Journal of Public Health and Pharmacy

e-ISSN 2775-4952
PUBLISHED BY
Universitas Muhammadiyah Palu, Indonesia

ORIGINAL RESEARCH

Invisible Families in Universal Health Coverage: Multilayered Exclusion of Underage Couples in Rural Bali, Indonesia

Desak Putu Yuli Kurniati[1,2*], Pande Putu Januraga[2], Ni Made Swasti Wulanyani[3], Dyah Kanya Wati[4], Anak Agung Sagung Sawitri[2], Ni Made Utami Dwipayanti[2], Ni Wayan Tianing[5], Ni Luh Putu Rita Primayuni[6], I Made Ady Wirawan[2]

[1]Doctoral Study of Biomedical Sciences, Faculty of Medicine, Udayana University, Bali, Indonesia
[2]Department of Public Health and Preventive Medicine, Faculty of Medicine, Udayana University, Bali, Indonesia
[3]Department of Psychology, Faculty of Medicine, Udayana University, Bali, Indonesia
[4]Department of Pediatrics, Faculty of Medicine, Udayana University, Bali, Indonesia
[5]Department of Biochemistry, Faculty of Medicine, Udayana University, Bali, Indonesia
[6]School of Public Health, Faculty of Medicine, Udayana University, Bali, Indonesia

Correspondence: Desak Putu Yuli Kurniati. Email: desak.yuli@unud.ac.id

ARTICLE HISTORY
Received: 24 December 2025
Revised: 05 June 2026
Accepted: 20 June 2026
Published: 08 September 2026

ARTICLE IDENTIFIERS
Volume 6 - **Issue** 3 - 2026
Pages 439-450
DOI: 10.56338/jphp.v6i3.9765

ABSTRACT

Introduction: Despite Indonesia's commitment to Universal Health Coverage (UHC), adolescents involved in customary marriages often remain beyond the reach of state protection. This study explores the "multilayered exclusion" experienced by these couples in accessing maternal health services in Munti Gunung, Bali.

Methods: This exploratory qualitative case study involved 16 purposively selected participants, including early-married adolescent mothers (n=5), family gatekeepers (husbands/in-laws, n=5), health workers (n=5), and a community leader (n=1). Data were collected through in-depth interviews and analyzed using thematic analysis to identify barriers across the socio-ecological spectrum.

Results: Inductively derived from localized empirical data, this study presents 'Administrative Invisibility' as an emergent conceptual construct describing how the lack of civil marriage certificates systematically excludes newborns from the National Health Insurance scheme. This qualitative exploration indicates that structural vulnerability is mediated by rigid household hierarchies and a mismatch in institutional capacity within resource-constrained primary care services. To secure immediate healthcare, families and local administrative actors navigate this socio-legal limbo by employing pragmatically effective yet legally high-risk informal workarounds.

Conclusion: Within this single-site qualitative scope, the intersection of customary child marriage and legal identity exclusion appears to form a compounded structural node within the multi-layered matrix of healthcare exclusion for newborns. Achieving health equity requires proactive, affirmative structural reforms, specifically, piloting a 'Conditional Humanitarian Enrolment' model powered by an API-driven digital bridging framework to formally decouple an infant's constitutional right to healthcare from parental marital status, safely integrating immediate neonatal survival with long-term socio-legal safeguards.

Keywords: Administrative Invisibility; Child Marriage; Conditional Humanitarian Enrollment; Universal Health Coverage; Indonesia

INTRODUCTION

Adolescents who marry early face severe risks related to pregnancy and childbirth (1). Globally, adolescent pregnancy raises risks of preeclampsia, anemia, preterm birth, and mental health issues for mother and baby (1,2). In Indonesia, 7% of women aged 15-19 have begun childbearing: 5% are already mothers, and 2% are pregnant with their first child (3). While effective health interventions are crucial (4), and the government mandates at least six antenatal care (ANC) visits to monitor health and detect complications (5–7), the implementation remains a challenge.

Realization of these health standards for adolescents is critically inadequate (8). The 2017 Indonesia Demographic and Health Survey revealed that 416 adolescent mothers (aged 15-19) utilized maternal healthcare services infrequently. Approximately 25% had fewer than four ANC visits, and 33.5% selected traditional delivery locations, such as home births with traditional attendants (8). Previous research attributes this to social barriers, low health literacy, and services unsuited to adolescent needs (9). This gap indicates a potential failure of the health system to uphold adolescents' rights to information and services as guaranteed by Health Law No. 17/2023 and the Convention on the Rights of the Child (9,10).

While national data highlight these gaps, they fail to explain the persistence of these disparities in socio-culturally marginalized areas (3,7). Furthermore, existing qualitative literature remains fragmented. Current studies in Southeast Asia and the Global South primarily focus on the stigma and barriers faced by unmarried adolescent pregnancies (11,12). Consequently, married adolescents are often overlooked in academic discourse, underpinned by the assumption that marriage provides social legitimacy and 'protective' access to care. However, this assumption creates an analytical blind spot. In jurisdictions such as Indonesia, where national health insurance eligibility is strictly tied to state-validated civil registration (13), the socio-cultural legitimacy of a customary marriage does not translate into administrative legibility (14,15). What remains under-examined is how administrative rules and socio-economic vulnerabilities (such as poverty and geographic isolation) intersect to produce healthcare exclusion for legally underage, yet socially married couples.

While economic barriers to Universal Health Coverage (UHC) are well-documented in the macro-analytic literature (16–18), existing literature typically treats legal identity exclusion as a financial barrier, solely a byproduct of poverty (14,15). Less attention has been paid to the dynamic socio-legal mechanisms whereby families formed through customary child marriages are actively rendered 'invisible'. This study bridges this gap by moving beyond explanations that focus solely on financial barriers to explore how administrative rigidities actively compound pre-existing socio-economic exclusions. Globally, structural and economic interventions often function merely as a 'time-delay strategy' targeting temporary eligibility rather than achieving sustainable value transformation (19). Specifically, we capture the dynamic, multilayered interplay between rigid state bureaucracy, localized primary care resource constraints, geographic isolation, and deeply entrenched household hierarchies (such as mother-in-law authority).

To unpack this phenomenon, this study purposively selected Munti Gunung in Bali, Indonesia, as a critical case study. Known historically for severe socio-economic marginalization, this region is characterized by deep poverty, high seasonal employment migration to urban centers, and entrenched customary child marriage (20). By focusing on this marginalized setting, we aim to offer a comprehensive framework that explains how systemic policy gaps, interpersonal hierarchies, and cultural exclusions intertwine. Ultimately, this research intends to inform policy reforms and youth-centered interventions to provide equitable, rights-based maternal and child health services for Indonesia’s most invisible communities.

METHODS

Research Type

This study used an exploratory qualitative method to examine barriers and facilitators affecting adolescent mothers' access to maternal health services after early marriage. A case study design was used to achieve an in-depth, contextual understanding of this phenomenon within the unique environment of Munti Gunung (21,22).

The Socio-Ecological Model (SEM) was operationalized as the primary structural framework to analyze these complex, intersecting factors at the individual, interpersonal, community, and systemic levels (23). Theory of Planned Behavior (TPB) and Social Norms Theory (SNT), were applied strictly as secondary interpretive lenses during the discussion phase to unpack specific individual attitudes and injunctive community norms, thereby ensuring analytical discipline without cluttering the primary SEM coding tree (24–26). We followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist in this report (27).

Research Location

This study was conducted in Munti Gunung, Tianyar Barat Village, Karangasem, Bali. We selected this location as a purposive 'extreme case' due to its unique socio-economic landscape. Geographically, it is characterized by arid land where traditional farming is nearly impossible. Historically, the hamlet has faced long-standing stigma as a 'Beggar Village' since the 1980s, a survival strategy involving women and children that contributes to high school dropout rates, reportedly affecting 20% of elementary and 34% of junior high students annually (20). The limited life choices fuel child marriage as a survival option (28). From the local data, Karangasem Regency reports a rising number of marriage dispensations (368 cases in 2024). The health implications in this setting are severe; local hospital data (2019–2025) recorded 34 adverse outcomes among adolescent mothers, including severe anemia and hemorrhage. This context of profound marginalization provides an ideal setting to explore the phenomenon of healthcare exclusion.

