MASALAH-MASALAH HUKUM
p-ISSN : 2086-2695 e-ISSN : 2527-4716

MASALAH-MASALAH HUKUM
Available online on https://ejournal.undip.ac.id/index.php/mmh/
Volume 55, Issue 1, March 2026

REPRODUCTIVE JUSTICE AND WOMEN'S HEALTH RIGHTS IN INDONESIA: BETWEEN LEGAL PROTECTION AND STRUCTURAL INEQUALITY

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Abstract

Women's reproductive health rights constitute a fundamental component of human rights, imposing an obligation on the state to respect, protect, and fulfill women's health rights in a fair, equal, and non-discriminatory manner. This study aims to analyze the legal protection of women's reproductive health rights in Indonesia from legal and human rights perspectives, with particular reference to Law Number 17 of 2023 concerning Health and Government Regulation Number 28 of 2024. This research employs a socio-legal method with a descriptive-analytical approach, supported by library research and policy analysis. The data consist of primary, secondary, and tertiary legal materials, including statutory regulations, academic literature, human rights instruments, and relevant policy documents, which are analyzed qualitatively through deductive reasoning. The findings indicate that Indonesia has developed a relatively progressive legal framework through the strengthening of reproductive rights, the expansion of maternal healthcare services, protection against discrimination and violence, and the recognition of women's reproductive autonomy. However, the implementation of these legal protections continues to face significant structural challenges. These include the unequal distribution of healthcare workers, limited healthcare infrastructure in remote and disadvantaged areas, socio-cultural barriers rooted in patriarchal norms, insufficient reproductive health education, and weak state accountability mechanisms in ensuring equal access to healthcare services. Furthermore, normative ambiguities concerning religious and moral values in the regulation of reproductive rights may potentially restrict women's autonomy and create uncertainty in service delivery. The study argues that the protection of women's reproductive health rights cannot rely solely on formal legal recognition, but must also be supported by effective implementation, institutional responsiveness, and substantive equality. Therefore, strengthening legal protection requires harmonization between national and regional policies, reinforcement of a human rights-based and gender-responsive approach, and improvement of equitable, accessible, and accountable healthcare services for women throughout Indonesia.

Keywords: Women's Reproductive Health; Human Rights; Legal Protection; Health Law; Gender Equality.

A. Introduction

Women's health constitutes a major concern within the discourse of law and human rights. Compared to men, women are more vulnerable to both communicable and non-communicable diseases due to intersecting biological, social, and economic factors. In Indonesia, persistent health issues include malnutrition among pregnant women and infants, high maternal mortality rates, health problems among adolescents and women of reproductive age, and limited access to healthcare services (Cini et al., 2023). At both national and global levels, women's health has

increasingly become a complex and unresolved issue influenced by armed conflict, natural disasters, poverty, socio-economic disparities, and entrenched traditional practices.

According to Indonesia's Ministry of Health, 4,150 maternal deaths were recorded in 2024. Although approximately 96% of childbirths were assisted by skilled health personnel and Indonesia has around 362,000 registered midwives supported by professional organizational networks extending to regional levels, this substantial workforce has not yet resulted in the equitable distribution of maternal healthcare services. This condition indicates that the healthcare system has not fully guaranteed women's right to safe, high-quality, and equitable healthcare services, particularly for women living in remote areas and those belonging to vulnerable groups (Komnas Perempuan, 2026). In Indonesia, one woman dies every hour due to complications during pregnancy, delivery, and postnatal period. Maternal mortality therefore remains a major public health concern, with a Maternal Mortality Ratio (MMR) reaching 189 deaths per 100,000 live births (Long Form Population Census, 2020). Access to quality maternal health services is essential to reducing preventable maternal deaths (Direktorat Jenderal Sumber Daya Manusia Kesehatan Kemenkes RI, 2025).

Table 1.
Number of Maternal Deaths by Cause in Indonesia in 2023

No	Cause of Death	Number of Deaths
1	Others	2.825
2	Hypertension in Pregnancy	412
3	Obstetric Hemorrhage	360
4	Other Obstetric Complications	204
5	Infection	86
6	Complications of Abortion	45
7	Complications Related to Anesthesia/Therapy Management	43
8	Non-Obstetric Complications	19

Source: Directorate General of Public Health, Ministry of Health of the Republic of Indonesia, 2024.

Referring to the Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family, Indonesia has reaffirmed its commitment to strengthening the health sector, particularly through the provision of quality healthcare services for women and children (World Health Organization, 2022). Women's health has consequently become one of the primary priorities within the 2020–2024 National Medium-Term Development Plan. The declaration emphasizes the importance of ensuring equitable and non-discriminatory healthcare services for women while recognizing the strategic role of the family in promoting public health and social well-being (Hardaningtyas et al., 2025). Nevertheless, women's access to healthcare services remains a pressing issue that requires comprehensive legal and policy interventions, including expanded access to healthcare facilities and broader health insurance coverage.

Within the field of health, feminism pays particular attention to women's reproductive health. Although feminist perspectives emphasize equality between women and men, they also acknowledge the biological distinctions between the female and male body. Consequently, many feminists critique the tendency of the medical profession to medicalize women's natural biological processes, including menstruation, childbirth, breastfeeding, and menopause, by construing them as pathological conditions rather than as normal stages within women's life cycles (Shai et al., 2021). Feminism is commonly defined as an ideology that challenges gender stratification and patriarchal domination. Feminist movements aim to advance justice, fairness, and gender equality, thereby fostering a social structure in which women and men occupy equal positions in all spheres of life (Ashraf, 2025).

In a global health policy, power dynamics and intersectionality continue to place women in vulnerable positions with regard to inequities in access, healthcare services, and decision-making

processes. Although feminist approaches in foreign policy and development have gained increasing attention, feminist perspectives within global health policy have not yet been implemented adequately. Consequently, various issues related to women's health remain insufficiently accommodated in both the formulation and implementation of health policies (Eger et al., 2024).

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) serves as a fundamental international instrument for the protection of women's rights. Unlike other human rights instruments, CEDAW specifically focuses on the promotion and protection of women's human rights across multiple dimensions of social, political, economic, and cultural life (Orta, 2025). The convention is grounded in the recognition that structural gender inequality and patriarchal systems continue to shape discriminatory practices against women globally. Accordingly, CEDAW addresses various forms of discrimination that result in violations of women's human rights and insufficient legal protection (Vijeyarasa, 2021).

Women's sexual and reproductive health constitutes an integral component of human rights and encompasses a broad range of rights as well as corresponding state obligations. The protection and fulfillment of women's sexual and reproductive health rights therefore represent essential responsibilities of the state (Hellum, 2021). Such efforts are not only necessary to safeguard women's welfare and fundamental rights, but also to promote the development of a more just, inclusive, and equitable society (Lwamba et al., 2022). In this regard, the state is required to actively respect, protect, and fulfill these rights through comprehensive legislation, accessible and high-quality healthcare services, and adequate public education (Nampewo et al., 2022).

Violations of women's reproductive rights are frequently rooted in patriarchal social norms and discriminatory perceptions regarding female sexuality and women's roles within the family. Women are often perceived primarily to their reproductive functions, resulting in harmful practices such as early marriage, repeated pregnancies, and inadequate birth spacing, frequently driven by cultural preferences for male children. These practices have detrimental and, in some cases, fatal consequences for women's physical and mental health. In addition, women are often blamed for infertility and subjected to social exclusion, stigma, and other forms of human rights violations (Loza, 2022).

One of the most significant reproductive health issues affecting women is unsafe abortion, which continues to be a major contributor to maternal mortality and morbidity. Ensuring the availability of safe and accessible abortion services therefore constitutes an essential aspect of the state's obligation to protect women's right to life and health during pregnancy (Ara et al., 2022). In addition to structural limitations, barriers to the fulfillment of women's health rights are also reinforced by patriarchal socio-cultural values that restrict women's autonomy over their bodies and reproductive choices (Ramelan et al., 2025). Practices such as child marriage, repeated pregnancies without safe birth spacing, and stigmatization related to infertility and abortion demonstrate that women's health issues are inseparable from unequal power relations and gender-based discrimination (Yundianto et al., 2026).

Under international human rights law, states have an obligation to respect, protect, and fulfill human rights related to maternal health, pregnancy, and childbirth. Preventable maternal deaths therefore reflect the failure of states to fulfill their fundamental human rights obligations. To guarantee women's right to life and health, the state must ensure the availability, accessibility, acceptability, and quality of sexual and reproductive healthcare services, including affordable and equitable access for vulnerable groups (Beninger, 2021).

The implementation of a human rights–based approach to maternal mortality and morbidity requires the examination of preventable deaths and injuries through the lens of equality and non-discrimination principles. This approach also necessitates an assessment of state obligations under international human rights law, as well as the identification of gaps in legal protection, public participation, and institutional accountability. Through this framework, governments are better

positioned to identify and reach marginalized groups of women who continue to experience limited access to healthcare services (Patterson, 2024).

In this regard, an intersectionality approach to women's health emphasizes that women's biological vulnerability cannot be separated from social factors such as poverty, race, ethnicity, and geographical location. Women from marginalized groups often encounter multiple and overlapping barriers in accessing reproductive healthcare services, ranging from discrimination to economic constraints. This condition demonstrates that women's health issues cannot be understood solely through a single dimension, such as gender or poverty alone (Crenshaw, 2013b).

The failure of healthcare systems to address these vulnerabilities is closely related to policies that remain universalistic and insufficiently responsive to intersectional experiences. In line with the perspective of Kimberlé Crenshaw (2013a), women should not be regarded as a homogeneous group, as their experiences of discrimination are shaped by multiple intersecting social identities. Therefore, health policies need to be designed in a more inclusive and responsive manner to accommodate the specific needs of women from diverse social backgrounds.

