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RISKY SEXUAL BEHAVIOR AMONG ADOLESCENTS LIVING WITH HIV AT RI SIDOMULYO INPATIENT PUBLIC HEALTH CENTER: A PHENOMENOLOGICAL STUDY

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Abstract:

Background: Risky sexual behavior represents the predominant transmission vector for Human Immunodeficiency Virus (HIV) among adolescents. Surging adolescent HIV diagnoses underscore the critical necessity to explore lived experiences, psychosocial dynamics, and behavioral contexts influencing risky sexual encounters among adolescents living with HIV.

Objective: To explore and understand the lived experiences regarding risky sexual behavior among adolescents living with HIV receiving healthcare at the RI Sidomulyo Inpatient Public Health Center, Pekanbaru City. Methods: A qualitative study utilizing a descriptive phenomenological approach was conducted in 2026. A purposive sample of eight adolescents living with HIV (all male, aged 21–24 years) was recruited based on data saturation principles from a clinic population of 79 registered adolescent patients. Data were collected through face-to-face in-depth semi-structured interviews (30–60 minutes), field observations, and institutional document reviews, triangulated with healthcare providers. Thematic analysis followed Braun and Clarke's six-phase framework.

Results: Thematic analysis identified seven overarching themes: (1) deficient baseline HIV knowledge prior to diagnosis; (2) limited awareness of risky sexual practices; (3) strained parental relationships and inadequate parental supervision/communication; (4) strong peer influence and social conformity pressures; (5) pervasive exposure to digital and social media sexual content; (6) profound psychological trauma following HIV diagnosis (denial, guilt, despair); and (7) constructive behavioral adaptations post-diagnosis (sexual abstinence/limitation, treatment adherence, and prosocial altruism). Social media emerged as a catalytic digital factor triggering exploratory sexual encounters through dating applications.

Conclusion: Adolescent risky sexual behavior leading to HIV infection is driven by interrelated gaps in sexual literacy, deficient parental communication, and unmonitored digital sexual exposure. Comprehensive multi-sectoral adolescent reproductive health education, family communication empowerment, and integrated psychosocial counseling are vital.

Keywords: Adolescents; HIV-positive; Lived experience; Phenomenology; Qualitative study; Risky sexual behavior; Social media

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1. INTRODUCTION

Human Immunodeficiency Virus (HIV) remains one of the most formidable global public health crises of the twenty-first century, attacking cluster of differentiation 4 (CD4+) T-lymphocytes and systematically compromising cellular immunity. When unmanaged, progressive viral replication culminates in Acquired Immunodeficiency Syndrome (AIDS), characterized by life-threatening opportunistic infections and systemic malignancies (World

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Health Organization [WHO], 2023). Epidemiological reports from the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that approximately 39.9 million people were living with HIV globally in 2023, with youth aged 15–24 years accounting for a disproportionate share of new acquisitions (UNAIDS, 2024). Adolescence represents a turbulent bio-developmental continuum marked by pubertal hormonal surges, heightened novelty-seeking drives, incomplete prefrontal executive impulse control, and exploratory behavioral experimentation (Santrock et al., 2014; Witriyani & Palupi, 2024). When rapid sexual maturation occurs without commensurate sexual health literacy, adolescents become extraordinarily susceptible to engaging in risky sexual practices such as early sexual debut, inconsistent condom utilization, and concurrent multi-partnering (Notoatmodjo, 2007; Rezeki et al., 2023).