Participants and Sampling Procedures

This study involved 16 participants selected through purposive sampling to capture a diverse range of perspectives within the Munti Gunung community. The participants were categorized into four groups to facilitate data triangulation: (1) married adolescent mothers (n=5) aged 15–19 years to provide lived experiences of healthcare access; (2) family gatekeepers (husbands and mothers-in-law, n=5) to clarify domestic decision-making dynamics; (3) health workers (midwives and program managers, n=5) to explain systemic barriers; and (4) a community leader (n=1) to offer socio-cultural context.

Recruitment was based on specific inclusion criteria: residing in the study setting, being in good physical health, and providing voluntary consent. Given the sensitive nature of the topic, the researchers prioritized ethical safety by employing the PedsQL™ Generic Core Scales as a screening instrument to assess general psychosocial well-being prior to full interview engagement (29). Potential participants scoring below the established operational threshold for acute distress (total score < 60) or exhibiting visible traumatic trigger symptoms during initial rapport-building were designated for exclusion and gentle referral to local community support networks. During the screening process, no potential informants scored below this threshold or met these exclusion criteria, allowing all recruited vulnerable voices to fully participate. Although the PedsQL™ is fundamentally established as a Health-Related Quality of Life (HRQoL) measure rather than a clinical psychiatric screening inventory, its emotional and social functioning subscales were intentionally adapted as a culturally non-stigmatizing proxy for psychological readiness. In highly marginalized and tightly-knit rural communities, conventional clinical distress inventories carry diagnostic stigma and risk provoking defensive non-disclosure or acute anxiety among vulnerable adolescents. Consequently, the PedsQL™ offered an ethically sensitive, non-threatening framework to ensure participant safety and uphold the principle of non-maleficence without compromising initial research rapport.

The final sample size was determined by data saturation (30). Given the structural heterogeneity across the participant tiers, saturation was operationalized and monitored independently within each distinct stakeholder subgroup (intra-tier redundancy) rather than aggregated globally. This was assessed continuously through interim comparative analyses conducted after every two interviews within each respective tier. Sampling within a specific subgroup ceased only when intra-tier conceptual code redundancy was achieved, defined as the point at which subsequent narratives from that stakeholder profile yielded no new conceptual codes, distinct structural barriers, or alternative dimensions of administrative exclusion. Crucially, for the community leader tier (n = 1), who served as a singular key informant due to their exclusive institutional role as the primary local health cadre bridging customary village governance and formal primary care, saturation was operationalized through interpretive cross-validation rather than thematic replication. Sampling for this tier was deemed complete when their macro-level socio-cultural perspectives achieved structural harmony and perfect informational redundancy with the empirical accounts generated across the other 15 interviews. We obtained written consent from all participants, including parental consent and adolescent assent. Everyone eligible agreed to participate.

Instruments and Data Collection Tools

In this qualitative study, the researchers served as the primary data collection instruments, supported by three key tools to ensure data richness and ethical safety. First, data were collected using a semi-structured interview guide developed based on the Socio-Ecological Model (SEM) (23). This guide was designed to explore barriers across individual, interpersonal, community, and systemic levels. Before data collection, the guide was pilot-tested with external individuals to ensure question clarity and cultural appropriateness.

Second, given the vulnerability of the study population, the PedsQL™ Generic Core Scales (29), were utilized as a preliminary ethical screening tool. As detailed in the sampling procedures, this tool served strictly to operationalize the distress threshold (< 60) to protect vulnerable adolescents from re-traumatization in a setting completely devoid of localized mental health support, ensuring psychological readiness before full interview engagement. This instrument was not used for statistical analysis, but rather to assess the participants' general well-being; adolescents exhibiting signs of acute emotional distress were excluded to prevent psychological harm during the in-depth interviews.

Third, technical tools included digital audio recorders to capture verbatim responses and reflective journals. The researchers used the journals to document field notes, nonverbal cues (such as family dynamics during interviews), and to practice reflexivity regarding their own biases and the power dynamics present in interactions with the marginalized community.

Researcher team and reflexivity

The research team consisted of male and female public health practitioners, psychologists, and pediatricians, all of Balinese origin. The lead researcher has more than ten years of experience engaging with the study setting through community service programs centered on maternal and child health. This long-term involvement provided profound contextual insights and facilitated immediate rapport with the community.

Nonetheless, this positionality also necessitated rigorous reflexivity. We acknowledged the potential for bias originating from the researcher's prior role as a program implementer. Consequently, we deliberately transitioned our perspective from assessing compliance to investigating upstream barriers, motivated by a dedication to redesigning interventions that are more structurally effective to achieve optimal health outcomes.

Although we considered ourselves “cultural insiders,” we stayed aware of our role as “socio-economic outsiders.” We acknowledged the power imbalance between our privileged professional roles and Munti Gunung's marginalized situation. To address this, we maintained reflective journals to document our assumptions and guarantee that participants' stories were interpreted within their structural context, rather than through our ideal health behaviors.

Data Collection Procedures

Between November 2024 and April 2025, two trained researchers (DPYK & NLPRP) carried out 16 face-to-face in-depth interviews. These discussions followed a semi-structured guide based on the Socio-Ecological Model, which had been pilot-tested to verify cultural appropriateness and clarity. Interviews were conducted at participants' homes or workplaces to accommodate their convenience. Although privacy was recommended, the researchers recorded field notes on family dynamics whenever gatekeepers (such as husbands or in-laws) stayed present during the sessions.

Each interview, lasting 60–90 minutes and audio-recorded, involved immediate validation of the participants' key points, which were summarized for participant confirmation to ensure data accuracy. Recruitment stopped once data saturation was reached, meaning no new themes or important information appeared. No repeat interviews were conducted. A double-translation process (Balinese/Indonesian to English) was used to ensure linguistic validity, complemented by reflective journaling to mitigate researcher bias during interpretation.

Data Analysis

Data were analyzed following Braun and Clarke's six-phase reflexive thematic analysis framework (31,32), using NVivo 14.23.1 software. We used a hybrid (abductive) coding approach: the initial codebook was based on the Socio-Ecological Model (deductive), but we also allowed new themes to emerge from participants' narratives (inductive). Two researchers (DPYK & NLPRP) independently coded line-by-line.

To maintain a rigorous evidentiary chain and prevent analytical conflation, the coding tree strictly segregated data into three distinct participant tiers before high-level thematic synthesis: (1) direct structural experiences reported by adolescent mothers, (2) institutional and clinical inferences reported by health workers, and (3) systemic socio-cultural observations from community leaders. This structural segregation was maintained throughout the initial analysis to prevent the premature conflation of descriptive narrative findings with high-level theoretical interpretations. Discrepancies in cross-tier coding were resolved through iterative consensus meetings and verified against field notes in the reflective journals, ensuring that high-level structural interpretations remained tightly tethered to participants' empirical accounts.

Trustworthiness

Methodological rigor was ensured by including credibility, transferability, dependability, confirmability, and authenticity, as outlined by Lincoln and Guba and adapted for thematic analysis by Nowell et al (31). Credibility was achieved through source triangulation, involving cross-referencing perspectives from adolescent mothers, family gatekeepers, and health workers to build a comprehensive understanding. Transferability was supported by offering a detailed 'thick description' of the Munti Gunung setting, which helped readers evaluate the applicability of the findings to other similar marginalized contexts. Dependability and confirmability were preserved by maintaining a comprehensive audit trail that included raw data, field notes, and analytical decisions. Finally, authenticity was maintained by protecting the adolescents' distinct voices verbatim, ensuring their marginalized experiences were not overshadowed by adult or professional narratives.