Women's health in Indonesia continues to face profound structural challenges, particularly as a consequence of the unequal distribution of healthcare personnel. The availability of midwives, obstetricians, and other specialized medical professionals remains heavily concentrated in Java and major urban areas, while remote regions, archipelagic areas, and eastern Indonesia experience severe shortages of healthcare personnel (Badan Kebijakan Pembangunan Kesehatan, 2024). This condition has left many women in these areas without adequate access to essential healthcare services, including antenatal care, safe delivery assistance, early screening for cervical and breast cancer, and reproductive health counseling (Antara, 2024). The unequal distribution of healthcare personnel has consequently contributed to persistently high rates of maternal and infant mortality rates, low immunization coverage, and limited contraceptive use, further exacerbating regional disparities in women's quality of life (World Health Organization, 2025).

These regional disparities are further exacerbated by the uneven development of healthcare infrastructure. Many community health centers and hospitals in underdeveloped regions remain inadequately equipped with basic medical facilities and technologies, such as ultrasonography (USG) machines, incubators, blood banks, and adequate emergency obstetric care services, resulting in frequent delays in referral processes and increased risks to patient safety (Shafira et al., 2025). In addition, limited transportation access, poor road conditions, inadequate electricity and clean water supply, as well as weak health information systems, continue to hinder preventive and promotive healthcare efforts for women, including maternal nutrition programs, stunting prevention initiatives, and the early detection of non-communicable diseases. The combination of shortages in healthcare personnel, fragile healthcare infrastructure, and interregional disparities has created a cycle of structural vulnerability that obstructs Indonesian women, particularly those living in marginalized areas, from fully exercising their fundamental right to healthcare services (World Health Organization, 2025).

Previous studies concerning the protection of women's health and the state's obligations to respect, protect, fulfill, and restore the right to health have often demonstrated limited effectiveness in practice due to the absence of clearly defined duty bearers responsible for ensuring the implementation of these rights (Bustreo et al., 2022). Moreover, racial and ethnic disparities in women's healthcare access have persisted for decades despite continuing efforts to improve reproductive health services (Sutton et al., 2021). The COVID-19 pandemic further intensified patriarchal repression globally, as reflected in increased gender-based violence, disproportionate employment losses among women, deteriorating working conditions, declining access to healthcare and reproductive rights, and growing resistance toward feminist movements and gender equality initiatives (Brysk, 2023). Another study examines the semiotic construction of prostitution within the contexts of law, power relations, and public health in Indonesia. Drawing upon the theory of power relations developed by Michel Foucault, the study investigates how

dominant legal narratives construct representations of women involved in prostitution through moralistic and criminalizing approaches (Natalis, 2025). Similarly, it is also found multiple layers of vulnerability experienced by women with vaginismus, resulting both from painful medical conditions and from inadequate legal protection (Hardiyanti et al., 2025). Another review identifies gender norms as one of the primary barriers affecting women's access to education and sexual and reproductive healthcare services (Ouahid et al., 2025). Another study emphasizes the importance of providing high-quality and inclusive sexual and reproductive healthcare services, accompanied by efforts to prevent violence against women and control non-communicable diseases, such as obesity (Carneiro, 2024). Finally, previous studies indicate that reproductive health plays a significant role in supporting women's mental health and overall well-being. Violations of reproductive rights, including limited access to healthcare services and the lack of gender-responsive mental health services, may result in long-term negative impacts on women's mental health (Howard et al., 2025).

Existing scholarship has generally approached women's health from medical and public health policy perspectives. While previous studies have emphasized medical, social, and economic factors contributing to high maternal mortality rates and limited access to reproductive healthcare, only a limited number of studies have comprehensively incorporated legal and human rights perspectives into analyses of state obligations concerning the fulfillment of women's reproductive health rights. Accordingly, this study seeks to contribute to the existing literature by reconceptualizing women's reproductive health as an issue of human rights fulfillment and state legal responsibility.

Despite various legal and policy initiatives, substantial disparities in healthcare access persist, particularly among economically disadvantaged women and those residing in remote and underdeveloped regions. This condition is reflected in the continuing challenges associated with educing maternal mortality rates among vulnerable populations. Consequently, strengthening legal protection and ensuring equitable healthcare access for women remain essential components of the state's obligations under both national and international human rights frameworks.

The novelty of this research lies in its examination of women's reproductive health through an integrated legal and human rights framework rather solely from medical and public health perspectives. This legal-human rights approach provides a normative foundation for strengthening state responsibility in protecting women's health rights. Accordingly, this article aims to analyze the relationship between law, human rights, and the protection of women's reproductive health in Indonesia.

B. Method

This study employed a socio-legal approach, which views law not merely as a set of written norms, but also as a social phenomenon shaped and practiced within society. This approach was adopted to examine the gap between the normative guarantees of women's reproductive health rights in Indonesia and the realities of their implementation. The legal analysis was grounded in national legal frameworks, particularly Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia, Law Number 17 of 2023 concerning Health, and its implementing regulations. From a human rights perspective, this study referred to international instruments, especially the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), both of which recognize reproductive health as an integral part of women's fundamental rights. To strengthen the critical dimension of the analysis, this research also incorporated feminist legal methods as developed by Katharine T. Bartlett (2018) and Rosemary Hunter (2019). In particular, these approaches were utilized to uncover gender-biased assumptions embedded within ostensibly neutral legal norms and to reveal the differential impacts of reproductive health policies on women from diverse social backgrounds.

This research relied on secondary data obtained through a systematic and staged library research process. Primary legal materials included relevant legislation and regulations, ranging from the 1945 Constitution, Law Number 17 of 2023 concerning Health, Government Regulation Number 28 of 2024 concerning Health, to Minister of Health Regulation Number 2 of 2025 on Women's Health. Secondary legal materials consisted of national and international scholarly journal articles, books on legal and socio-legal theories, as well as reproductive health policy documents issued by ministries and related institutions. The literature search was conducted systematically through legal databases, university library catalogs, and scientific repositories using relevant keywords, particularly those related to socio-legal approaches to women's reproductive health issues in Indonesia.

The collected data were qualitatively analyzed using a deductive reasoning method, in which specific conclusions were derived from general premises grounded in legal norms and human rights principles. The analytical process began with the identification of positive legal norms and universal human rights principles, followed by an assessment of policy data and documented social realities presented in the literature. Within this framework, the feminist approach functioned as a critical lens through which to examine gender-based power relations and the asymmetrical impacts of reproductive health policies on women. Through this approach, the study not only produced a doctrinal legal analysis but also offered a transformative perspective in formulating legal protections that are more responsive to gender justice.

C. Results and Discussion

1. The Reality of Reproductive Rights Fulfillment: Data and Facts

The fulfillment of women's reproductive rights in Indonesia constitutes a multidimensional issue that intersects with health, social, and legal dimensions within a complex framework. Recent data and empirical evidence demonstrate that significant challenges continue to persist, while also indicating notable progress in regulatory reforms and programmatic achievements.

One of the primary pillars of reproductive rights fulfillment is access to safe and affordable contraception. Data from the National Population and Family Planning Agency showed that the prevalence of modern contraceptive use in Indonesia reached 62.92 percent in 2023 and was projected to increase to 63.41 percent in 2024. Meanwhile, the unmet need for family planning was recorded at 7.70 percent in 2023, with a target reduction to 7.40 percent in 2024. This target is particularly significant because couples of reproductive age who no longer wish to have children but are unable to access contraception may contribute to accelerated population growth (Direktorat Pelaporan dan Statistik Kementerian Kependudukan dan Pembangunan Keluarga, 2024).

Reproductive and sexual health services for women and adolescent girls in Indonesia continue to encounter significant structural barriers, making these services difficult to access and insufficiently prioritized within public policy frameworks. In various contexts, including disaster situations, the demand for reproductive health services substantially increases. Nevertheless, findings from the National Commission on Violence Against Women in refugee and evacuation areas such as Aceh, Nias, Yogyakarta, Porong, East Nusa Tenggara, Maluku, and Poso indicated that reproductive and sexual health services remained severely limited. Women in these displacement settings often lost access to privacy and became increasingly vulnerable to violations of bodily autonomy and sexual rights. Married couples, for instance, were frequently deprived of private spaces for intimate relations, while pregnant women and mothers lacked adequate facilities that ensure privacy, dignity, and safety during pregnancy and childbirth (Murdijana et al., 2019).

Although the government has allocated budgets and implemented numerous reproductive health programs, their impact on women's lives remains limited. This condition reflects the government's failure to identify structural barriers that hinder women and adolescent girls from accessing available health services. Consequently, many well-intentioned initiatives remain

ineffective because they are not accompanied by adequate efforts to address the structural discrimination and gender-based inequalities that constitute the root causes of these problems.

The urgency of strengthening women's health systems has also been highlighted by the Minister of Women's Empowerment and Child Protection, who stated that women constitute approximately 49.6 percent of Indonesia's total population, or around 142 million people in the first semester of 2025. Therefore, the quality of women's health directly influences the quality of national human resources. Although progress has been made in improving women's health indicators, the challenges remain highly complex. Indonesia's Maternal Mortality Rate (MMR) has declined; however, it remains the third highest in ASEAN, indicating the need for more comprehensive policy interventions. Furthermore, cervical cancer cases reach approximately 36,000 annually, a condition closely associated with low screening coverage and limited public awareness regarding vaccination (Kementerian Pemberdayaan Perempuan dan Perlindungan Anak, 2026).

