourse—such as those emphasizing *maslahah* (public benefit) and responsible parenthood—gain greater acceptance than those presented through secular or biomedical rationales (Hidayat, Khairina, Husni, Yustiloviani, & Rizal, 2025; Ananto, 2024). Yet, inconsistencies among religious authorities in interpreting Islamic rulings on contraception continue to generate moral

ambiguity and resistance. The resulting tension between state policy and religious ethics demonstrates that contraceptive acceptance is deeply influenced by theological interpretation and communal moral values rather than by health policy alone.

Research focusing on adolescents reveals another layer of complexity. Although health outreach has expanded through *Posyandu* and *Puskesmas*, many young people remain constrained by limited understanding, peer misinformation, and moral stigma (Yusuf, 2014). Studies have shown that when adolescents receive reproductive information outside moral or parental guidance, they may misinterpret contraceptive use as a license for premarital sexual behavior, prompting anxiety among religious leaders and parents (Ataullahjan & Routray, 2019). At the same time, sociological evidence suggests that lack of accurate information increases the likelihood of misuse or health risks rather than improving moral outcomes (World Health Organization, 2024). These findings highlight the necessity of contextualized strategies that integrate moral education with reproductive health promotion.

Critically, much of the existing literature focuses either on macro-level demographic analysis or on small-scale attitudinal studies. Few have bridged these approaches to explain how policy implementation interacts with religious authority, family dynamics, and adolescent moral reasoning. There remains limited empirical evidence on how national family planning policies are localized, resisted, or adapted within rural Islamic communities. This study seeks to fill that gap through a grounded qualitative examination of contraceptive policy implementation in Sukarapih Village, a rural Muslim community in Bekasi District. It contributes to the growing Southeast Asian scholarship on religion, health, and morality in three ways. First, it documents the moral and behavioral implications of contraceptive access among Muslim adolescents—an issue seldom addressed in previous studies. Second, it elucidates the mediating roles of families, religious leaders, and health workers in shaping community responses to policy interventions. Third, it offers policy-relevant insights for designing culturally and religiously sensitive reproductive health strategies that balance public health goals with the preservation of moral and spiritual values. Accordingly, this study investigates the implementation of government policy on contraceptive legalization in Sukarapih Village and examines its moral implications for Muslim adolescents. By analyzing both positive and negative impacts, the research aims to inform the formulation of reproductive health policies that uphold public health objectives while maintaining moral and religious integrity.

B. Methods

This qualitative descriptive study was conducted from March to May 2024 in Sukarapih Village, Tambelang District, Bekasi Regency, Indonesia. The study examined the implementation of government contraceptive policy under the Family Planning program and its moral implications for adolescents in a predominantly Muslim rural community. Data were generated through eighteen in-depth interviews and two focus group discussions with key stakeholders selected through purposive sampling and

supplemented by snowball recruitment. Participants comprised four religious leaders, three midwives, six adolescents aged fifteen to nineteen years with mixed gender, and five community members including parents and village leaders. Two focus groups were held, one with six to eight adolescents and another with six to eight parents or community influencers. Inclusion criteria were residency in Sukarapih for at least six months, a relevant role, and ability to provide informed consent, while non-residents or those residing less than six months and those unable to consent were excluded.

Interviews lasted forty five to sixty minutes and focus groups approximately ninety minutes. All sessions were audio recorded with consent, transcribed verbatim, and anonymized. A semi structured guide covered perceptions of contraceptive policies, religious and moral norms related to contraception, service delivery experiences and challenges, adolescents' knowledge, attitudes, and behaviors, family and community influence, and suggestions for policy improvement. Field observations complemented interview and focus group data and were used to contextualize accounts provided by participants.

Data were analyzed thematically following Braun and Clarke's six phase approach. Coding and theme development were conducted iteratively to connect emerging patterns with the study aims. Credibility was supported through triangulation across interviews, focus groups, and observations, along with reflexive note taking during analysis. Ethical approval was obtained from the Research Ethics Committee of STAIHAs (Approval No. X/04/2024). Written informed consent was obtained from adult participants, with parental consent and adolescent assent for minors. Participation was voluntary, and confidentiality was maintained through anonymization and secure data handling.