Ethical Approval

This study has received ethical approval from the Research Ethics Committee of the Faculty of Medicine, Udayana University (No: 2598/UN14.2.2.VII.14/LT/2024).

RESULTS

Characteristic of Participants

A total of 16 participants were recruited, representing diverse perspectives within the Munti Gunung ecosystem. The primary group consisted of five adolescent mothers aged 15–19 years, all of whom were primiparous (first-time mothers). This group showed considerable socio-economic vulnerability; most had not finished junior high school, and all were connected through customary (traditional) marriages that lacked legal registration.

Participants' experiences with early marriage varied. Most unions resulted from premarital pregnancy, with marriage serving to legitimize the child and reduce social stigma. However, this pattern was not universal; one adolescent mother specifically stated her personal readiness and choice to marry, contradicting the idea that difficult circumstances alone drive all early marriages in this context. This variation shows that, although structural drivers dominate, individual agency still influences their experiences.

To understand household decision-making dynamics, interviews were conducted with five family gatekeepers, including husbands (n=2) and mothers-in-law (n=3), who hold the primary authority over health matters in the home. Five health professionals, including the Head of the Community Health Center and village midwives, along with one community leader (health cadre), provided the systemic and community perspectives. Notably, all health worker informants had more than 5 years of experience in this specific community, ensuring a thorough understanding of the local context. Demographic data are summarized in Table 1.

Table 1. Characteristics of participants

Participant Group	Number (n)	Main Characteristics
Young Mothers	5	Age Range: 15-19 years Education: Most did not graduate from junior high school Marital Status: Traditional marriage/unregistered Parity: Primiparous (first pregnancy/birth)
Family Members	5	Relationship: Husband (2), mother-in-law (3) Role: Primary decision-maker in the household
Health Worker	5	Role: Head of Community Health Center, Village Midwife, Mother and Child Health Program Manager in the Community Health Center, and the local hospital. Experience: >5 years working in the community
Community Leader	1	Role: Health Cadre

Source: Primary Data

The thematic analysis uncovered a complex landscape of adolescent maternal healthcare, organized into two main themes and one emerging facilitator. The first theme describes a pattern of symptom-driven, suboptimal care, which is often reactive rather than preventive. The second theme uncovers a complex system of exclusion, highlighting interconnected barriers at the individual, interpersonal, community, and systemic levels within the Socio-Ecological framework Model. Additionally, the findings highlight the proactive role of health workers and community actors as essential facilitators in overcoming these issues and challenges. A detailed summary of these themes, sub-themes, and key findings is provided in Table 2.

Table 2. The key findings

Major Themes	Sub-Themes	Key Descriptive Findings
Symptom-Based and Suboptimal Utilization	Reactive & Delayed Care	ANC visits are not preventive but symptom-driven or triggered by the inability to hide pregnancy (concealment). Initiation is often delayed until the 2nd or 3rd trimester.
	Ultrasound-Centric Motivation	Adolescents prioritize ultrasound for gender determination and pregnancy confirmation over holistic health monitoring (nutrition, BP checks).
	Neglected Postnatal Care	Postpartum care is absent mainly or relies on traditional remedies (driven by mothers-in-law), sought only in cases of severe complications.
A Multilayered System of Exclusion (Barriers)	Individual: Low Literacy & Risk Perception	Adolescents equate "feeling healthy" with "being healthy," leading to missed check-ups. They lack awareness of ANC benefits beyond ultrasound.
	Interpersonal: Restricted Autonomy	Decision-making is dominated by husbands (providing passive support or transport) and mothers-in-law (acting as gatekeepers who favor traditional medicine).
	Community: Stigma & Unfriendly Services	Fear of judgment, such as premarital pregnancy, leads teens to avoid local centers. These services are seen as "not youth-friendly' and tend to treat scared teens like experienced adults.
	Systemic: Administrative Invisibility	Lack of legal documents (marriage certificate/ID) due to underage customary marriage results in exclusion from National Health Insurance, causing financial barriers.
	Systemic: Resource Constraints	Remote facilities encounter shortages of specialist doctors and ultrasound equipment, reducing the quality of care.
Emerging Facilitators: Institutional Resilience & Adaptive Navigation	Proactive Non-Discriminatory Support	Despite barriers, health workers aim to provide non-judgmental care and promote the use of ultrasound to involve adolescents in primary health care.
	Outreach to "Invisible" Groups	Midwives perform home visits for high-risk and working adolescents, but are often limited by their mobility and reluctance.
	Informal Bureaucratic Accommodation	Village officials use 'age adjustment' tactics to circumvent strict legal rules. They administratively raise the couple's ages to facilitate marriage registration, allowing newborns to access National Health Insurance and prioritizing humanitarian support over strict adherence to the law.

Source: Primary Data

Symptom-driven and suboptimal utilization

The study reveals a predominant pattern of symptom-driven healthcare utilization, where adolescents equate "feeling healthy" with "being healthy." This low-risk perception leads many to dismiss the need for routine check-ups. As one participant rationalized, *"I don't think that being pregnant at a young age made me sick"* (Adolescent mother 1). Consequently, antenatal care (ANC) initiation is often delayed until the second or third month and fails to meet national prevention standards. One mother admitted to a sporadic schedule, stating, *"So, during pregnancy, I only had check-ups in the second, fifth, and eighth months"* (Adolescent mother 5).

Beyond personal perception, social pressure exacerbates these delays. While adolescent mothers experienced this avoidance as a deeply personal mechanism to conceal shame and avoid immediate social judgment, health workers institutionalized this behavior as a systematic breakdown in early clinical tracking. A health worker explained this avoidance behavior: *"They feel ashamed if they are not married but are already pregnant... They prefer to go to Kuta"* (Health Worker

1). When they finally access services, their motivation is often instrumental rather than holistic. Care is dominated by a desire for ultrasonography to confirm the baby's gender or viability, while essential components like nutritional monitoring are neglected. As Health Worker 2 observed: *"Young pregnant women's motivation is more focused on the ultrasound examination... and ensuring the possibility of a standard delivery*.

This "symptom-driven" mentality persists firmly into the postpartum period. Similar to their pregnancy experience, adolescent mothers often bypass postnatal care (PNC) because they perceive the absence of visible illness as evidence of good health. Professional care is deemed unnecessary unless acute symptoms arise. In this vacuum of medical monitoring, care relies heavily on traditional home practices directed by family hierarchies. One mother described how she substituted medical visits with traditional remedies under her mother-in-law's instruction: *"I didn't go back to the midwife because the baby didn't have a fever and didn't cry much. I felt fine, too, so I just stayed home. Usually, if the baby has a mild fever, my mother-in-law helps me treat it with traditional onion compresses. Only if the condition doesn't improve am I told to go to the midwife or the Community Health Center."* (Adolescent mother 2)

A multilayered system of exclusion in maternal healthcare

Thematic analysis shows that barriers to healthcare are interconnected and function as a multilayered system of exclusion within the Socio-Ecological Model. At the individual level, the main challenges include low health literacy and mismatched risk perceptions. Adolescents frequently see antenatal care (ANC) as a cure rather than prevention, which causes them to skip services when they don't have physical symptoms. One mother illustrated this lack of preventive urgency, reasoning, *"I don't know how often I should [have checkups]. Because I feel healthy, the baby in my womb must also be healthy"* (Adolescent mother 4).

At the interpersonal level, adolescent autonomy is entirely surrendered to family gatekeepers. While husbands may offer logistical support, such as transportation, they remain emotionally distant from the clinical process. One participant described her husband's passive role, noting that he *"doesn't come inside; he waits outside... smoking and chatting with friends, rather than entering with me [his wife]"* (Adolescent mother 1). At the same time, mothers-in-law frequently assert their authority by favoring traditional remedies instead of modern medical advice.