At the same time, the 2025 Annual Record (CATAHU) of Komnas Perempuan documented 330,097 cases of gender-based violence against women in 2024, representing a 14.17 percent increase compared to the previous year. The majority of victims were women aged 18–24 years, while perpetrators predominantly belonged to productive and older age groups. These findings underscore the urgent need to strengthen recovery and support services for women survivors of violence as part of the state's obligation to ensure the rights to safety, health, and dignified recovery (Komnas Perempuan, 2025a).

Various indicators further demonstrate the persistent vulnerability of women's reproductive health in Indonesia. The 2024 Indonesian Gender Inequality Index reported that maternal mortality remained alarmingly high, reaching 4,150 deaths, far exceeding the target established in the 2024 National Medium-Term Development, namely 183 deaths per 100,000 live births. Additionally, Statistics Indonesia data from 2024 indicated that women report higher rates of health complaints (12.81 percent) than men (11.42 percent). Other persistent challenges included high rates of unintended pregnancies contributing to unsafe abortion practices, the continued practice of female genital mutilation/cutting (FGM/C), and limited healthcare services for survivors of sexual violence, many of which were not fully covered by the national health insurance scheme (Komnas Perempuan, 2025a).

Reproductive health problems are also experienced by women workers. The implementation of reproductive health rights protection within workplaces continues to demonstrate numerous violations. A 2023 survey conducted by Gajimu.com revealed that 32 companies failed to provide full wages during maternity leave, 8.8 percent of women workers did not receive the legally mandated three-month maternity leave, and several workers experienced dismissal as a consequence of taking maternity leave. Furthermore, 31.6 percent of women workers were not provided with breastfeeding breaks, 64 companies failed to provide lactation rooms, and 26.5 percent of male workers did not receive full wages during paternity leave (Komnas Perempuan, 2025b).

Komnas Perempuan also documented multiple complaints regarding violations of reproductive health rights among women workers during the 2020–2024 period. The most common forms of violations included deductions or denial of menstrual and maternity leave rights, as well as discrimination against pregnant workers through transfers, demotions, and dismissals. Many companies continued to fail to provide basic maternity facilities such as lactation rooms and childcare services, while the reproductive health rights of informal workers were frequently neglected. In addition, workplace sexual harassment and violence were often inadequately addressed, further undermining women workers' reproductive health rights. Gender bias and structural discrimination remained deeply entrenched, particularly within sectors perceived as masculine. These patterns indicate that reproductive health rights have not yet been fully

recognized as an integral component of labor justice and gender equality (Komnas Perempuan, 2025b).

These inequalities demonstrate that reproductive and sexual rights in Indonesia are still not fully recognized as fundamental human rights interconnected with the rights to life, freedom from violence, and freedom of expression. Government responses to reproductive and sexual rights remain fragmented and sectoral in nature. Moreover, state recognition of these rights is frequently constrained by religious, moral, and socio-cultural norms, which ultimately restrict the comprehensive fulfillment of such rights. For example, government efforts to reduce maternal mortality primarily focus on improving healthcare services without adequately incorporating women's empowerment and transformative social approaches aimed at reducing harmful traditional practices (Komnas Perempuan, 2019).

The government's double standards in recognizing reproductive and sexual rights have generated various vulnerabilities that place women and girls at greater risk, including threats to their lives. The clear relationship between child marriage and maternal mortality, as well as the contribution of unsafe abortion to maternal deaths, is often treated as separate issues. As a result, policy interventions remain fragmented and ineffective. Women belonging to marginalized groups—including adolescent girls, women with disabilities, migrant women workers, prostituted women, women living with HIV/AIDS, and women with minority sexual orientations—continue to be overlooked in the provision of basic public services.

Therefore, strategic and cross-sectoral measures are urgently required to strengthen the fulfillment of reproductive and sexual rights in Indonesia. The Ministry of Health, Ministry of Women's Empowerment and Child Protection, Ministry of Religious Affairs, National Population and Family Planning Board, and Ministry of Education should integrate education on reproductive rights, sexual rights, and reproductive health into the national curriculum as part of comprehensive sexuality education. The implementation of such education across all educational levels is expected not only to improve public understanding of reproductive and sexual health, but also as a preventive strategy against gender-based violence and other forms of reproductive rights violations.

2. Women's Right to Health in the Legal Dimension

Health constitutes a fundamental element of both individual and societal well-being. The World Health Organization defines health not merely as the absence of disease or infirmity, but as a state of complete physical, mental, and social well-being. As an integral component of human rights, the right to health encompasses access to adequate healthcare services, a healthy environment, and essential medicines (Krahn et al., 2021). Within this context, women's health rights require particular attention due to the persistent structural inequalities that affect women's access to healthcare services and reproductive autonomy. Internationally, the right to health is recognized under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which obliges states to undertake the necessary measures to ensure the highest attainable standard of health for all individuals (Coomans, 2011).

In the context of a rule-of-law state, the realization of public welfare requires the legal frameworks capable of ensuring adequate protection for women's health rights. Such protection includes the right to health, equal and non-discriminatory access to healthcare services, and protection from violence and discrimination (Cook, 2020). Legal awareness and education are equally important in empowering women to advocate for and exercise their rights effectively. Roscoe Pound (Pound, 2017) conceptualized law as an instrument of social engineering intended to promote social development and public welfare. Accordingly, within a rule-of-law framework, the right to health must be guaranteed as part of broader development objectives aimed at achieving social justice and collective well-being.

Normatively, legal protection for women's right to health in Indonesia has been reinforced through the ratification of the CEDAW under Law No. 7 of 1984. Article 12 of CEDAW explicitly obliges the state to eliminate discrimination against women in healthcare and to ensure equal access to healthcare services, including reproductive healthcare (Kasuma & Irianto, 2023). Nevertheless, despite the existence of a formal legal framework, discriminatory practices and unequal access to healthcare services remain prevalent, particularly among economically disadvantaged women and women living in remote areas.

The right to health refers to every individual's entitlement to attain the highest possible standard of physical and mental health. This right includes access to adequate healthcare services, essential medicines, and a healthy environment. In particular, women's health rights encompass reproductive and sexual health rights, including access to contraception, maternal healthcare services, and accurate information concerning sexual and reproductive health (Sellin, 2015). However, women often encounter gender-specific and structural barriers to accessing healthcare services as a result of social, economic, and cultural inequalities. Consequently, women's health rights must be understood within the broader human rights framework, which guarantees every individual the opportunity to live a healthy and productive life without discrimination. Persistent structural barriers within healthcare systems continue to hinder the realization of women's health rights, particularly sexual and reproductive health rights, due to the lack of gender-responsive healthcare policies and services (Temmerman, 2015).

The 1945 Constitution of the Republic of Indonesia, as amended in 2002, explicitly recognizes the right to health under Article 28H, which affirms that every individual has the right to physical and spiritual well-being, a healthy environment, and access to healthcare services. Furthermore, Article 34 guarantees every citizen's right to social security, particularly for vulnerable and marginalized groups (Aulia et al., 2022).

Legal protection for women's health rights in Indonesia has undergone significant transformation following the enactment of Law No. 17 of 2023 concerning Health, which replaced Law No. 36 of 2009 and consolidated various healthcare regulations into a more comprehensive legal framework. This legislative reform reflects a paradigm shift from fragmented sectoral regulation toward an integrated national health system based on a human life-cycle approach, including enhanced protection for vulnerable groups such as women. Accordingly, Law No. 17 of 2023 constitutes an important legal foundation for strengthening the protection of women's health rights in Indonesia. However, without integrating a human rights–based approach into healthcare policies and service implementation, such legal protection risks remaining merely formalistic and normative, without effectively addressing women's actual reproductive health needs (Qibtiyah et al., 2025).

The development of Indonesia's healthcare sector is closely linked to the availability and distribution of healthcare personnel. Although the number of healthcare workers has increased over time, disparities in their distribution continue to pose a major challenge due to regional inequalities in economic development and welfare. Law No. 17 of 2023 affirms that health is a fundamental human right that must be fulfilled through the provision of healthcare services that are safe, equitable, affordable, and of good quality. Embedded within this framework is the principle of non-discrimination, which obliges the state to ensure equal access to healthcare services for women, including reproductive and maternal healthcare services (Rayyan et al., 2025).

One significant example concerns the shortage of general practitioners. According to World Health Organization standards, the ideal doctor-to-population ratio is 1:1,000 (Nayyar & Agarwal, 2022), meaning that Indonesia requires approximately 278,700 doctors to meet national healthcare needs. By comparison, Malaysia, with a population of approximately 32.7 million, requires substantially fewer healthcare professionals. Currently, Indonesia has approximately 141,950 healthcare professionals, indicating a shortage of nearly 130,000 doctors based on WHO standards.

Although the number of doctors has increased significantly—from approximately 118,300 in 2018 to more than 141,000 in recent years—the shortage remains considerable (Indraswari, 2023).

Access to adequate healthcare services constitutes a fundamental right that should be equally accessible to all individuals. Such access includes the availability of healthcare facilities, qualified medical personnel, and equitable healthcare services provided without discrimination. Barriers to healthcare access are often associated with economic constraints, geographical isolation, and social inequalities. Addressing these challenges is essential to ensuring that every individual can attain the highest possible standard of health. Within this framework, women's reproductive and sexual health rights deserve particular attention as a prerequisite for achieving substantive health equity.

The Center for Indonesia's Strategic Development Initiatives, through its White Paper on Indonesia's Health Sector Development 2024–2034, identified the unequal distribution of healthcare workforce as one of the country's most pressing healthcare challenges (Hasibuan, 2026). This disparity has contributed to inadequate healthcare services across several regions, particularly in remote and underdeveloped areas where access to healthcare remains severely limited.