In Indonesia, national epidemiological surveillance from the Ministry of Health demonstrates a concerning escalation of HIV incidence among adolescents and young adults (15–24 years), rising from approximately 17,000 newly reported cases in 2022 to over 19,000 in 2023, and surpassing 21,000 in 2024 (Kementerian Kesehatan RI, 2022, 2023, 2024). Transmission epidemiology indicates that unprotected sexual contact encompassing both heterosexual and male-to-male sexual encounters represents the predominant transmission route in the archipelago (Kementerian Kesehatan RI, 2023). At the regional level, Riau Province documented over 1,300 new HIV cases in 2024, with adolescents and young adults contributing 17% to 19% of all notifications (Dinas Kesehatan Provinsi Riau, 2024). Pekanbaru City, the provincial capital, represents the primary epicenter, reporting over 560 new cases annually, with 18% to 22% concentrated among youth aged 15–24 years (Dinas Kesehatan Kota Pekanbaru, 2024).

Among municipal health facilities in Pekanbaru, the RI Sidomulyo Inpatient Public Health Center (Puskesmas Rawat Inap Sidomulyo) ranks as the third highest facility in total People Living with HIV (PLHIV/ODHIV) receiving active antiretroviral therapy (ART) (Dinas Kesehatan Kota Pekanbaru, 2025). Clinical registries at the HIV Polyclinic of Puskesmas RI Sidomulyo revealed that adolescent voluntary counseling and testing (VCT) visits surged from 134 in 2023 to 485 in 2024, with confirmed positive adolescent diagnoses increasing from 15 in 2023, to 33 in 2024, and 20 new adolescent cases in 2025, culminating in a cumulative registry of 75 to 79 adolescents living with HIV by early 2026. Living with HIV imposes severe double burdens upon adolescents: beyond managing life-long pharmacotherapy, they confront internalized stigma, anticipated social discrimination, fear of interpersonal rejection, and acute emotional distress (Qur'aniati et al., 2024; UNAIDS, 2022).

Extensive empirical literature confirms that adolescent sexual decision-making is governed by complex socio-ecological interactions encompassing individual health literacy, parental communication, peer group conformity, and digital media environments (Baraki & Thupayagale-Tshweneagae, 2024; Bronfenbrenner & Morris, 2007; Ramadani et al., 2024). Open parent-adolescent communication regarding sexuality significantly buffers against risky sexual behaviors (Liu et al., 2023; Widman et al., 2018). Conversely, peer approval of permissive sexual norms and pervasive digital exposure to sexually explicit media or geolocation dating applications accelerate risky sexual experimentation (Doornwaard et al., 2015; Nesi et al., 2018; Vasilenko et al., 2025). Although numerous quantitative surveys have identified behavioral risk factors in high schools (Ramadani et al., 2024; Simak et al., 2026), in-depth qualitative phenomenological studies capturing the authentic lived experiences, retrospective turning points, and post-diagnosis psychological adaptations of adolescents living with HIV in secondary cities of Sumatra remain remarkably scarce.

Therefore, this study aimed to explore and understand the lived experiences regarding risky sexual behavior among adolescents living with HIV receiving healthcare at the RI Sidomulyo Inpatient Public Health Center, Pekanbaru City. The resulting empirical insights are intended to provide community health nurses, midwives, clinical counselors, and adolescent health policymakers with grounded evidence to design empathetic, culturally attuned reproductive health education and psychosocial support interventions.

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2. METHODS

2.1 Research Design

This study employed a descriptive qualitative research design utilizing a phenomenological approach. Descriptive phenomenology was selected to explore, illuminate, and understand the lived experiences (*lebenswelt*) and subjective meanings attributed by adolescents living with HIV to their prior risky sexual behaviors and subsequent life transitions following diagnosis (Creswell & Poth, 2018; Neubauer et al., 2019; Sundler et al., 2019).

2.2 Research Informants and Sampling Strategy

The study population comprised all 79 adolescents aged 15–24 years registered in the HIV Care, Support, and Treatment (CST) Polyclinic at Puskesmas RI Sidomulyo, Pekanbaru. A purposive sampling technique was employed. Sample size was governed by the methodological principle of data saturation the point at which subsequent interviews yielded informational redundancy and no novel thematic codes emerged (Creswell & Poth, 2018). A final sample of eight key informants (designated I1 through I8) completed the in-depth interviews. Inclusion criteria were: (1) adolescents aged 15–24 years; (2) confirmed laboratory HIV-positive diagnosis; (3) actively receiving ART or clinical follow-up at Puskesmas RI Sidomulyo; (4) capable of coherent verbal communication; and (5) willing to provide signed informed consent. Exclusion criteria were individuals experiencing acute opportunistic medical instability, severe cognitive impairment, or refusal to be audio-recorded.