While family gatekeepers framed these domestic choices as traditional protection, frontline health workers inferred that such interpersonal dynamics directly fueled clinical isolation and fear at the community level. This community-level disconnect was further highlighted by a health worker who observed how social stigma surrounding early or out-of-wedlock pregnancies actively hindered service utilization. A health worker highlighted this disconnect: *"They feel ashamed about being pregnant before marriage, so they avoid the community health center. There is no specialized approach; those who arrive are treated the same as other mothers. However, these children appear confused and afraid."* (Health worker 1)

Finally, at the systemic level, structural barriers render many mothers "administratively invisible.' Since numerous adolescents marry under customary law without formal registration, they lack essential documents, such as Marriage Certificates or Family Cards, necessary to access the National Health Insurance. In the Indonesian civil registration system, this administrative exclusion operates as a rigid cascade of failures governed by distinct institutional mandates and statutes. Following the enactment of Marriage Law No. 16/2019, the legal marriage age is set at 19 for both sexes, requiring a strict legal Court Dispensation from the Religious or District Court for underage unions (33–35). Without this judicial dispensation, customary marriage cannot obtain a state-validated Marriage Certificate (*Akta Nikah)*. Consequently, under Law No. 24/2013 on Civil Administration, the Civil Registry Office (*Dukcapil*) is legally barred from separating adolescents from their parents' documents to establish an independent Family Card (36,37). When a child is born to this union, the lack of a joint Family Card *(Kartu Keluarga - KK)* prevents the automated issuance of a National Identification Number (*Nomor Induk Kependudukan - NIK*) under the father's legal lineage. This bureaucratic gridlock effectively violates Presidential Regulation *(Perpres)* No. 82/2018 on Health Insurance, which mandates a valid NIK for scheme enrolment (13), thereby blocking the newborn's registration into the National Health Insurance scheme *(Jaminan Kesehatan Nasional – JKN/BPJS Kesehatan)* within the critical 28-day neonatal window and transferring the entire financial burden of care back to the impoverished household.

The authors interpret this statutory gridlock as an institutional production of administrative invisibility, which manifests empirically in the daily lives of families as a multigenerational denial of state protection. A parent-in-law explained the multigenerational impact of this legal void. *"My daughter-in-law had BPJS before she got married... [but] as for the baby, he doesn't have it yet because they don't have the [legal] documents yet. Their parents' marriages are also only customary."* (Parent-in-law 2). This combination of obstacles, from the personal belief that "feeling healthy means being healthy" to the absence of legal acknowledgment, systematically creates the "Invisible Mother," isolating her and the baby from essential care.

Emerging facilitators: institutional resilience & adaptive navigation

Despite systemic failures, the study highlights frontline health workers' resilience as key. When institutions fall short, midwives and community leaders often go beyond their mandates to fill gaps. They aim to provide non-discriminatory care to reduce stigma. A community leader affirmed this proactive approach, mentioning that midwives offer support by avoiding discrimination and actively encouraging young pregnant women to seek check-ups and use ultrasound services. Health workers use assertive outreach, like home visits, to find 'invisible' adolescents. However, health workers reported that these clinical interventions frequently clashed with the adolescents' economic survival strategies, specifically their high mobility driven by seasonal labor. As Health Worker 2 revealed: *"When I visit their house, they're often not home because they work*

in a spa in Denpasar... They won't come back for check-ups unless it's urgent, even though I asked their mother-in-law to contact them... but they still refused." (Health worker 2)

Apart from health workers, the study revealed that village officials also participate in informal adaptive strategies to circumvent rigid legal barriers. Recognizing that strict enforcement of age limits for marriage registration would permanently exclude these families from social protection, some officials discreetly assist with the 'age adjustment' process for the couple. By administratively 'upgrading' the adolescents' ages to meet the legal minimum, officials facilitate the issuance of Family Cards, Birth certificates, and health insurance. *"When my daughter-in-law gave birth, she used the BPJS [health insurance] from when she was single, based on her parents' family data. It was still valid because her name is still listed on their Family Card. It is the baby who doesn't have coverage yet. Right now, the grandfather and the Kelian [hamlet head] are helping process it at the village office, to* increase her age *so that the [new] Family Card can be issued. This way, we can process the baby's birth certificate and BPJS."* (Mother-in-law 2). Although legally ambiguous, the authors analyze this pragmatic maneuver as a vital, local adaptive mechanism operating within the governance framework. It temporarily navigates administrative friction to ensure that the most vulnerable newborns are not completely denied life-saving medical coverage due to their parents' underage status, even while leaving the broader systemic policy misalignments unaddressed.

DISCUSSION

This study highlights a notable gap between Indonesia's official maternal health standards and the real experiences of early-married adolescent girls in Munti Gunung. Despite national policies requiring comprehensive antenatal care (ANC), evidence shows a continued trend of symptom-driven use and insufficient utilization. This reflects national trends where a low perception of risk and the cultural view of pregnancy as a 'natural event' discourage seeking preventive care (38). Using the Socio-Ecological Model (SEM) as our primary structural framework, we see this not merely as individual negligence, but as the result of a "multilayered system of exclusion" that operates across personal and structural levels.

Crucially, 'administrative invisibility' is positioned not as a standalone factor driving healthcare exclusion, but as a mechanism through which various structural vectors converge into an ultimate dead end (19,23,39). The empirical findings reveal that legal-documentation barriers do not operate in a vacuum; instead, they interact dynamically with a broader, pre-existing pattern of multi-layered exclusion. At the macro-environmental level, Munti Gunung's arid topography and geographic isolation constrain local agrarian livelihoods, directly increasing economic vulnerability and prompting adolescents to migrate for employment in seasonal urban spa sectors in Denpasar or Kuta (20), thereby structurally disrupting the continuity of regular antenatal care. At the service delivery level, this geographic vulnerability is compounded by primary care resource constraints, such as the chronic shortage of youth-friendly reproductive health services and of functional ultrasonography, which lowers initial health literacy and risk perception. At the micro-interpersonal level, these systemic factors are heavily mediated by traditional household hierarchies and strict mother-in-law gatekeeping authority, which privileges customary legitimacy over timely clinical intervention. When evaluated through the lens of structural violence (39), this exclusion is not produced by Rigid clinical gatekeeping but by the systemic configuration in which these pre-existing socioeconomic vulnerabilities, geographic, and domestic deprivations meet strict, unyielding bureaucratic insurance rules. In this context, the administrative system acts to finalize, rather than initiate, the structural erasure of these families from state protection.

To deeply examine the individual and interpersonal dimensions within our socio-ecological framework, the discussion utilizes specific sub-constructs of the Theory of Planned Behavior (TPB) and Social Norms Theory (SNT) strictly as secondary interpretive lenses (25,26,40). Although TPB suggests intention influences behavior, our findings show adolescent agency is limited. Consistent with previous research on health literacy, adolescents often perceive "feeling healthy" as equivalent to "being healthy," which reduces their intrinsic motivation (11,41,42). These adolescents usually engage with the health system only when symptoms appear or for specific reasons, like gender determination through ultrasound. This reflects a broader trend in the 'social consumption' of ultrasound, prioritizing the 'visual reassurance' of technology over clinical monitoring (43). The 'symptom-driven' behavior seen in Munti Gunung reflects broader Indonesian trends, where a lack of perceived need continues to be a primary reason for underusing maternal health services (38). Our qualitative data shed light on the reasons behind this statistic: cultural normalization of pain and dependence on traditional remedies, such as onion compresses, often serve as the initial response before seeking professional assistance.