Ensuring women's health rights also requires the availability of adequate healthcare personnel in remote areas, which continue to struggle to attract medical professionals. Most healthcare workers prefer to work and live in urban areas that provide better infrastructure and economic opportunities. Moreover, the effectiveness of healthcare services depends heavily on transportation, communication, and energy infrastructure. Fore4xample, vaccines and medicines require proper cold chain storage supported by stable electricity supply, while surgical procedures also depend on stable electrical systems. Consequently, inadequate infrastructure significantly undermines the quality and accessibility of healthcare services (Wahyuni & Ferial, 2023).

Based on the foregoing discussion, the right to health constitutes a fundamental human right that entitles every individual to an adequate standard of health and healthcare services, while simultaneously imposing obligations upon the state to ensure public health protection. The World Health Organization defines the right to health as a condition of complete physical, mental, and social well-being rather than merely the absence of disease or infirmity (Grugel et al., 2024).

Accordingly, the state is responsible for protecting individual freedoms and ensuring the fulfillment of health-related rights. Such freedoms include the right to exercise autonomy over one's body and health, including lawful sexual and reproductive autonomy, as well as freedom from coercion, torture, non-consensual medical treatment, and medical experimentation. Women's health protection in Indonesia is regulated through various statutory instruments and public health policies aimed at safeguarding women's reproductive rights and ensuring access to healthcare services. One of the most significant legal developments in this area is the enactment of Law No. 17 of 2023 concerning Health, which establishes a comprehensive legal framework concerning reproductive health rights and the responsibilities of the state in protecting maternal and child health.

a. Law Number 17 of 2023 concerning Health

Law No. 17 of 2023 concerning Health represents a significant transformation in Indonesia's healthcare regulatory framework, particularly in relation to the protection of women's reproductive health rights. The law demonstrates a progressive legal orientation by recognizing reproductive health not merely as a medical issue, but as an integral part of human rights protection, gender equality, and state responsibility (Natalis et al., 2026). Articles 40, 54, and 55 of the law establish normative guarantees concerning maternal health services, reproductive autonomy, access to health information, and protection against discrimination and violence.

Philosophically, the Health Law is grounded in the values of Pancasila and the 1945 Constitution of the Republic of Indonesia, which affirm the state's obligation to protect its citizens and guarantee the right to health as an integral component of human rights. Within the framework of the welfare state, health is regarded as a fundamental right that must be fulfilled through equitable, inclusive, and sustainable health development aimed at establishing a healthy and productive population. Sociologically, the enactment of this law was driven by the public's need for accessible, equitable, and high-quality healthcare services amid various challenges, including disparities in healthcare access, shortages of healthcare personnel and facilities, the emergence of new infectious diseases, and weaknesses in national health resilience, particularly following the COVID-19 pandemic. These conditions underscored the urgency of transforming the healthcare system through strengthening primary and referral healthcare services, healthcare financing, human resources for health, and health technology. Juridically, the law was established to ensure legal certainty and harmonization among health regulations that had previously fragmented, overlapping, and no longer aligned with societal needs and the dynamics of modern healthcare systems. Therefore, the simplification and unification of health regulations were deemed necessary to support an effective and comprehensive transformation of the national health system (Badan Legislasi DPR, 2023).

A central aspect of the law is the adoption of a rights-based approach to healthcare governance. In Article 40 paragraph (3), women are explicitly granted the right to obtain healthcare facilities and services that meet standards of safety, quality, and affordability. This provision is legally important because it elevates maternal healthcare from a discretionary public service to a constitutionally relevant entitlement. Consequently, the state is no longer positioned solely as a policy regulator but also as a duty bearer with legal obligations to respect, protect, and fulfill women's reproductive health rights.

The assignment of responsibility to both the Central Government and Regional Governments under Article 40 paragraph (4) also reflects the decentralized structure of healthcare governance in Indonesia. Since healthcare administration is partly delegated to regional authorities, the provision seeks to ensure that reproductive health services remain a national obligation regardless of regional disparities. Legally, this creates a framework of shared governmental accountability in which failures to provide adequate maternal healthcare may potentially constitute a violation of statutory obligations and constitutional health rights under Article 28H of the 1945 Constitution.

Furthermore, Article 54 broadens the legal understanding of reproductive health by including pregnancy regulation, contraceptive services, sexual health, and reproductive system health within the scope of healthcare protection. This provision signifies a shift from a narrow maternal-health-centered approach to a more comprehensive reproductive health framework. In legal and policy terms, the article recognizes that women's reproductive rights include not only safe pregnancy and childbirth but also autonomy in reproductive decision-making and access to preventive healthcare services.

The inclusion of contraceptive services and pregnancy regulation also indicates the State's recognition of reproductive autonomy. From a human rights perspective, reproductive autonomy is essential component of bodily integrity and personal freedom. By legally recognizing access to contraception and reproductive healthcare information, the law aligns itself with international human rights instruments such as the CEDAW, which obliges States Parties to eliminate discrimination in healthcare access and family planning services (Paes & Geraldes, 2021).

Another significant aspect of the law is reflected in Article 55, which explicitly guarantees the right to a healthy and safe reproductive and sexual life free from discrimination, coercion, and violence. This provision is particularly progressive because it acknowledges that reproductive health cannot be separated from issues of gender-based violence, coercion, and

bodily autonomy. The law therefore adopts a broader conception of health that includes physical, psychological, and social well-being.

Moreover, Article 55 also guarantees access to accurate and accountable reproductive health information, education, and counseling. Legally, this provision reinforces the principle of informed consent in healthcare services. Women cannot exercise meaningful reproductive autonomy without adequate access to information regarding contraception, pregnancy, sexual health, and healthcare risks. Thus, the provision strengthens the relationship between healthcare rights and informational rights.

The recognition of healthcare and recovery rights for victims of sexual violence further demonstrates the law's integrated approach between healthcare protection and victim protection mechanisms. This is significant because survivors of sexual violence often face multiple barriers, including social stigma, limited access to healthcare services, and inadequate psychological support (Yuliartini et al., 2025). By explicitly recognizing recovery rights, the law provides a stronger legal basis for trauma-informed healthcare services and victim-centered protection.

Nevertheless, despite its progressive character, the law also presents several normative and practical challenges. One significant concern lies in the phrase contained in Article 55 regarding the implementation of reproductive and sexual rights "with due respect for noble values in accordance with religious norms." From a legal interpretation perspective, this provision may create ambiguity, as the concepts of religious and moral values are open to varying interpretations by policymakers, regional governments, and healthcare providers. In practice, such ambiguity may lead to restrictive local policies or conservative interpretations that potentially limit reproductive rights, particularly in relation to contraception, sexual education, and reproductive autonomy.

In addition, implementation challenges remain substantial. Indonesia continues to experience disparities in healthcare infrastructure between urban and rural regions, unequal distribution of medical personnel, and limited reproductive healthcare access in remote areas. Sociocultural stigma associated with reproductive and sexual health may also discourage women from seeking healthcare services or reporting violence. Consequently, although the law provides strong normative guarantees, the realization of these rights depends heavily upon institutional capacity, political commitment, adequate budget allocation, and effective monitoring mechanisms (Liyanto et al., 2022).

Health regulations in Indonesia have established a strong legal framework for the protection of women's health. However, a significant gap remains between progressive regulatory provisions and their implementation in practice. Unequal access to healthcare services, particularly in underdeveloped, frontier, and outermost regions; the limited availability of supporting services such as mental healthcare and safe abortion services; and the lack of a stronger gender-sensitive perspective continue to pose major challenges requiring immediate attention and policy intervention.

b. Government Regulation No. 28 of 2024 concerning the Implementation of Regulation of Law No. 17 of 2023 concerning Health: Strengthening the Protection of Women's Reproductive Health Rights in Indonesia

Government Regulation No. 28 of 2024 concerning the Implementation of Regulation of Law No. 17 of 2023 concerning Health constitutes an important legal instrument in strengthening the protection and fulfillment of reproductive health rights in Indonesia, particularly those relating to women and vulnerable groups. The regulation operationalizes the normative guarantees established under Law No. 17 of 2023 by providing a more comprehensive and integrated framework for the governance of reproductive health. In particular, the provisions contained in Articles 96 to 130 demonstrate the state's commitment

to translating constitutional and statutory health rights into concrete healthcare policies and implementation mechanisms.

Reproductive health represents a fundamental aspect of women's lives because it encompasses biological, psychological, and social dimensions associated with pregnancy, childbirth, reproductive functions, and sexual well-being. Consequently, the protection of women's reproductive health extends beyond medical concerns and also involves broader issues of human dignity, gender equality, social justice, and sustainable development (Harry et al., 2024). In this context, Government Regulation No. 28 of 2024 reflects the recognition that investment in women's reproductive health contributes not only to individual welfare but also to the well-being of families, communities, and society as a whole.

The regulation aims to manage, maintain, and improve the reproductive health of the Indonesian population through a systematic healthcare approach. Its objectives include the establishment of policies and programs aimed at enhancing reproductive health services, including funding mechanisms and implementation strategies. In addition, the regulation guarantees every individual's right to access reproductive healthcare services that are safe, affordable, equitable, and of high quality. The regulation also emphasizes the prevention and control of sexually transmitted infections (STIs), alongside efforts to increase public awareness regarding reproductive and sexual health risks (Minichiello et al., 2023). Through these objectives, the Government Regulation attempts to integrate preventive, promotive, curative, and rehabilitative healthcare measures within the national healthcare system.