2.3 Research Setting and Time

The study was carried out at the RI Sidomulyo Inpatient Public Health Center (Puskesmas Rawat Inap Sidomulyo), located in Tuah Madani / Tampan District, Pekanbaru City, Riau Province, Indonesia. Fieldwork, preliminary surveys, and in-depth qualitative interviews were conducted between January and March 2026.

2.4 Research Procedures

The research procedure followed four systematic phases: preparatory, recruitment, interviewing, and analytical. In the preparatory phase, institutional permissions and research clearance were secured. During recruitment, eligible patients were approached privately by the principal investigator and clinic nurse counselor in a confidential consultation room. Following rapport building and informed consent, face-to-face in-depth interviews were conducted individually in a private, sound-proof counseling space ensuring total auditory and visual privacy. Each interview lasted approximately 30 to 60 minutes and was audio-recorded with participant assent, complemented by immediate post-interview field notes capturing non-verbal expressions.

2.5 Data Collection Techniques and Instruments

Primary data collection was executed using in-depth semi-structured interviews guided by an open-ended interview schedule. In qualitative phenomenology, the researcher functions as the primary research instrument (human instrument) (Creswell & Poth, 2018). The interview guide explored seven thematic domains: (1) baseline HIV/AIDS knowledge

prior to diagnosis; (2) awareness of risky sexual practices; (3) parental relationships, family communication, and supervision; (4) peer group influences and social interactions; (5) digital social media exposure; (6) psychological impacts upon receiving HIV diagnosis; and (7) behavioral modifications post-diagnosis. Secondary data were gathered from clinic annual epidemiology logs and program registries.

2.6 Data Analysis

All audio recordings were transcribed verbatim. Data analysis followed the six-phase thematic analysis framework developed by Braun and Clarke (2021): (1) dataset familiarization through repeated transcript reading; (2) generating initial semantic and latent codes; (3) searching for overarching candidate themes; (4) reviewing and refining themes against coded extracts; (5) defining and naming final themes; and (6) producing the scientific report. Reflexivity was maintained by the research team to bracket pre-existing clinical assumptions (epoche) (Neubauer et al., 2019; Sundler et al., 2019).

2.7 Trustworthiness and Rigor

Methodological rigor was established following Lincoln and Guba's criteria: Credibility was ensured via prolonged engagement, empathetic interviewing, and member checking with informants to verify transcript accuracy; Dependability was maintained through a detailed audit trail of transcripts, audio files, and coding trees; Confirmability was reinforced through source triangulation, cross-verifying adolescent narratives with key informant interviews from Puskesmas HIV nurse counselors; and Transferability was facilitated through rich, thick descriptive narrative contextualization (Creswell & Poth, 2018).

2.8 Ethical Considerations

The study adhered to the Declaration of Helsinki and ethical guidelines for vulnerable populations living with chronic stigmatizing illness. Formal ethical approval was issued by the Health Research Ethics Committee of Institut Kesehatan dan Teknologi Al Insyirah (KEP-IKTA) under Approval Certificate Number: 08/IKTA/LPPM-KR/KEP/VI/2026. Absolute confidentiality and anonymity were guaranteed: all personal identifying details were removed and replaced with alphanumeric codes (I1–I8). Participation was entirely voluntary, with full rights to withdraw without compromising clinical healthcare delivery.