Crucially, family hierarchies often override adolescents' intentions to seek care. The SNT describes this pattern (25): because adolescents have limited autonomy, subjective norms (especially the expectations of spouses and in-laws) hold more sway than their personal attitudes. Decision-making authority lies with husbands, who are typically passive, and mothers-in-law, who tend to support traditional practices. This aligns with existing literature demonstrating that husband support is a critical determinant of maintaining regular ANC compliance (44). However, our study highlights an important distinction: being physically present does not necessarily mean active participation. Although husbands in Munti Gunung often offered transportation, their passive role during consultations, waiting outside, reflects the cultural detachment described in other Indonesian contexts (45). This confirms that family dynamics can be a double-edged sword: they provide logistical support but often serve as gatekeepers in hierarchical contexts, preventing access to modern care.

At the community level, this study provides a nuanced contrast to existing literature. While global research focuses on the stigma faced by unmarried adolescents (46), our analysis shows that married adolescents in Munti Gunung also experience a unique form of "shame" and exclusion. They are caught in a paradox: culturally sanctioned to be mothers by their community, yet treated as "confused children" by a health system lacking youth-friendly competencies (47,48). While national macro-level surveys successfully establish a structural correlation between civil registration deficits and barriers to access to Universal

Health Coverage (UHC) (14,15), relying strictly on these macro-inventories risks obscuring localized limits of transferability and the non-linear operational dynamics at play. Existing demographic literature in Southeast Asia frequently operates under a conventional 'protective social buffer' hypothesis, suggesting that legitimizing an adolescent pregnancy through customary marriage effectively cushions the young mother from acute community ostracization and service denial (46,49). Our micro-level qualitative data from Munti Gunung actively challenge and refine this macro-assumption. We demonstrate that entering into an underage customary union shifts the nature of the challenge from community-level moral judgment to an inadvertent 'capacity mismatch' within an overburdened primary care system. In low-resource settings, frontline health workers, frequently operating under heavy structural workloads and acute resource constraints, often lack specialized, youth-friendly clinical guidelines tailored for married adolescents (47,50). Consequently, without formal training, providers may unintentionally perceive these young mothers as developmentally unready for maternal responsibilities, which can inadvertently manifest as patronizing clinical communication or highly transactional tracking rather than an empathetic, collaborative patient-provider dynamic (46,47). This study therefore extends the current literature by demonstrating that structural exclusion under the JKN framework is driven not by deliberate provider exclusion at the clinical front line, but by a complex socio-legal process in which administrative illegibility collides with the structural distress of overburdened health workers, ultimately producing unintended alienation for these vulnerable families (14,17).

Finally, at the systemic policy level, this study uncovers the structural gridlock that converts underage customary marriages into absolute institutional exclusion. While the administrative progression from obtaining judicial court dispensations under Law No. 16/2019 as Law of Marriage to fracturing multi-generational household registries per Law No. 24/2013 on Civil Administration appears linear on paper, its operational collision with national health coverage criteria determined in Presidential Regulation No. 82/2018 on Health Insurance creates a prohibitive barrier for the newborn, trapping the child in a state of institutional invisibility (14,49). In Munti Gunung, this 'Administrative Invisibility' operates as a structural trap rather than an accidental omission. Unlike adult couples who navigate temporary bureaucratic delays, underage customary couples face a permanent statutory deadlock. By systematically chaining a newborn's access to emergency medical coverage to the state-sanctioned validation of their parents' marital union, the formal policy design inadvertently punishes the infant for the legal non-compliance of the parents, illustrating a form of structural violence (39), that actively transforms a protective social safety net into an engine of public health exclusion.

Critically, this exclusion disproportionately impacts newborns. While the adolescent mother may retain residual health coverage under her parents' documents, the infant is born into a situation where legal paternity is absent due to the parents' unregistered marriage; the infant is ineligible for health insurance. By linking a newborn's right to survival with the legality of their parents' marriage, the existing policy framework inadvertently exacerbates clinical vulnerability, creating acute financial deterrents that delay emergency treatment for highly manageable neonatal conditions such as sepsis or low birth weight (1,14). In socio-legal terms, this gridlock traps these families in a 'legal limbo', depriving them of their rights to state protection and health services (49). This phenomenon underscores a fundamental conflict between rigid legal compliance and humanitarian imperatives, demonstrating the urgency of a child rights-based approach (10) to rectify a policy design that remains detached from the complex realities of marginalized communities.

Furthermore, our field data highlight a clear need to examine how villagers unofficially bypass these rules. In practice, families and local leaders frequently alter documents and adjust ages on the spot as a desperate way to survive. While these unofficial tricks successfully save lives, they trap local officials in a painful moral dilemma, forcing them to choose between strictly obeying the law or fulfilling their basic human duty to save a newborn (51). This reality aligns with global evidence showing that while top-down strict laws often fail, it is this kind of flexible, local leadership that actually keeps marginalized groups alive (19). Legally, however, these survival tactics are highly dangerous; they solve the healthcare crisis today, but they expose both poor families and village leaders to severe criminal penalties under Indonesian law for falsifying population data (37).

Policy Recommendations and Future Research Directions

Achieving health equity for this vulnerable group requires a fundamental shift in approach, moving from interventions focused solely on individual education to comprehensive systemic reform (19,52,53). Based on the findings, we suggest recommendations across three strategic pillars.

First, reforming the structural policy for registering with the National Health Insurance is essential. The current requirement for a Family Card, which underage couples are legally unable to obtain, creates bureaucratic hurdles. We recommend adopting an affirmative policy approach that allows newborns to be registered for health insurance using only a Birth Notification from the health facility, without requiring parents to be legally married or to provide separate civil registration documents. Formally decoupling a child's right to healthcare coverage from the legal status of the parental marriage aligns with Article 28H of the Indonesian Constitution and the Child Protection Law No. 35/2014, which mandates state protection for infant survival regardless of birth lineage (54,55). From a technical implementation standpoint, executing this decoupling mechanism requires overcoming interoperability constraints in Indonesia's social protection registries, where the National Health Insurance *(JKN/BPJS Kesehatan)* master-client index is strictly hardcoded to the Directorate General of Population and Civil Registration's (*Dukcapil*) Population Administration Information System *(Sistem Informasi Administrasi Kependudukan - SIAK)* database via the National Identification Number (NIK). To bridge this operational hurdle without disrupting existing national data infrastructure, we propose the integration of an Application Programming Interface (API)-driven 'bridging system' within the BPJS platform, aligning with the national interoperability mandate for public services (Presidential Regulation No. 39/2019) and the Electronic-Based Government System framework (Presidential Regulation No. 132/2022) (56,57). Activated directly through the unique registration number of a standardized Birth Notification Letter issued

by accredited health facilities, this provisional token would grant an immediate 'Provisional Humanitarian ID,' ensuring life-saving coverage for the infant during the critical neonatal window (14). This operational architecture is highly feasible within Indonesia's current digital landscape, as it directly leverages the API-first data exchange standards already scaled by the Ministry of Health's SATUSEHAT platform (58). We propose that this 'Conditional Humanitarian Enrollment' model operate as an intermediate holding account for a maximum of one year, granted under the legal condition that the village administration and local social workers enroll the underage parents into mandatory family counseling and multi-sectoral support programs aimed at preventing repeat rapid adolescent pregnancies and transitioning the family toward formal legal dispensation pathways. This mechanism mirrors global frameworks of 'presumptive eligibility' and humanitarian insurance that have been successfully utilized in low-resource settings to ensure universal newborn coverage (59,60). Ultimately, this legal safeguard ensures that the state prioritizes the infant's survival over administrative rigidities without implicitly reinforcing or normalizing underage marriage. By proposing this integrated digital and socio-legal bypass, this study helps address a critical policy gap, illustrating how the intersection of customary child marriage and legal identity exclusion creates a multi-layered matrix of systemic healthcare exclusion. This operational framework directly instantiates the 'structural-plus' approach required in low- and middle-income countries, which goes beyond mere financial subvention by integrating immediate access to health resources with transformative institutional protections (19). Ultimately, our qualitative material underscores that the primary obstacle for underage customary couples is fundamentally administrative rather than strictly financial. This contextual finding aligns with broader national assessments indicating that without overcoming institutional registration barriers, vulnerable populations remain excluded from the national health insurance scheme regardless of economic status (18).