From a legal perspective, Government Regulation No. 28 of 2024 serves as a strategic implementing instrument that strengthens the State's obligations to respect, protect, and fulfill reproductive health rights. The regulation reflects a rights-based approach to healthcare governance by affirming that reproductive health constitutes an integral component of the right to health as guaranteed under the Indonesian constitutional framework and international human rights instruments. Accordingly, the state is not only responsible for formulating healthcare policies but also for ensuring the accessibility, availability, acceptability, and quality of reproductive health services throughout Indonesia.

One of the significant aspects of the regulation is its emphasis on equal access to reproductive healthcare services. This provision is particularly important in the Indonesian context, where disparities in healthcare infrastructure and medical services remain evident between urban and rural regions. By guaranteeing access to affordable and high-quality reproductive healthcare, the regulation provides a stronger legal basis for reducing inequalities in healthcare access and improving maternal and reproductive health outcomes (Rahman, 2024).

Furthermore, the regulation demonstrates the state's increasing recognition of reproductive health as a multidimensional issue that intersects with education, social protection, gender equality, and public health policy. The inclusion of STI prevention and public awareness programs illustrates that reproductive healthcare is not solely focused on treatment but also prioritizes preventive healthcare measures and public education. Such an approach is consistent with contemporary public health principles, which emphasize prevention, early intervention, and community participation as essential components of sustainable healthcare governance.

The Government Regulation also reinforces the legal protection of women's reproductive autonomy. By guaranteeing access to reproductive healthcare information and services, the regulation strengthens women's capacity to make informed decisions regarding their reproductive health. In this regard, reproductive autonomy is closely linked to bodily integrity, human dignity, and the principle of non-discrimination. The regulation therefore contributes to the advancement of gender equality within Indonesia's healthcare system.

Moreover, the regulation reflects Indonesia's broader commitment to international human rights standards, particularly those relating to women's rights and healthcare protection. Its

provisions are substantively aligned with international legal instruments such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), both of which recognize reproductive healthcare as a fundamental to the right to health and gender equality (Cook, 2020).

Nevertheless, despite its progressive normative framework, the implementation of Government Regulation No. 28 of 2024 faces several significant challenges. Structural inequalities in healthcare infrastructure, unequal distribution of healthcare professionals, budgetary limitations, and sociocultural stigma associated with reproductive and sexual health may hinder the effective realization of reproductive health rights. In certain regions, conservative cultural and religious interpretations may also influence the implementation of reproductive health policies, particularly concerning sexual education, contraception, and reproductive autonomy. As a result, the practical effectiveness of the regulation will depend heavily upon intergovernmental coordination, adequate institutional capacity, sustainable healthcare funding, and effective monitoring mechanisms.

In addition, the regulation raises important questions concerning the balance between public morality, religious values, and reproductive rights. While the incorporation of moral and religious considerations reflects Indonesia's sociocultural context, such provisions may create normative ambiguity if interpreted restrictively by policymakers or healthcare providers. Consequently, there is a need for careful legal interpretation to ensure that moral considerations do not undermine the protection of fundamental reproductive health rights guaranteed under national and international law.

Based on the foregoing discussion, it may be argued that although Law Number 17 of 2023 concerning Health and Government Regulation Number 28 of 2024 reflect a progressive orientation toward the recognition of women's reproductive health rights, both regulations continue to exhibit fundamental weaknesses at the normative and implementation levels. These shortcomings potentially diminish the effectiveness of the protection of women's health rights that should be comprehensively guaranteed by the state. One of the most fundamental issues lies in the normative ambiguity contained in Article 55 of Law Number 17 of 2023, which stipulates that the exercise of reproductive and sexual rights must be conducted with due regard to noble values in accordance with religious norms. This provision creates legal uncertainty because the concepts of "noble values" and "religious norms" are inherently abstract, open to vrying interpretations, and heavily influenced by the subjective perspectives of policymakers and implementing authorities at both the national and regional levels. Within the context of Indonesia's pluralistic society, characterized by diverse religious interpretations, such normative ambiguity potentially creates space for the emergence of restrictive policies concerning women's reproductive rights under the justification of morality and religion.

This issue further complicatedby the fact that Government Regulation Number 28 of 2024 fails to establish clear interpretative boundaries regarding the extent to which religious norms may be invoked to limit reproductive rights. Consequently, regional authorities may adopt policies restricting access to contraception for certain groups, opposing comprehensive sexuality education, or even legitimizing forms of reproductive control over women's bodies based on moral and social considerations. From a human rights perspective, this situation reflects an inherent contradiction within the regulatory framework. On the one hand, the state formally recognizes women's reproductive autonomy as part of the right to health; on the other hand, it simultaneously preserves broad discretionary space for moral and religious intervention, which historically has often functioned as a mechanism for controlling women's bodies and reproductive choices.

In addition to these normative concerns, significant weaknesses also emerge at the implementation level, particularly in addressing structural inequalities within Indonesia's

healthcare system. Although both regulations establish relatively comprehensive standards for reproductive health protection, they do not provide sufficiently concrete and binding corrective mechanisms to address regional disparities in healthcare access. Persistent inequalities in healthcare infrastructure, limited medical facilities in remote areas, and the uneven distribution of healthcare professionals—predominantly concentrated in urban centers— continue to constitute substantial barriers to women's access to adequate reproductive healthcare services. In practice, economically disadvantaged women, women living in geographically isolated regions, and survivors of sexual violence in communities characterized by strong social stigma continue to face multiple barriers to accessing essential healthcare services, including contraception, safe maternal healthcare, and trauma recovery services.

The absence of more robust affirmative measures demonstrates that these regulations remain largely normative and are not supported by sufficiently strong implementation mechanisms. In fact, effective protection of women's health rights requires proactive state intervention through equitable distribution of healthcare personnel, incentive schemes for medical professionals serving remote regions, the strengthening reproductive healthcare facilities, and the enforcement of minimum service standards supported by clear supervisory and sanction mechanisms. Without such measures, the recognition of reproductive health rights risks remaining merely formalistic rather than substantively realizable in social practice.

Furthermore, the decentralization framework that grants broad authority to regional governments introduces additional challenges. Article 40 of the Health Law positions local governments as key actors in healthcare administration; however, the law does not provide sufficiently strong legal safeguards to prevent the enactment of discriminatory local regulations targeting women. Within Indonesia's legal and political landscape, numerous local regulations influenced by moralistic considerations have restricted women's freedoms in the basis of particular interpretations of religion and social norms. The absence of an explicit supremacy clause affirming that women's reproductive health rights must be interpreted in accordance with human rights principles and international standards, particularly the CEDAW, renders legal protection vulnerable to conservative interpretations at the local level.

Overall, the principal weakness of Law Number 17 of 2023 and Government Regulation Number 28 of 2024 lies in the internal contradiction between their commitment to a human right–based recognition of reproductive autonomy and their simultaneous accommodation of broad moral and religious considerations. The absence of clear interpretative limitations, combined with weak implementation and oversight mechanisms, may result in inconsistent standards of protection for women's health rights across regions. Therefore, without the clear interpretative guidelines, effective accountability mechanisms, and a stronger state commitment to ensuring uniform national standards, the protection of women's health rights will remain fragile and highly influenced by local political, social, and ideological dynamics.

c. Maternal and Child Health Programs and the Protection of Women's Health Rights

The protection of women's health rights is implemented not only through legal regulations but also through various healthcare programs designed to improve maternal and reproductive health outcomes. In Indonesia, several national healthcare initiatives have been developed to improve women's and children's access to maternal, reproductive, and primary healthcare services. These initiatives demonstrate the state's commitment to fulfilling its constitutional and human rights obligations concerning women's health and well-being (Andriani et al., 2022).

One of the most important healthcare initiatives is the Maternal and Child Health Program, which was established in response to historically high maternal and child mortality rates. The program aims to improve the health of pregnant women, mothers during delivery, and the postpartum periods, infants, and children under five years of age through integrated healthcare

interventions. Historically, maternal and child mortality was closely associated with limited access to healthcare services, inadequate medical infrastructure, and the unequal distribution of healthcare professionals, particularly in rural and underserved regions (Riana et al., 2021). Consequently, the program was developed as a strategic effort to strengthen maternal healthcare services and reduce preventable maternal and child mortality.

The Maternal and Child Health Program encompasses a wide range of healthcare services, including antenatal care, childbirth assistance, postnatal services, immunization, nutritional support, and regular health monitoring for infants and young children. Through these services, the program ensures the continuity of healthcare throughout pregnancy, delivery, and the postpartum period. This integrated healthcare approach reflects the understanding that maternal and child health are closely interconnected and constitute essential components of public health and sustainable development (Suhartono & Irianto, 2026).

Improving maternal and child health has implications that extend beyond individual well-being. Healthy mothers and children contribute significantly to social stability, economic productivity, and human capital development. Women who have access to adequate healthcare services are more likely to experience safer pregnancies and delivery, while healthy children are more likely to achieve better educational and developmental outcomes. Therefore, investment in maternal and child health is not only a healthcare policy objective but also a broader strategy for promoting social welfare and sustainable national development.

In addition to maternal and child healthcare programs, primary healthcare centers serve as the foundation of the national healthcare system and play a crucial role in providing healthcare services at the community level. These healthcare centers function as frontline institutions responsible for delivering accessible and affordable healthcare services to the population, particularly in remote and economically disadvantaged areas. Beyond curative healthcare services, these institutions also conduct preventive and promotive healthcare activities, including maternal counseling, vaccination programs, school health education, nutrition programs, and community-based healthcare outreach initiatives (Udiana & Pramana, 2025).

The role of primary healthcare centers is particularly significant in relation to women's health rights because they provide comprehensive healthcare services tailored to women's healthcare needs. These services include reproductive healthcare, family planning services, antenatal care, delivery assistance, postpartum care, and reproductive health counseling. By ensuring that healthcare services are geographically and financially accessible, these healthcare centers contribute substantially to reducing inequalities in healthcare access and improving maternal health outcomes (Pillai & Kostruba, 2021).