3. RESULTS AND DISCUSSION

3.1. Result

A total of eight male adolescents living with HIV participated in this phenomenological study. Table 1 delineates the demographic profile of the informants, including age, biological sex, highest formal educational attainment, and total duration living with confirmed HIV diagnosis. Table 1 presents the demographic and clinical characteristics of the eight informants involved in this study, including age, biological sex, educational attainment, and duration since HIV diagnosis. In terms of age, the informants ranged from 21 to 24 years old, indicating that all participants belonged to a relatively young adult population. Specifically, three informants (I5, I7, and I8) were 21 years old, four informants (I2, I3, I4, and I6) were 23 years old, and one informant (I1) was 24 years old. Furthermore, all eight informants were male, indicating a homogeneous distribution in terms of biological

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sex. This demographic profile provides an important context for understanding the experiences and challenges of young men living with HIV.

Table 1. Demographic Profile of Adolescent Informants Living with HIV (n = 8)

No	Informant Code	Age (Years)	Biological Sex	Educational Attainment	Duration Since HIV Diagnosis
1	I1	24	Male (L)	Senior High School (SMA)	43 Months (~3.6 Years)
2	I2	23	Male (L)	Bachelor's Degree (S1)	28 Months (~2.3 Years)
3	I3	23	Male (L)	Bachelor's Degree (S1)	4 Months
4	I4	23	Male (L)	Primary School (SD)	2 Months
5	I5	21	Male (L)	Senior High School (SMA)	8 Months
6	I6	23	Male (L)	Senior High School (SMA)	8 Months
7	I7	21	Male (L)	Bachelor's Degree (S1)	24 Months (2.0 Years)
8	I8	21	Male (L)	Senior High School (SMA)	1 Month

Source: In-depth interview demographic data at Puskesmas RI Sidomulyo, Pekanbaru, 2026.

Regarding educational attainment, the informants demonstrated diverse educational backgrounds. Four informants (I1, I5, I6, and I8) had completed senior high school (SMA), representing the largest educational group. Meanwhile, three informants (I2, I3, and I7) held a bachelor's degree (S1), while one informant (I4) had completed primary school (SD). This variation indicates differences in the participants' formal educational experiences and may provide different perspectives on understanding health-related information, HIV treatment, and healthcare services. The diversity in educational backgrounds also offers valuable contextual information for exploring how individuals perceive and respond to their health conditions.

In terms of the duration since HIV diagnosis, the informants showed considerable variation, ranging from 1 month to 43 months (approximately 3.6 years). Informant I1 had the longest duration since diagnosis, at 43 months, followed by I2 at 28 months (approximately 2.3 years) and I7 at 24 months (2 years). In contrast, I8 had the shortest duration since diagnosis, at only 1 month, followed by I4 at 2 months and I3 at 4 months. Meanwhile, I5 and I6 had both been diagnosed for 8 months. These differences indicate that the informants had varying levels of experience in living with HIV, ranging from those who had recently received their diagnosis to those who had lived with the condition for several years. Such differences may be relevant to understanding the participants' experiences of psychological adjustment, acceptance, coping strategies, and adaptation to their HIV status.

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Table 2. Source Triangulation Matrix Between Adolescent Informants and Clinic Healthcare Personnel