C. Results and Discussion

1. Results

Field data from eighteen in depth interviews and two focus group discussions reveal how the government's contraceptive policy is implemented and negotiated within Sukarapih Village. The findings illustrate that contraceptive access is not only a health intervention but also a moral and social process mediated by religious authority, family supervision, and peer interaction. Five major themes emerged from the analysis: knowledge and misconceptions, religious norms and gatekeeping, service delivery and outreach, social control and family influence, and adolescents' social ecology. Together these themes describe the intersection between state health programs and Islamic moral values in a rural community context.

1) Knowledge and Misconceptions

Most adolescents demonstrated limited understanding of contraceptive methods and often depended on informal sources of information, especially peers. Misconceptions included confusion over purpose, timing, and appropriate users of contraceptives. One participant stated, "Many teens are unsure how to use contraceptives properly"

(Adolescent FGD). These accounts suggest that although contraceptives are physically available through local health services, accurate comprehension remains inadequate. Health workers observed that incomplete knowledge can lead to fear, avoidance, or misuse, especially when moral anxiety discourages adolescents from seeking professional guidance. This condition reflects a broader gap between national reproductive health education goals and the local socioreligious environment.

2) Religious Norms and Gatekeeping

Religious norms strongly regulate community attitudes toward contraception. Religious leaders and elders function as moral authorities who interpret Islamic teachings for the community. Their guidance influences both parental decisions and adolescent behavior. As one religious leader explained, "Our community believes contraception goes against faith" (Religious leader IDI). Such interpretations create a moral boundary distinguishing married from unmarried individuals and position contraceptive use within a framework of permissible and forbidden acts. In practice, these moral evaluations act as informal gatekeeping mechanisms that determine who can access contraceptive information or services. Religious teachings are not always expressed as explicit prohibitions but often as moral reminders, signaling that faith and modesty must guide reproductive decisions. This dynamic shows how the implementation of a national policy becomes refracted through local religious discourse.

3) Service Delivery and Outreach

The *Puskesmas* and *Posyandu* serve as the main institutions implementing the Family Planning program. Health workers organize counseling, distribute contraceptives, and coordinate periodic outreach. A midwife described this practice: "The health post provides monthly counseling sessions" (Midwife IDI). Yet these services are shaped by social negotiation. Some parents permit their daughters to attend counseling, while others avoid participation due to religious apprehension. Midwives and health cadres reported that they often need to adapt messages to emphasize health benefits rather than directly addressing sexual behavior. The approach reflects an effort to reconcile public health objectives with local moral expectations. Despite these adaptations, service coverage remains uneven across neighborhoods, and adolescents are rarely direct targets of formal outreach unless accompanied by parents or teachers.

4) Social Control and Family Influence

Families are central to the moral education of adolescents. Parents and elders reinforce norms about chastity, gender roles, and responsible behavior. They also monitor interaction between boys and girls and serve as the first layer of decision making regarding access to health services. One parent emphasized, "Parents always remind children about morality and behavior" (Parent FGD). Many parents link contraceptive discussion with moral risk, believing that knowledge may encourage experimentation. Consequently, adolescents who seek information often face mixed messages: encouragement to act responsibly but restriction from discussing sensitive topics. These

patterns illustrate how familial social control sustains moral order while simultaneously constraining open communication about reproductive health.

5) Adolescents' Social Ecology

Peer influence constitutes another layer of the social environment. Friends and classmates exchange stories and information that sometimes conflict with religious and parental guidance. "Friends often share rumors that are misleading about contraception," said one participant (Adolescent FGD). Adolescents navigate multiple moral expectations: loyalty to peers, respect for family, and compliance with religious norms. This negotiation creates ambivalence in moral reasoning. Some adolescents interpret contraceptives as a responsible measure aligned with health advice, while others view them as incompatible with religious values. The interplay among these influences explains variation in adolescents' attitudes and behaviors, even within the same community.

Thus, the results show that contraceptive policy in Sukarapih Village operates within a multilayered moral system. The national Family Planning program is implemented through institutional structures such as health posts, yet its acceptance depends on religious interpretation, parental mediation, and peer discourse. Religious leaders provide moral boundaries, families exercise social supervision, and peers shape behavioral models. Knowledge gaps and conflicting moral messages collectively determine how adolescents internalize the policy and translate it into practice. These findings highlight that the moral dimension of public health interventions cannot be separated from the cultural and religious context in which they unfold.