Another important development in the healthcare system is the establishment of a national health insurance program that aims to provide universal healthcare coverage for all citizens. Through this healthcare financing system, women are guaranteed access to comprehensive healthcare services, including reproductive and maternal healthcare, hospitalization, preventive healthcare services, and delivery assistance. The existence of universal health coverage is particularly important because financial limitations often constitute one of the primary barriers preventing women from accessing healthcare services (Andayani et al., 2021).

From a legal and policy perspective, universal health insurance strengthens the realization of the right to health by reducing economic disparities in access to healthcare. Women who previously lacked the financial resources to obtain medical treatment can now access healthcare services more easily and affordably. This contributes to greater equality, accessibility, affordability, and non-discrimination in healthcare services. Furthermore, healthcare financing mechanisms play an essential role in reducing maternal mortality and improving reproductive health outcomes by ensuring that women can access healthcare services without facing an excessive financial burden.

Despite the existence of these healthcare programs and legal protections, women continue to face substantial barriers in accessing healthcare services. These barriers include poverty, geographical inequality, limited healthcare infrastructure, inadequate healthcare personnel, and sociocultural norms that restrict women's autonomy in making decisions regarding their health. In many societies, patriarchal structures continue to influence women's healthcare choices, particularly in relation to reproductive health and family planning. As a result, women may experience difficulties in exercising autonomy over their own bodies and reproductive decisions.

In addition, women's health rights are often narrowly understood as relating exclusively to reproductive functions, whereas women's health encompasses broader physical, psychological, and social dimensions (Smith & Sinkford, 2022). Such limited perspectives may contribute to the neglect of other important healthcare concerns affecting women, including mental health, protection from gender-based violence, occupational health, chronic diseases, and access to adequate nutrition. Consequently, women's health rights must be approached through a holistic framework that recognizes women as autonomous individuals entitled to comprehensive healthcare throughout all stages of life.

The State has a fundamental obligation to protect women from preventable maternal mortality and reproductive health risks. This obligation includes ensuring the availability of healthcare facilities, trained healthcare professionals, family planning services, pregnancy care, delivery assistance, and postpartum healthcare services (Rosdianti & Limbong, 2021). The failure to provide adequate healthcare services may constitute not only a public health issue but also a violation of women's human rights, including the rights to life, health, dignity, equality, and non-discrimination.

Experiences from various developing regions around the world further demonstrate that weak healthcare systems, poverty, inadequate education, and ineffective public policies significantly contribute to violations of women's health rights (Souza et al., 2024). High maternal mortality rates in several regions illustrate how structural inequality disproportionately affects women, particularly those from economically marginalized and vulnerable communities. These examples highlight the urgent need for coordinated legal, institutional, and social measures to strengthen healthcare systems and protect women's health rights more effectively.

Ultimately, women's health rights encompass the right to equal access to safe, affordable, acceptable, and high-quality healthcare services without discrimination. These rights include access to reproductive healthcare information, family planning services, pregnancy care, delivery assistance, postpartum services, and protection from sexual violence and coercion. Women must also be guaranteed the freedom to make informed decisions regarding their reproductive health autonomously and without external pressure. Accordingly, the state bears both legal and moral obligations to respect, protect, and fulfill these rights through effective healthcare policies and programs, institutional accountability, and equitable healthcare service delivery.

In conclusion, maternal and child healthcare programs, community-based primary healthcare services, and universal health insurance mechanisms represent important instruments for advancing women's health rights and improving public health outcomes. However, the realization of substantive equality in healthcare access requires continuous governmental commitment, equitable distribution of healthcare services, gender-sensitive healthcare policies, public education, and the removal of structural and sociocultural barriers that continue to limit women's full enjoyment of their health rights.

Indonesia has developed a relatively progressive legal framework for the protection of women's health rights through constitutional guarantees, Law No. 17 of 2023 concerning Health, and Government Regulation No. 28 of 2024. These legal instruments demonstrate a

shift toward a human right–based approach emphasizing reproductive autonomy, equality, and non-discrimination. Nevertheless, substantial challenges remain, particularly concerning healthcare inequality, sociocultural barriers, limited healthcare infrastructure, and uneven distribution of healthcare personnel. Consequently, the effectiveness of legal protection depends not only on normative regulation but also on institutional capacity, policy implementation, and the state's commitment to achieving substantive healthcare equality for women.

Table 2.
Legal Analysis of Women's Right to Health in Indonesia

No	Aspect	Legal Basis	Analysis	Challenges
1	Right to Health	ICESCR; Article 28H of the 1945 Constitution	Health is recognized as a fundamental human right protected by the State	Unequal healthcare access
2	Women's Health Rights	CEDAW; Law No. 7 of 1984	Guarantees equality and non-discrimination in healthcare services	Persistent gender inequality
3	Law No. 17 of 2023 concerning Health	Articles 40, 54, 55	Strengthens reproductive rights, maternal healthcare, and protection from violence	Weak implementation in remote areas
4	Government Regulation No. 28 of 2024	Articles 96–130	Operationalizes reproductive healthcare policies and services	Infrastructure and budget limitations
5	Reproductive Autonomy	Law No. 17 of 2023	Recognizes women's rights over reproductive decisions	Sociocultural and religious barriers
6	Healthcare Accessibility	National Health Policies	Expands access through primary healthcare and health insurance	Unequal distribution of healthcare workers
7	Maternal and Child Health Programs	National Health Programs	Reduces maternal and child mortality through integrated healthcare services	Limited healthcare facilities in rural areas
8	Human Rights Perspective	International Human Rights Standards	Emphasizes equality, dignity, and non-discrimination	Structural inequality and weak enforcement

Source: Author's Analysis Results

3. Women's Health Rights from a Human Rights Perspective

Human rights have consistently remained a central subject of legal, political, and academic discourse due to the persistent occurrence of human rights violations throughout history and in contemporary society. The continued relevance of human rights discussions is closely associated with the reality that violations frequently occur within social institutions, governmental structures, and community practices. Any action, policy, or legal framework perceived as violating human rights inevitably generates public debate, support, and opposition (Freeman, 2022). Within this context, women constitute one of the groups most vulnerable to human rights violations because of structural inequalities, discrimination, and deeply rooted patriarchal systems that continue to shape social and legal relations in many societies.

Women's human rights refer to the rights possessed by women both as human beings and as individuals with specific gender-related experiences and vulnerabilities. Within the framework of international and national human rights law, women's rights are recognized and protected through various legal instruments, conventions, and constitutional guarantees. The recognition of women's rights extends across multiple dimensions, including civil, political, economic, social, cultural, and health-related rights. Consequently, women's health rights should be understood not merely as medical concerns but as integral components of universal human rights protection (Erdman & Cook, 2006).

In several international human rights instruments, women are categorized as a vulnerable group alongside children, minorities, refugees, and other marginalized populations. This categorization reflects the recognition that women frequently occupy socially and economically disadvantaged positions and therefore face a higher risk of discrimination, exploitation, and violence (Krisnalita, 2018). Such vulnerabilities often result in unequal access to education, employment, political participation, and healthcare services, including reproductive and maternal healthcare.

The relationship between health and human rights has been extensively developed within international human rights scholarship. Mann et al. (1994) introduced an influential framework emphasizing the interdependence between health and human rights through three principal approaches. First, health policies, healthcare programs, and public health practices may produce both positive and negative impacts on human rights, particularly where state authority influences healthcare governance. Second, human rights violations themselves can generate serious physical, psychological, and social health consequences. Systematic discrimination, violence, poverty, and social exclusion directly affect both individual and collective well-being. Third, the advancement of health and the protection of human rights are fundamentally interconnected, meaning that the fulfillment of one cannot be achieved without the protection of the other. This perspective is particularly relevant to women's healthcare access because discrimination and inequality often function as structural barriers preventing women from obtaining adequate healthcare services.

International human rights standards require states to harmonize their laws, policies, and institutional practices with established human rights principles. Over recent decades, important progress has occurred in the field of sexual and reproductive health, partly due to growing recognition that legal frameworks aligned with human rights standards contribute positively to public health outcomes (Brown et al., 2019). Conversely, restrictive laws and discriminatory policies frequently generate harmful consequences for women's health by limiting access to reproductive healthcare services, sexual education, and health information.

Human rights standards impose obligations upon states to respect, protect, and fulfill human rights through affirmative legal and policy measures. These obligations include ensuring equality and non-discrimination, protecting the rights to health and life, preventing gender-based violence and harmful practices, guaranteeing access to health information, and promoting participation, transparency, and accountability in healthcare governance. In the context of women's health rights, these obligations require governments to establish healthcare systems capable of ensuring equitable and accessible healthcare services for all women regardless of socioeconomic status, ethnicity, religion, or geographical location (Huzaimah et al., 2023).

Women's right to health is closely connected to international human rights instruments, particularly the CEDAW. These instruments affirm that every individual has the right to enjoy the highest attainable standard of physical and mental health without discrimination. The CEDAW specifically obligates States Parties to eliminate discrimination against women in healthcare access and to ensure equal access to healthcare services, health information, and reproductive healthcare protection (Nabila & Budhiartie, 2025). The Convention also emphasizes the importance of protecting women from harmful practices and discriminatory social structures that negatively affect women's health and dignity.

The UDHR further establishes the normative foundation for the right to health through Article 25, which recognizes every individual's right to an adequate standard of living necessary for health and well-being, including access to food, housing, clothing, medical care, and social services. This provision demonstrates that health is inseparable from broader socioeconomic conditions and social protection mechanisms. Accordingly, the right to health extends beyond access to medical treatment alone to encompass living conditions that support physical, mental, and social well-being.