No	Identified Thematic Domain	Primary Informants (Adolescents Living with HIV)	Key Informant (Puskesmas HIV Nurse Officer)	Data Congruence
1	Deficient Baseline HIV Knowledge	Most informants admitted having negligible understanding of HIV transmission routes and asymptomatic viral phases prior to diagnosis.	Confirmed that newly diagnosed adolescents consistently present with profound misconceptions and limited biological literacy.	Consistent
2	Knowledge of Risky Sexual Behavior	Informants acknowledged engaging in condomless sex and partner turnover, but only recognized the true infection risks retrospectively.	Stated that adolescents frequently view themselves as invulnerable and only receive comprehensive risk education post-testing.	Consistent
3	Parental Relationships & Supervision	Informants reported emotional distance, strict taboos surrounding sexual health communication at home, and unmonitored curfews.	Observed that nearly all adolescent patients lack family accompaniment during clinic visits due to fear of domestic rejection.	Consistent
4	Peer Influence & Social Norms	Informants described peer encouragement, shared sexual narratives, and fear of group ostracization as catalysts for sexual debut.	Identified peer group norms as the primary external social driver initiating recreational and risky sexual encounters.	Consistent
5	Social Media & Dating Applications	Pervasive exposure to sexual content online and utilization of location-based dating applications facilitated casual sexual partnering.	Observed that the vast majority of adolescent patients met sexual partners through digital social applications and dating platforms.	Consistent
6	Psychological Trauma Post-Diagnosis	Initial reactions encompassed severe shock, depressive withdrawal, guilt, suicidal ideation, and acute existential despair.	Reported that psychological distress is nearly universal during initial post-test counseling, requiring intensive counseling.	Consistent
7	Positive Behavioral Adaptation	Informants demonstrated high commitment to daily ART, adopted sexual abstinence or strict condom use, and embraced healthy habits.	Verified that with ongoing psychosocial support, most adolescents achieve remarkable treatment compliance and clinical stability.	Consistent

Source: Qualitative source triangulation analysis, Puskesmas RI Sidomulyo, 2026.

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Thematic synthesis derived from in-depth interviews and confirmed by source triangulation (Table 2) generated seven primary themes:

3.1.1 Theme 1: Deficient Baseline Knowledge Regarding HIV

Prior to their diagnosis, nearly all informants possessed vague, superficial, or entirely inaccurate understandings of HIV. Informants recognized HIV only as a fatal disease, without comprehending asymptomatic transmission, biological fluid risks, or preventive barriers. As expressed by Informant 1: 'Previously, I only knew that HIV was a dangerous disease, but I did not understand how transmission occurred clearly.' Informant 2 stated: 'Before testing positive, I did not know what HIV was or that my behavior could lead to infection.' Informant 4 reflected: 'I only learned about HIV after I was diagnosed and started searching for information independently.'

3.1.2 Theme 2: Retrospective Comprehension of Risky Sexual Behaviors

Informants acknowledged engaging in high-risk sexual practices prior to infection, including inconsistent or absent condom use, multiple concurrent partners, and unprotected receptive/insertive anal intercourse. However, this comprehension was largely formed retrospectively. Informant 3 stated: 'Having same-sex anal intercourse and changing partners... I had no idea that intercourse between men carried such an enormous risk.' Informant 5 shared: 'Sex without protection and not knowing the health status of partners... misplaced trust made me ignore the risks.

3.1.3 Theme 3: Strained Parental Relationships and Inadequate Supervision

A dominant shared experience among informants was emotional distance and communication barriers with parents. Families maintained strict taboos surrounding sexual education. Informants reported that parents monitored neither their late-night curfews nor their peer associations. Informant 1 noted: 'My relationship with my parents was just ordinary. Communication was rare. They never discussed sexuality or reproduction.' Informant 3 explained: 'I did not live with my parents and rarely saw them, so parental oversight was minimal.'

3.1.4 Theme 4: Peer Influence, Group Conformity, and Social Curiosity

Peer networks exerted profound socializing pressures. Informants described hearing explicit sexual narratives from friends, receiving direct sexual invitations, and succumbing to peer pressure out of curiosity and fear of social exclusion. Informant 6 stated: 'I was invited by a male friend to engage in sex; initially I refused, but curiosity overcame me... I am the compliant type who gets easily influenced.' Informant 7 recounted: 'When I started university, I did not filter my friendships, and I fell into the wrong social circle.'