Secondly, strengthening the health system involves mandating the implementation of youth-friendly services. Instead of copying standard adult care, these services must feature specific protocols to tackle the stigma and psychosocial needs unique to married adolescents. This aligns perfectly with the success of Yogyakarta's 'Unala' model (61), which proved that specialized, non-judgmental care markedly increases healthcare utilization among youth, including young married couples who often feel judged or alienated in standard maternal clinics.

Third, community mobilization should extend beyond the adolescents themselves to engage family gatekeepers, specifically husbands and mothers-in-law, in transforming restrictive social norms. Reflecting on the national 'Suami SIAGA' (Alert Husband) campaign (62), our study suggests that the gap lies not in the concept itself but in its penetration into local contexts. While the campaign offers a robust framework for male engagement, its core messages regarding advocacy and shared decision-making have failed to reach husbands in Munti Gunung. Consequently, their understanding of 'readiness' remains superficial, limited to logistical transport rather than meaningful partnership. Therefore, future interventions must be two-pronged: revitalizing 'Suami SIAGA' education to deepen husbands' accountability, while simultaneously involving mothers-in-law to ensure that this shift in male participation is culturally welcomed and supported.

Regarding future research, this study provides a foundational qualitative understanding of the "multilayered exclusion" faced by married adolescents and their newborns. To validate and build upon these findings, future studies should adopt a multi-level framework that directly aligns with our proposed strategic pillars. First, to support systemic reform, research should move beyond exploration to quantify the macroeconomic scale of 'administrative invisibility' via mixed-method studies and evaluate the legal and technical feasibility of implementing API-driven provisional registration pathways within national health and civil registries. Second, implementation research is urgently needed to assess the adaptability of youth-friendly service models in resource-constrained primary care settings, with a specific focus on the institutionalization of stigma-reduction protocols for frontline health workers. Third, behavioral intervention studies should rigorously evaluate family-centered curricula tailored for husbands and mothers-in-law to determine whether this two-pronged approach effectively shifts restrictive household decision-making dynamics and ultimately improves long-term adolescent maternal and neonatal health outcomes.

Strengths and Limitations

A key strength of this study is its multi-stakeholder approach. Integrating the voices of adolescents, husbands, mothers-in-law, and health providers enabled robust source triangulation. This ensured that structural barriers were analyzed through lived, clinical, and institutional lenses simultaneously.

Nevertheless, the study has limitations. First, as a qualitative case study in Munti Gunung, the results offer analytical transferability rather than statistical generalizability to all rural Indonesian contexts. Second, the sensitivity of child marriage and reproductive health may have caused social desirability bias. We addressed this through long-term rapport, rigorous reflexivity, and cross-verification of adolescent accounts with family and provider data. Third, our ethical choice to use the PedsQL™ distress screening meant that highly traumatized mothers could have been excluded to prioritize participant safety. Fortunately, no participants fell below the threshold, allowing us to safely capture the full spectrum of vulnerability. Finally, informal village workarounds, such as age adjustments, were documented indirectly through family accounts rather than through direct interviews with village leaders. Therefore, our framework cannot directly evaluate the subjective motivations, legal liabilities, or ethical dualities faced by local officials.

CONCLUSION

In conclusion, this study reveals the exact ways customary child marriage intersects with rigid civil registries. This intersection renders underage couples and their newborns 'administratively invisible,' forcing families to rely on delayed, symptom-driven emergency treatment rather than timely maternal and postnatal care. Furthermore, our findings show that administrative barriers do not operate in isolation; instead, they multiply existing structural inequities, worsening health disparities where deep poverty meets unyielding bureaucratic rules. Ultimately, while this single-site qualitative study cannot measure the

nationwide macroeconomic scale of Universal Health Coverage (UHC) gaps, it clearly demonstrates a critical systemic flaw. Therefore, future interdisciplinary research must urgently evaluate the feasibility of adaptive pathways, such as API-driven provisional enrollment, to decouple an infant's constitutional right to healthcare from their parents' marital status, without inadvertently normalizing child marriage.

DECLARATIONS

Author contributions: All authors contributed to the study's conceptualization and to the review and editing of the manuscript. DPYK, IMAW, PPJ, and NMSW designed the research methodology. DPYK and NLPRP were responsible for the investigation, data validation, software application, and formal analysis. DPYK drafted the original manuscript and managed the acquisition of funding from the Faculty of Medicine, Udayana University. IMAW. PPJ, NMSW, DKW, AASW, NMUD, and NWT supervised the study.

Conflicts of interest: The authors declare no potential conflicts of interest concerning the research, authorship, and/or publication of this article. All authors have read and approved the final version of the manuscript.

Declaration of Generative AI And AI-Assisted Technologies in the Writing Process: During the preparation of this work, the authors used Grammarly to improve the manuscript's readability and language quality. After using this tool, the authors reviewed and edited the content as needed and took full responsibility for the publication's content.

Source of Funding Statements: This work was supported by the Faculty of Medicine, Udayana University, under grant number (B/255.53/UN14.4.A/PT.01.03/2024). The funding agency had no role in the study design, data collection, analysis, and interpretation, the writing of the report, or the decision to submit the article for publication.

Acknowledgments: The authors gratefully acknowledge the support provided by Udayana University and the academic team during the preparation of this manuscript. We extend our deepest gratitude to all research participants from the Munti Gunung community for their time and willingness to share their lived experiences. Finally, we thank the local stakeholders who facilitated data collection.