From a human rights perspective, women's health rights encompass not only reproductive healthcare but also broader rights related to dignity, equality, autonomy, and participation (Ojong et al., 2024). However, existing literature demonstrates that gender-based discrimination and inequality remain significant barriers to women's access to healthcare services. Women frequently experience discriminatory treatment within healthcare institutions, lack access to accurate health information, and face limitations in obtaining essential medicines and healthcare services. Such barriers are often exacerbated by poverty, social exclusion, and restrictive cultural norms that limit women's autonomy in making healthcare decisions (Beninger, 2021).

The Sexual Rights as Human Rights guideline published by the World Association for Sexual Health (WAS) in 2014 affirms that sexual rights constitute universal human rights. The guideline encompasses a wide range of rights, including equality and non-discrimination, bodily autonomy, freedom from violence, privacy, access to sexual and reproductive health services, comprehensive sexuality education, and the right to make decisions regarding family and reproductive life. In addition to mapping these rights within the framework of international law, the guideline also emphasizes the obligation of states to respect, protect, and fulfill sexual rights, thereby serving as an important instrument for human rights advocacy, policymaking, and healthcare provision (Kismödi et al., 2017).

Poverty constitutes one of the major barriers to the fulfillment of women's health rights, as economic limitations may reduce women's access to quality healthcare services, including reproductive healthcare, medical treatment, and continuity of care. This condition is further exacerbated by women's higher healthcare needs throughout their life cycle, resulting in many women bearing substantial out-of-pocket healthcare expenses that adversely affect both their health and economic security (Borchelt, 2018). Sandra Fredman (2016) argues that women remain the poorest group globally despite global commitments to gender equality. This demonstrates that development-oriented approaches alone are insufficient to address gendered poverty. Therefore, a human rights–based approach is necessary, recognizing equality as a fundamental right and framing the eradication of women's poverty as a state obligation rather than merely an act of charity.

Many violations of women's health rights are directly associated with reproductive and sexual concerns. Women in various parts of the world continue to experience coercion, harmful traditional practices, sexual violence, early marriage, unsafe reproductive practices, and restrictions on reproductive autonomy. Practices such as female genital mutilation, forced virginity testing, child marriage, female infanticide, and unsafe sexual practices represent serious violations of women's bodily integrity, dignity, and health rights. These practices illustrate how deeply embedded cultural and patriarchal norms continue to undermine women's autonomy and health protection.

Based on a human rights perspective, women's health rights encompass several essential dimensions. First, women are entitled to equitable access to quality healthcare services without discrimination. This includes equal access to healthcare facilities, medicines, treatment, and information. Second, women possess the right to autonomy in making decisions concerning their own health and bodies. This principle requires respect for informed consent and women's ability to make healthcare decisions free from coercion or external pressure. Third, women have the right to comprehensive reproductive healthcare services, including access to family planning, reproductive healthcare information, sexual healthcare services, pregnancy care, and preconception counseling. Fourth, women have the right to protection from all forms of violence, including violence occurring within healthcare settings (Beninger, 2021).

The fulfillment of women's health rights is inseparable from broader efforts to prevent and address sexual violence. The high prevalence of sexual violence demonstrates the urgent need for legal frameworks capable of protecting women's bodily integrity, dignity, and reproductive autonomy. International standards, including the Programme of Action of the International Conference on Population and Development, emphasize that reproductive rights must be grounded

in freedom from discrimination, coercion, and violence. Accordingly, states bear a fundamental obligation to establish legal and institutional frameworks that enable women to make reproductive decisions freely, safely, and without fear of violence or discrimination (Zampas & Nihlén, 2025).

The concept of the "right to health" in relation to women highlights the integration of healthcare with broader principles of dignity, justice, equality, participation, and non-discrimination. Since most countries have ratified international human rights instruments recognizing the right to health, the protection of women's health rights has become a matter of increasing concern for governments, international organizations, academics, and human rights advocates. Assessing women's health from a human rights perspective requires recognition that healthcare is not solely a medical issue but also a matter of social justice and human dignity. Consequently, the realization of women's health rights depends upon the existence of legal systems, healthcare institutions, and social structures that actively promote equality, participation, accountability, and substantive protection for women in all aspects of healthcare access and provision (Sofokleous, 2020).

From a legal perspective, women's health rights represent an extension of universal human rights principles into the healthcare sector. The right to health is categorized as a fundamental human right because it directly influences the enjoyment of other rights, including the rights to life, dignity, equality, privacy, and freedom from discrimination (Nunes, 2021). Therefore, violations of women's health rights should not be understood merely as healthcare failures but also as human rights violations that generate legal responsibility for the State.

The integration of human rights principles into healthcare governance reflects the transition from a charity-based approach toward a rights-based approach. Under a rights-based framework, women are recognized as rights holders, while the state functions as the duty bearer obligated to ensure the availability, accessibility, acceptability, and quality of healthcare services. This framework also emphasizes accountability, participation, transparency, and non-discrimination as essential components of healthcare policy (Onie, 2024).

The CEDAW plays a particularly important role in shaping women's health rights because it explicitly requires states to eliminate discriminatory laws, policies, and practices affecting women's healthcare access. The Convention recognizes that gender inequality is structurally embedded within many legal and social systems and therefore requires affirmative governmental measures to address these inequalities.

Nevertheless, significant challenges remain in the implementation of women's health rights. Patriarchal cultural norms, poverty, weak healthcare infrastructure, unequal healthcare distribution, and discriminatory practices continue to limit women's access to healthcare services in many countries. In some societies, women's reproductive autonomy remains restricted by legal, religious, or social controls that limit access to contraception, reproductive healthcare information, or sexual health services.

Furthermore, many healthcare systems continue to adopt a narrow understanding of women's health by focusing primarily on reproductive functions while neglecting broader dimensions of women's physical and mental well-being. Such approaches risk reducing women's identity to reproductive roles rather than recognizing women as autonomous individuals entitled to comprehensive healthcare protection throughout all stages of life (Zampas, 2013).

Table 3.
Human Rights Dimensions of Women's Health Rights

No	Human Rights Dimension	Women's Health Context	Human Rights Implication
1	Equality	Women must receive equal healthcare access without discrimination	Discrimination in healthcare constitutes a human rights violation
2	Dignity	Women's health protection is closely related to human dignity and bodily integrity	Harmful practices undermine women's dignity
3	Autonomy	Women have the right to make independent reproductive and healthcare decisions	Restrictive norms limit reproductive freedom
4	Protection from Violence	Women must be protected from sexual violence and coercion	Violence negatively affects physical and mental health
5	Access to Information	Women are entitled to accurate reproductive and health information	Lack of information weakens informed consent
6	Social Justice	Healthcare rights are linked to poverty, education, and welfare	Economic inequality limits healthcare access
7	State Responsibility	Governments are obligated to provide accessible and quality healthcare services	Weak healthcare systems hinder rights fulfillment
8	Rights-Based Healthcare	Healthcare policies must prioritize participation, accountability, and non-discrimination	Formal legal protection alone is insufficient

Source: Author's Analysis Results

Based on this analysis, one of the principal weaknesses in the protection of women's health rights lies in the fragility of state accountability mechanisms in implementing the principles of equality and non-discrimination. Although many countries have ratified the CEDAW and formally incorporated human rights principles into their domestic legal systems, their implementation within healthcare policies and services remains ineffective. This failure is reflected in persistently high maternal mortality rates, limited access to reproductive healthcare services, and the continued existence of discriminatory practices against women within healthcare systems. In many cases, states remain confined to normative regulatory frameworks without establishing adequate mechanisms for supervision, evaluation, and remedies for violations of women's health rights. Consequently, legal protection for women remains merely symbolic and has not yet succeeded in achieving substantive equality in access to healthcare services.

4. Feminist Perspectives on Women's Health Rights in Indonesia

Women's health rights constitute a fundamental component of human rights closely associated with the principles of gender equality, social justice, and individual autonomy over one's own body (Zampas & Nihlén, 2025). From a feminist perspective, women's health is not merely understood as a biological or medical concerns, but also as a political, legal, social, and cultural concern shaped by power relations within society. Women's bodies frequently become objects of state control, religious influence, and patriarchal culture through regulations governing reproduction, sexuality, and women's morality. Consequently, women's health cannot be separated from social structures that position women in subordinate roles across various sectors of life.

To address this issue, the concept of intersectionality introduced by Kimberlé Crenshaw (2013a) has become a significant analytical framework for understanding how discrimination and social injustice operate in complex and overlapping ways. Crenshaw argues that individuals do not experience discrimination solely on the basis of a single identity, such as gender or race, but rather through the intersection of multiple social identities, including gender, race, social class, ethnicity,

disability, sexual orientation, and other forms of identity. Consequently, women's experiences of injustice cannot be understood as uniform, since each woman occupies a distinct social position shaped by intersecting identities. The intersectionality framework is particularly relevant in the context of reproductive rights, as it highlights how certain groups of women experience heightened vulnerability due to multidimensional and structural discrimination.

Intersectionality also demonstrates how discrimination against reproductive rights may manifest in various forms, including forced sterilization, restrictions on access to contraception and maternal healthcare services, criminalization of women's reproductive choices, and the neglect of the reproductive health needs of vulnerable groups. In many cases, women from marginalized communities lose autonomy over their bodies because reproductive decisions are shaped by unequal power relations within families, societies, and state policies. For example, forced sterilization practices targeting women with disabilities and Indigenous women in several countries reflect state and societal control over women's bodies deemed "undesirable" or "unfit." Furthermore, impoverished women often face economic barriers that prevent them from accessing safe and quality reproductive healthcare services (Crenshaw, 2013b).