3.1.5 Theme 5: Pervasive Social Media and Digital Dating Exposure

Digital technology emerged as a critical catalyst. Informants spent 4 to 8 hours daily on smartphones, encountering algorithmic pornography, erotic content, and location-based dating applications (such as Walla). This digital exposure stimulated curiosity and directly facilitated physical hookups. Informant 1 noted: 'Social media affects sexual behavior because sexual videos attract us... you want to try and imitate it.' Informant 3 revealed: 'I met partners through chat applications... sexual content definitely pushed me to engage in sex.' Informant 4 stressed: 'All of this curiosity started because I watched sexual content on social media.'

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3.1.6 Theme 6: Profound Psychological Trauma Following HIV Diagnosis

The immediate aftermath of an HIV-positive diagnosis provoked acute existential crises, severe depression, shame, guilt, and suicidal ideation. Informants feared social ostracization and felt unworthy of future romantic partnerships. Informant 3 shared: 'I feel regret, that my dreams are blocked, and that I have no future... I feel unworthy of passing this illness to a woman I love.' Informant 6 confessed: 'Stress, depression, and easily angered at the beginning, but now I have accepted it.'

3.1.7 Theme 7: Constructive Behavioral Transformations Post-Diagnosis

Following counseling and initial emotional stabilization, diagnosis served as a transformational turning point. All informants demonstrated constructive behavioral modifications: strict abstinence or consistent condom use, cessation of casual partner turnover, diligent daily ART adherence, physical exercise, and a desire to educate peers. Informant 1 noted: 'I restrict sexual relations and focus on my job.' Informant 7 stated: 'Now I focus on taking medication and ensuring I never transmit this to a partner.'

3.2 Discussion

A. Research Findings

The central finding of this phenomenological study reveals that risky sexual behavior among adolescents living with HIV is driven by an intricate convergence of predisposing health literacy deficits, unmonitored digital social media exposure, and pervasive peer group socialization, set against a backdrop of emotionally distant family microsystems. While informants engaged in unprotected sex and partner turnover prior to infection, their understanding of specific viral transmission mechanics was severely deficient. Significantly, social media and location-based dating platforms functioned as primary technological catalysts accelerating casual partnering. However, post-diagnosis experiences revealed that despite acute initial psychological trauma, adolescents developed remarkable cognitive reframing and behavioral adaptation, embracing daily ART compliance and adopting responsible sexual ethics to prevent secondary transmission.

B. Comparison with Previous Studies

These empirical observations align closely with global and national adolescent sexual health literature. Nakato et al. (2025) and Ramadani et al. (2024) observed that poor baseline HIV literacy directly correlates with elevated sexual risk-taking among school-going youth. Regarding family systems, our findings confirm Widman et al. (2018) and Liu et al. (2023), who demonstrated that the absence of open parent-adolescent reproductive communication significantly escalates adolescent involvement in casual sex. Furthermore, the powerful role of digital applications in facilitating sexual debut mirrors findings by Doornwaard et al. (2015), Holmstrom et al. (2021), and Nesi et al. (2018), who established that unmonitored internet access fosters permissive sexual scripts and expands online-to-offline sexual partnering. In post-diagnosis adaptation, our observations parallel Malekinejad et al. (2023) and Thurman et al. (2024), who confirmed that an HIV diagnosis frequently functions as a life-course turning point, driving rapid risk reduction and treatment engagement when supported by healthcare workers.

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C. Theoretical Explanation and Pharmacological Mechanism

The multifaceted phenomenon of adolescent risky sexual behavior can be comprehensively conceptualized through Urie Bronfenbrenner's Bioecological Systems Theory, Albert Bandura's Social Cognitive Theory, and Simon and Gagnon's Sexual Script Theory (Bandura, 1986; Bronfenbrenner & Morris, 2007; Simon & Gagnon, 2017). Within Bronfenbrenner's framework, breakdown in the family microsystem (poor communication, lack of supervision) creates an ecological vacuum that is readily colonized by peer microsystems and digital exosystems. Under Bandura's Social Cognitive Theory, adolescents acquire permissive sexual norms through observational learning and vicarious reinforcement from peers and digital media models. Furthermore, Sexual Script Theory explains how algorithmic social media platforms supply idealized, eroticized 'cultural scenarios' that adolescents internalize as intrapsychic scripts, driving experimental hookups without realistic cognitive appraisal of health hazards (Simon & Gagnon, 2017).