REFERENCES

1. Nam JY, Oh SS, Park EC. The Association Between Adequate Prenatal Care and Severe Maternal Morbidity Among Teenage Pregnancies: A Population-Based Cohort Study. Front Public Health. 2022 May 31; 10:782143. https://doi.org/10.3389/fpubh.2022.782143
2. Jones N, Presler-Marshall E, Baird S, Luckenbill S, Seager J, Dileep S, et al. Child marriage and its consequences for adolescent mental health in conflict-affected contexts: evidence from Bangladesh, Ethiopia and Jordan. Vulnerable Child Youth Stud. 2025;20(3):307–28. https://doi.org/10.1080/17450128.2025.2467697
3. National Population and Family Planning Board (BKKBN), Statistics Indonesia (BPS), Ministry of Health (Kemenkes), ICF. Indonesia Demographic and Health Survey 2017. Jakarta: BKKBN, BPS, Kemenkes, and ICF; 2018. Available from: https://www.dhsprogram.com/publications/publication-FR342-DHS-Final-Reports.cfm
4. Rahayu A. Child Marriage and Its Impact in Indonesia in 2021. Journal of International Conference Proceedings. 2022 Dec 24;5(5):112-124. https://doi.org/10.32535/jicp.v5i5.1977
5. Kementerian Kesehatan Republik Indonesia. Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.01.07/MENKES/320/2020 Tentang Standar Profesi Bidan (Pedoman Pelayanan Antenatal Terpadu). Jakarta: Kementerian Kesehatan RI; 2020. Available from: https://repositori-ditjen-nakes.kemkes.go.id/294/
6. Kementerian Kesehatan Republik Indonesia. Peraturan Menteri Kesehatan No 21 Tahun 2021 tentang Penyelenggaraan Pelayanan Kesehatan Masa Sebelum Hamil, Masa Hamil, Persalinan dan Masa Sesudah Melahirkan, Pelayanan Kontrasepsi dan Pelayanan Kesehatan Seksual. Jakarta: Kementerian Kesehatan RI; 2021. Available from: https://peraturan.bpk.go.id/permenkes-no-21-tahun-2021
7. Gayatri RV, Hsu YY, Damato EG. Utilization of Maternal Healthcare Services among Adolescent Mothers in Indonesia. Healthcare (Basel). 2023 Mar 1;11(5):678. https://doi.org/10.3390/healthcare11050678
8. Kartika, Rukmini SD, Haksama S, Ismuntania, Rakhman F. Determinant factors of antenatal care used by pregnant women in Indonesia: A systematic review. African Journal of Reproductive Health. 2024;28(10s):26–238. https://doi.org/10.29063/ajrh2024/v28i10s.27
9. Presiden Republik Indonesia. Undang-Undang Republik Indonesia Nomor 17 tahun 2023 Tentang Kesehatan. Jakarta: Sekretariat Negara; 2023. Available from: https://peraturan.bpk.go.id/uu-no-17-tahun-2023
10. United Nations High Commissioner for Human Rights. Strengthening a child rights-based approach in the work of United Nations. Geneva: OHCHR; 2024. Available from: https://www.ohchr.org/sites/default/files/documents/issues/children/mainstreaming/Guidance-Note-Child-Rights-Mainstreaming.pdf
11. Yunitasari E, Matos F, Zulkarnain H, Kumalasari DI, Kusumaningrum T, Putri TE, et al. Pregnant woman awareness of obstetric danger signs in developing country: systematic review. BMC Pregnancy Childbirth. 2023 Dec 1;23(1):336. https://doi.org/10.1186/s12884-023-05674-7
12. Kistiana S, Fajarningtiyas DN, Riany YE. Assessing Child Marriage in Indonesia: A Call for Educational Empowerment. Jurnal Kesehatan Masyarakat (Kemas). 2025;20(3):512–22. https://doi.org/10.15294/kemas.v20i3.14145
13. Presiden Republik Indonesia. Peraturan Presiden Republik Indonesia No 82 tahun 2018 Tentang Jaminan Kesehatan. Jakarta: Sekretariat Negara; 2018. Available from: https://peraturan.bpk.go.id/perpres-no-82-tahun-2018
14. Bappenas, PUSKAPA, UNFPA. Marriage Registration and Child Marriage in Indonesia: Background and Objectives. Jakarta: PUSKAPA UI; 2023. Available from: https://puskapa.org/assets/uploads/2025/12/Quantitative-ENG-PUSKAPAs-study-on-CRVS-Gender.pdf
15. PUSKAPA UI. Seeking Recognition: Child Marriage Registration amid Religious and Customary Pathways (Executive Summary). Jakarta: PUSKAPA UI; 2021. Available from: https://indonesia.unfpa.org/sites/default/files/pub-pdf/2025-12/
16. Mulyanto J, Kringos DS, Kunst AE. Socioeconomic inequalities in healthcare utilisation in Indonesia: A comprehensive survey-based overview. BMJ Open. 2019 Jul 24;9(7): e026164. https://doi.org/10.1136/bmjopen-2018-026164
17. Soewondo P, Johar M, Pujisubekti R. Akses Pelayanan Kesehatan Keluarga Berstatus Ekonomi Rendah di Era JKN. Jurnal Ekonomi dan Pembangunan Indonesia. 2021 Jan 1;21(1):108–24. https://doi.org/10.21002/jepi.2021.08
18. Mulyanto J, Dartanto T, Usman FR, Siregar CH, Bintara H, Pramono WP. Expanding Universal Health Coverage in the Presence of Informality in Indonesia: Challenges and Policy Implications. LPEM FEB UI Working Paper. 2015. Available from: https://www.lpem.org/repec/lpe/papers/201511.pdf
19. Kurniati DPY, Januraga PP, Wulanyani NMS, Wati DK, Sawitri AAS, Dwipayanti NMU, et al. Community-Based Interventions for Preventing Child Marriage in Low- and Middle-Income Countries: A Systematic Review. Asia-Pacific Journal of Public Health. 2026;38(2):114-127. https://doi.org/10.1177/10105395261437254
20. Nuharta P, Pratiwi S, Fedryansyah M, Nurwati N. Perubahan sosial pada masyarakat Dusun Munti Gunung: Dari mekurup, menggepeng, hingga kembangkan potensi wisata. Focus: Jurnal Pekerjaan Sosial. 2024;6(2):168-177. Available from: https://jurnal.unpad.ac.id/sosioglobal/article/view/51384
21. Chowdhury A, Shil NC. Thinking 'Qualitative' Through a Case Study: Homework for a Researcher. American Journal of Qualitative Research. 2021 Nov 5;5(2):190–210. https://doi.org/10.29333/ajqr/11280