2. Discussion

The findings indicate that the implementation of contraceptive policy in Sukarapih Village reflects an ongoing moral negotiation between state objectives and religiously grounded community values. While the Family Planning program seeks to improve reproductive health and control population growth, its success depends on local acceptance mediated by religious authority, family supervision, and peer networks. These results align with previous Indonesian studies showing that reproductive health interventions must adapt to the moral and social contexts in which they operate to avoid cultural resistance and misinterpretation (Ulfah & Aeni, 2024).

Religious leaders serve as moral gatekeepers who interpret policy goals through the lens of Islamic ethics. Their influence can legitimize or restrict adolescent access to contraceptive information. This dynamic mirrors findings by Rohim (2016), who argued that Islamic jurisprudence supports family planning when it serves the principles of *maslahah* (public benefit) and the protection of life and lineage. Similarly, Yusran et al. (2025) and Mahmud et al. (2024) highlight that contraception is permissible in Islam when guided by moral intent and health necessity. In Sukarapih, the interpretive authority of local *ulama* determines the social boundaries of policy implementation. When religious

endorsement is present, community acceptance increases; when absent, moral uncertainty prevails.

Family control further reinforces this moral order. Parents transmit religious and ethical values to adolescents, guiding them toward modesty and moral behavior. Yet, this moral protection also limits open dialogue about sexuality and contraceptive use. As a result, adolescents often depend on peers or informal networks, which can perpetuate misinformation. Such patterns reflect broader evidence that family involvement and communication quality are key determinants of reproductive health literacy (Aristyasari, Nisa, & Indriastuti, 2021). Family engagement rooted in trust and shared values can balance moral guidance with accurate health knowledge, reducing the stigma surrounding reproductive topics.

The role of health workers and local institutions such as *Puskesmas* and *Posyandu* is equally critical. Midwives in Sukarapih have attempted to adapt counseling messages to emphasize health protection rather than permissiveness. This practice echoes international findings that localized, value-sensitive communication enhances program legitimacy and behavioral change (Kriel et al., 2019). When reproductive health services are framed in moral terms that resonate with community values, adolescents are more likely to perceive contraceptive use as responsible and ethical rather than deviant. Such an approach is consistent with Najimudeen (2020), who noted that Islamic teachings allow birth spacing for family welfare and maternal well-being.

In addition, digital and peer-based communication can complement religious and institutional outreach. Research by Rahmatika and Rahman (2020) shows that social media, when moderated by educators or health professionals, can strengthen reproductive health awareness among adolescents. Structured digital platforms and school-based programs help correct myths, reinforce moral narratives, and support the emotional needs of young people navigating competing norms. However, as Ulfah and Aeni (2024) observe, digital strategies are effective only when combined with participatory, community-based education that involves parents, teachers, and religious figures.

These findings illustrate that contraceptive policy implementation in Sukarapih is not merely a technical exercise in service delivery but a moral and cultural process. The success of public health interventions depends on their ability to engage with the ethical frameworks of the community. Integrating Islamic values such as *maslahah*, family responsibility, and the protection of human dignity can enhance both moral legitimacy and behavioral outcomes. Programs that combine institutional counseling, family dialogue, and peer or digital outreach—anchored in moral reasoning—are likely to achieve greater acceptance and sustainability in Muslim-majority contexts like Sukarapih.

D. Conclusion

This study demonstrates that the implementation of Indonesia's contraceptive policy in Sukarapih Village operates within a complex moral and social context. While the Family Planning program aims to manage population growth and promote reproductive health, its realization at the community level is shaped by religious authority,

family supervision, and peer interaction. The findings reveal that adolescents' access to contraceptive knowledge is influenced less by service availability and more by moral interpretation and social control within the family and community.

Religious leaders play a decisive role in mediating the acceptance or rejection of contraceptive use. Their interpretations of Islamic teachings determine the moral boundaries through which policy implementation is understood. Families reinforce these values through supervision and guidance, creating a moral structure that shapes adolescent behavior. Health workers adapt their messages to local sensitivities, framing contraception in health-protective rather than permissive terms. Together, these dynamics explain how a national policy is redefined through local negotiation between public health goals and community ethics. This study highlights that the success of contraceptive policy in Muslim-majority rural settings depends on moral alignment as much as on service delivery. Effective implementation requires collaboration between health institutions, families, and religious authorities to ensure that health education and moral instruction support rather than contradict each other. Culturally and religiously sensitive approaches can foster responsible reproductive behavior while maintaining the community's ethical integrity.

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