Conversely, post-diagnosis behavioral transformation is illuminated by the Health Belief Model (HBM) and the Theory of Planned Behavior (TPB) (Ajzen, 2020; Glanz et al., 2021). Receiving a laboratory-confirmed HIV diagnosis serves as a profound 'cue to action', radically elevating perceived severity and susceptibility while reshaping subjective norms. This cognitive shift generates strong behavioral intentions toward treatment adherence and protective abstinence, reinforced by psychological resilience (Govindasamy et al., 2020; Mishel, 2018).

A critical appraisal of the empirical data requires highlighting that all eight informants were male, with several disclosing same-sex sexual encounters (men who have sex with men [MSM]). Biological males in urban Indonesian environments navigate distinct subcultural dynamics and digital networking spaces (e.g., gay-oriented chat platforms) that carry disproportionate HIV acquisition risks. Because the purposive sample included no female adolescents living with HIV, gender-specific vulnerabilities, such as gender-based violence, transactional sex, and vertical transmission anxieties, remain entirely unrepresented in this analysis. Furthermore, reliance on retrospective self-reports introduces potential recall and social desirability biases.

This study bridges an important empirical gap in adolescent public health by providing nuanced qualitative insights into the lived realities of youth diagnosed with HIV in Sumatra. Demonstrating that digital applications serve as the primary sexual conduit underscores that public health interventions can no longer rely on conventional classroom posters alone, but must urgently establish digital outreach and peer navigation within social media spaces.

3.2.1 Implications

Public health authorities and primary healthcare centers (Puskesmas RI Sidomulyo) should: (1) Deploy peer-led digital health educators on social media to disseminate youth-friendly sexual health information; (2) Establish community parenting workshops empowering parents to conduct open, non-judgmental sexual health dialogues with adolescents; (3) Integrate routine psychological counseling alongside antiretroviral dispensing to address post-diagnosis trauma; and (4) Foster non-stigmatizing youth-friendly health services (PKPR).

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3.2.2 Research contribution

This study offers qualitative phenomenological documentation detailing the lived experiences and behavioral turning points of adolescents living with HIV in Pekanbaru, contributing grounded empirical evidence to Indonesian adolescent healthcare literature.

3.2.3 Limitations

Several limitations must be acknowledged: (1) The sample was entirely male (n = 8), omitting the perspectives of female adolescents; (2) The qualitative design within a single public health center restricts broader socio-cultural generalizability; and (3) Retrospective reporting is susceptible to recall bias

3.2.4 Suggestions

Future research should implement mixed-methods, multi-center longitudinal designs capturing both male and female adolescents living with HIV across diverse geographical settings, incorporate digital ethnographic tracking of dating applications, and evaluate the clinical efficacy of peer-led digital support groups on long-term viral suppression.

3. CONCLUSION

This phenomenological study reveals that risky sexual behavior among adolescents living with HIV at Puskesmas RI Sidomulyo is driven by an interplay of deficient baseline HIV literacy, lack of parental reproductive guidance, peer conformity, and pervasive digital social media exposure that catalyzes unmonitored sexual hookups. While an HIV diagnosis precipitates acute psychological trauma and despair, ongoing counseling and healthcare support foster profound behavioral transformations, including strict treatment adherence, reduced sexual risk-taking, and active responsibility to protect others. Comprehensive multi-sectoral sexual health education, family communication empowerment, and empathetic adolescent clinical services are essential to curtail adolescent HIV transmission.

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ZR: conceptualization, methodology, investigation, data curation, formal analysis, writing original draft. ND, DM, RNY: supervision, validation, methodology, writing review and editing, project administration.

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