22. Lim WM. What Is Qualitative Research? An Overview and Guidelines. Australasian Marketing Journal. 2025 May 1;33(2):199–229. https://doi.org/10.1177/14413582241264619
23. Pourtaheri A, Mahdizadeh M, Tehrani H, Jamali J, Peyman N. Socio-ecological factors of girl child marriage: a meta-synthesis of qualitative research. BMC Public Health. 2024 Dec 1;24(1):378. https://doi.org/10.1186/s12889-023-17626-z
24. Yakub H. A Theoretical Framework for Social Norms in Child Marriage: Parents' Lived Experience in Decision-Making in Sub-Saharan Africa. Universal Library of Medical and Health Sciences. 2024 Apr 20;2(1):22–31. https://doi.org/10.70315/uloap.ulmhs.2024.0201002
25. Bicchieri C, Lindemans J. A Social Norms Perspective on Child Marriage: The General Framework. Philadelphia: University of Pennsylvania/UNICEF; 2014. Available from: https://www.researchgate.net/publication/316698124
26. Koçak A, Mouratidis A. When Are You Going to Marry? Intention to Marry through the Lens of Theory of Planned Behavior and Self-Regulatory Focus. Turkish Psychological Counseling and Guidance Journal. 2024 Mar 29;14(72):48–62. https://doi.org/10.17066/tpdrd.1251530_4
27. Tong A, Sainsbury P, Craig J. Consolidated criteria for Reporting Qualitative research Checklist (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007 Dec;19(6):349–57. https://doi.org/10.1093/intqhc/mzm042
28. Kusumaningrum S, Agastya NLPM, Pratama G, Adhi AA, Sari RK, Rizal T, et al. Pencegahan Perkawinan Anak untuk Perlindungan Berkelanjutan Bagi Anak. Jakarta: PUSKAPA UI; 2023. Available from: https://puskapa.org/assets/uploads/2023/04/Policy-Brief-_Pencegahan-Perkawinan-Anak.pdf
29. Varni JW, Seid M, Kurtin PS. PedsQL 4.0: Reliability and Validity of the Pediatric Quality of Life Inventory Version 4.0 Generic Core Scales in healthy and patient Populations. Med Care. 2001 Aug;39(8):800–12. https://doi.org/10.1097/00005650-200108000-00006
30. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52(4):1893–907. https://doi.org/10.1007/s11135-017-0574-8
31. Nowell LS, Norris JM, White DE, Moules NJ. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. Int J Qual Methods. 2017 Sep 28;16(1):1-13. https://doi.org/10.1177/1609406917733847
32. Jnanathapaswi SG. Thematic Analysis & Coding: An Overview of the Qualitative Paradigm. Figshare; 2021. https://doi.org/10.6084/m9.figshare.17159249
33. Nurfieni A. The Impact of Law Number 16 Of 2019 Marriage Dispensation and Child Marriage Gap. Indonesian Journal of Law and Islamic Law (IJLIL). 2023 Dec 24;5(2):50–61. https://doi.org/10.35719/ijlil.v5i2.330
34. Chusnida NL, Anggriawan TP. Dispensation of Marriage in The Perspective of Children's Rights: Best Interest of The Children. Jurnal Penelitian Hukum De Jure. 2022 Sep 30;22(3):295-310. https://doi.org/10.30641/dejure.2022.v22.295-310
35. Presiden Republik Indonesia. Undang-Undang Republik Indonesia No 16 Tahun 2019 Tentang Perkawinan. Jakarta: Sekretariat Negara; 2019. Available from: https://peraturan.bpk.go.id/uu-no-16-tahun-2019
36. Fajriyah IMD, Marhamah S, Anggriani DS. The Pitfall of Child Marriage Dispensation: A Study of Court Judgments in East Java. Indonesian Journal of Socio-Legal Studies. 2023;2(2):120-135. https://doi.org/10.54828/ijsls.2023v2n2.5
37. Presiden Republik Indonesia. Undang-Undang Republik Indonesia Nomor 24 Tahun 2013 Tentang Administrasi Kependudukan. Jakarta: Sekretariat Negara; 2013. Available from: https://peraturan.bpk.go.id/uu-no-24-tahun-2013
38. Titaley CR, Dibley MJ, Roberts CL. Factors associated with underutilization of antenatal care services in Indonesia: results of Indonesia Demographic and Health Survey 2002/2003 and 2007. BMC Public Health. 2010 Aug 17; 10:485. https://doi.org/10.1186/1471-2458-10-485
39. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. PLoS Medicine. 2006 Oct;3(10): e449. https://doi.org/10.1371/journal.pmed.0030449.
40. Bosnjak M, Ajzen I, Schmidt P. The theory of planned behavior: Selected recent advances and applications. Europe's Journal of Psychology. 2020 Aug 31;16(3):352–6. https://doi.org/10.5964/ejop.v16i3.3107
41. Asari AA, Birhanu Z, Godesso A. Adolescents' health literacy perspectives and implications. BMC Public Health. 2025 Dec 1;25(1):441. https://doi.org/10.1186/s12889-025-22341-y
42. Baharvand P, Anbari K, Abdolian M. Health Literacy and Its Predictors Among Pregnant Women: A Cross-sectional Study. Journal of Education and Community Health. 2022 Sep 1;9(3):170–5. https://doi.org/10.34172/jech.2022.25
43. Suryaningsih EK, Wu SF, Yan XY, Lin HR. Indonesian mother's feeling and thought during pregnancy: a qualitative study. Journal of Health Technology Assessment in Midwifery. 2018 Nov 30;1(2):57–63. https://doi.org/10.31101/jhtam.606
44. Sumariati. Hubungan dukungan suami dengan kunjungan antenatal care pada ibu hamil. Jurnal Kebidanan. 2025;14(1):32-45. Available from: https://ejournal.poltekkes-denpasar.ac.id/index.php/JUK
45. Untari J, Nugroho A. Qualitative study of family support for women's health seeking-behaviour in rural areas district Sleman. Jurnal Kesehatan Masyarakat. 2024;19(2):88-97. Available from: https://www.researchgate.net/publication/345369300
46. Ayuandini S, Habito M, Ellis S, Kennedy E, Akiyama M, Binder G, et al. Contemporary pathways to adolescent pregnancy in Indonesia: A qualitative investigation with adolescent girls in West Java and Central Sulawesi. PLOS Global Public Health. 2023 Oct 1;3(10):e0001700. https://doi.org/10.1371/journal.pgph.0001700
47. Corley AG, Sprockett A, Montagu D, Chakraborty NM. Exploring and Monitoring Privacy, Confidentiality, and Provider Bias in Sexual and Reproductive Health Service Provision to Young People: A Narrative Review. International Journal of Environmental Research and Public Health. 2022 Jun 1;19(11):6576. https://doi.org/10.3390/ijerph19116576
48. Souvatzi E, Katsikidou M, Arvaniti A, Plakias S, Tsiakiri A, Samakouri M. Trust in Healthcare, Medical Mistrust, and Health Outcomes in Times of Health Crisis: A Narrative Review. Societies. 2024 Dec;14(12):269. https://doi.org/10.3390/soc14120269
49. Horii H, Wirastri TD. Living in a Legal Limbo: Mechanisms to "Fix" The Legal and Social Positions of Unregistered Children in Indonesia. Indonesian Journal of Socio-Legal Studies. 2022;2(1):45-62. https://doi.org/10.54828/ijsls.2022v2n1.1
50. Laksono AD, Wulandari RD, Soedirham O. Regional Disparities of Health Center Utilization in Rural Indonesia. Malaysian Journal of Public Health Medicine. 2019;19(1):158-166. Available from: https://mjphm.org/index.php/mjphm/article/view/48
51. Abdul Mahsyar. Coping Behaviors Oleh Street Level Bureaucrats Dalam Pelayanan Kesehatan Masyarakat di Kota Makassar. Jurnal Otoritas. 2013;3(2):104-115. Available from: https://repository.unhas.ac.id/id/eprint/7801/
52. Hegdahl HK, Musonda P, Svanemyr J, Zulu JM, Grønvik T, Jacobs C, et al. Effects of economic support, comprehensive sexuality education and community dialogue on sexual behaviour: Findings from a cluster-RCT among adolescent girls in rural Zambia. Soc Sci Med. 2022 Aug 1; 306:115125. https://doi.org/10.1016/j.socscimed.2022.115125
53. Okonofua F, Ntoimo LF, Yaya S, Igboin B, Solanke O, Ekwo C, et al. Effect of a multifaceted intervention on the utilisation of primary health for maternal and child health care in rural Nigeria: A quasi-experimental study. BMJ Open. 2022 Feb 8;12(2):e049499. https://doi.org/10.1136/bmjopen-2021-049499.
54. Presiden Republik Indonesia. The 1945 Constitution of the Republic of Indonesia. Jakarta: Sekretariat Negara; 1945. Available from: https://peraturan.bpk.go.id/
55. Presiden Republik Indonesia. Undang-Undang Republik Indonesia No 35 Tahun 2014 Tentang Perlindungan Anak. Jakarta: Sekretariat Negara; 2014. Available from: https://peraturan.bpk.go.id/uu-no-35-tahun-2014
56. Presiden Republik Indonesia. Peraturan Presiden Republik Indonesia Nomor 132 Tahun 2022 Tentang Arsitektur Sistem Pemerintahan Berbasis Elektronik Nasional. Jakarta: Sekretariat Negara; 2022. Available from: https://peraturan.bpk.go.id/perpres-no-132-tahun-2022
57. Presiden Republik Indonesia. Peraturan Presiden Republik Indonesia No 39 Tahun 2019 Tentang Satu Data Indonesia. Jakarta: Sekretariat Negara; 2019. Available from: https://peraturan.bpk.go.id/perpres-no-39-tahun-2019
58. Zamroni SA, Sulistiadi W. Analisis Implementasi SATUSEHAT sebagai Platform Integrasi Data Kesehatan Nasional: Literature Review. Jurnal Kesehatan Masyarakat. 2024;10(2):145-156. Available from: https://kemkes.go.id/

59. Dzakpasu S, Powell-Jackson T, Campbell OMR. Impact of user fees on maternal health service utilization and related health outcomes: A systematic review. Health Policy and Planning. 2014 Feb;29(2):137–50. https://doi.org/10.1093/heapol/czs142
60. Ottersen T, Norheim OF. Making fair choices on the path to universal health coverage. Bulletin of the World Health Organization. 2014 Jun;92(6):389. https://doi.org/10.2471/BLT.14.139139
61. Nurgiyanti T, Solihah Amini D, Sinta Rizka Aisya F, Moni Hamakonda A. Unala Attempt In Realizing the Third Sdgs (Well-Being and Health) For Women in the Special Region of Yogyakarta. Jurnal Kesehatan Reproduksi. 2023;9(2):75-84. Available from: https://www.proceedings.asteec.com/index.php/acp-ss/article/download/86/153
62. Kurniati A, Chen CM, Efendi F, Elizabeth Ku LJ, Berliana SM. Suami SIAGA: Male engagement in maternal health in Indonesia. Health Policy Plan. 2017 Oct 1;32(8):1203–11. https://doi.org/10.1093/heapol/czx073