The intersectionality approach emphasizes that the protection of reproductive rights cannot rely solely on formal recognition within legal and policy frameworks. A more comprehensive reproductive justice approach is required, one that connects reproductive rights with broader issues of social, economic, and political justice. The concept of reproductive justice positions women as subjects who possess full autonomy over their bodies, health, and reproductive choices, while simultaneously acknowledging that their ability to exercise these rights is profoundly shaped by surrounding structural conditions. Accordingly, the state is not only obligated to establish regulations protecting reproductive rights, but must also eliminate structural barriers such as poverty, discrimination, social stigma, and inequalities in access to healthcare services (Crenshaw, 2019).

Through the lens of intersectionality, the fulfillment of reproductive rights must be implemented in an inclusive manner that is sensitive to the diversity of women's experiences. Reproductive health policies cannot be designed through a universal and uniform approach, as different groups of women possess distinct needs and vulnerabilities. Therefore, states should develop policies that are not only gender-responsive but also responsive to other social identities, including race, ethnicity, disability, sexual orientation, and socioeconomic status. Such an approach ensures that the protection of reproductive rights is not merely an effort to fulfill individual rights, but also part of a broader struggle to achieve substantive social justice for all women, particularly those who occupy the most vulnerable positions within social structures (Crenshaw, 2019).

Feminist perspectives argue that gender inequality directly influences women's access to healthcare services. Within patriarchal societies, women are often positioned as responsible for reproduction and family morality, yet they are not granted full authority over their own bodies and reproductive health. This condition leads to various forms of discrimination against women in accessing safe, equal, and non-discriminatory sexual and reproductive healthcare services. Studies on international human rights law demonstrate that sexual and reproductive health rights are an integral part of human rights that must be protected by the state through a rights-based approach (Zampas & Nihlén, 2025).

In the Indonesian context, women's health rights continue to be significantly shaped by patriarchal culture and religious conservatism in the formulation of state policies. The state frequently assumes a regulatory role in public morality through regulations that restrict women's reproductive autonomy. Women's bodies are often constructed as symbols of social honor that must be protected in order to preserve societal moral values. As a consequence, reproductive health policies in Indonesia remain largely paternalistic and have not fully recognized women as subjects possessing the right to determine choices concerning their own bodies.

This condition is reflected in various regulations governing women's reproductive health, including policies concerning contraception, sexual education, prostitution, HIV/AIDS, and abortion. The state continues to frame women's reproductive health within the discourse of social morality rather than fully within the framework of human rights. Feminist perspectives view this approach as evidence of how the state utilizes law as an instrument of control over women's bodies. As a result, women frequently experience limited access to health information and services as well as legal protection related to their sexual and reproductive health (Cook & Ngwena, 2006).

One of the issues demonstrating the state's strong control over women's bodies is Indonesia's prostitution policy and HIV/AIDS management. The state continues to employ a criminalization approach toward sex workers on the grounds of maintaining public order and morality. However, such an approach has instead further marginalized sex workers socially and limited their access to healthcare services. Sex workers are often reluctant to seek reproductive healthcare or undergo HIV testing due to fears of stigma, discrimination, and repressive measures by state authorities. Research concerning prostitution policies in Indonesia indicates that criminalization approaches actually increase women's vulnerability to sexual violence, economic exploitation, and the spread of HIV/AIDS (Natalis, 2026b).

From a feminist perspective, sex workers should be viewed as vulnerable groups requiring health and social protection rather than merely as perpetrators of moral violations. Criminalization does not resolve the issue of sexual exploitation; instead, it reinforces women's subordinate position within social structures. The state fails to recognize that the majority of sex workers operate under conditions of economic coercion and gender inequality that make it difficult for them to escape cycles of exploitation.

The issue of HIV/AIDS also reveals the existence of gender inequality within Indonesia's healthcare system. Women living with HIV/AIDS frequently experience more severe stigma than men because the disease is associated with women's sexual morality. Within patriarchal cultures, women are regarded as responsible for maintaining the sexual purity and honor of the family. When women become infected with HIV/AIDS, they are often positioned as the guilty party, despite the fact that many women contract the virus from their spouses. Global studies on women's health indicate that unequal gender relations contribute to women's greater vulnerability to HIV/AIDS and other sexually transmitted infections (STIs) (Langer et al., 2015).

Gender inequality also limits women's ability to negotiate contraceptive use or refuse risky sexual relations. In many cases, women do not possess equal bargaining power within sexual relationships or household structures. This condition demonstrates that women's health issues are not solely related to medical services, but are also deeply connected to unequal power relations within social and familial contexts.

Beyond HIV/AIDS, gender inequality in women's health is also evident in the limited availability of comprehensive sexual education in Indonesia. Sexual education is frequently regarded as conflicting with cultural and religious norms, leading to restrictions on discussions concerning sexuality. Consequently, women often obtain information regarding reproductive health from unreliable and unscientific sources. Feminist perspectives describe this condition as *epistemic injustice* (Fricker, 2007), namely injustice in the distribution of knowledge that deprives women of access to information regarding their own bodies and reproductive health (Natalis, 2026a).

The lack of comprehensive sexual education renders women more vulnerable to sexual violence, unintended pregnancies, and sexually transmitted infections. The state has not yet succeeded in establishing a science-based and gender-sensitive reproductive health education system. In fact, comprehensive sexual education constitutes an essential component in strengthening women's awareness of bodily autonomy and reproductive rights.

Women's health rights are also highly visible in abortion regulations. Indonesia continues to impose strict limitations on abortion practices and only permits abortion under specific conditions,

such as medical emergencies and cases involving rape victims. However, in practice, access to such services remains difficult due to complicated bureaucratic procedures, social stigma, and limited healthcare facilities. Feminist perspectives interpret these restrictions as forms of state control over women's bodies through legal instruments and social morality.

The criminalization of abortion does not eliminate abortion practices; rather, it drives women to seek unsafe and illegal services that pose serious risks to their health and lives. Research on women's reproductive rights demonstrates that restrictions on access to safe abortion contribute to increased maternal mortality rates resulting from unsafe abortion practices (Hill, 2009). From a feminist standpoint, the state should prioritize women's health and safety rather than maintaining moralistic approaches that ultimately endanger women.

Feminist analysis also emphasizes that women's experiences in accessing healthcare services are not homogeneous, but are shaped by multiple intersecting social dimensions. The perspective of intersectional feminism demonstrates that factors such as social class, ethnicity, geographical location, sexual orientation, economic status, and disability significantly contribute to women's vulnerability to discrimination within healthcare systems. In this context, poor women, Indigenous women, migrant workers, women with disabilities, and other marginalized groups of women tend to encounter more complex barriers to healthcare access compared to women from more socially privileged groups.

Within the Indonesian context, women living in remote areas continue to face limited healthcare facilities, shortages of medical personnel, and inadequate transportation access to healthcare services. Such geographical disparities demonstrates that women's health rights are shaped not only by gender, but also by structural developmental gaps and unequal distribution of economic resources. Studies concerning gender inequality and healthcare access reveal that women from vulnerable groups are often the most severely affected by weak state social protection systems (Schaaf & Khosla, 2021).

Gender-based violence also constitutes a critical issue in discussions concerning women's health rights in Indonesia. Sexual violence has long-term consequences for women's physical, psychological, and reproductive health. Although Indonesia has enacted the Sexual Violence Crime Law, its implementation continues to face significant obstacles rooted in patriarchal culture and practices of victim blaming. Many victims of sexual violence are reluctant to report incidents because they fear humiliation, blame, or disbelief from society and law enforcement institutions (Triantono et al., 2025).

From a feminist perspective, this condition demonstrates that formal legal protection alone is insufficient without broader cultural transformation and changes in gender relations within society. The state has not yet fully provided healthcare and legal systems that are sensitive to the experiences of survivors of sexual violence. In reality, survivors require integrated healthcare, psychological support, and legal assistance in order to recover both physically and mentally.

Thus, feminist perspectives demonstrate that women's health rights issues in Indonesia cannot be separated from patriarchal structures that continue to shape state policymaking and social relations. The state still tends to adopt moralistic approaches in regulating women's bodies rather than adopting human rights-based approaches. As a result, women have yet to achieve full autonomy over their sexual and reproductive health.

Therefore, healthcare reform in Indonesia should be directed toward strengthening human rights-based approaches, implementing comprehensive sexual education, protecting vulnerable groups, and eliminating discriminatory regulations against women. Feminist perspectives emphasize that women's health is not merely a medical issue, but also an issue of social justice, bodily autonomy, and gender equality. When women possess full control over their own bodies and reproductive choices, the state moves closer toward establishing a healthcare system that is more inclusive, democratic, and equitable.

The fulfillment of women's health rights requires a strong commitment from the state through gender-responsive policies, strengthened healthcare systems, and equitable access to healthcare services. The government must ensure the availability of quality, affordable, and accessible healthcare services, particularly for women in remote areas and vulnerable groups. In addition, the protection of women's health rights should encompass reproductive healthcare, mental health services, comprehensive sexuality education, and protection from gender-based violence.

Furthermore, the state must address various structural barriers such as poverty, discrimination, social stigma, and patriarchal culture that continue to limit women's access to healthcare services and decision-making over their own bodies. These efforts should be supported through strengthened public education, social protection mechanisms, and collaboration among governments, healthcare providers, educational institutions, and civil society organizations. Thus, the fulfillment of women's health rights should be understood not only as part of healthcare provision, but also as a manifestation of human rights protection and social justice.

D. Conclusion

In conclusion, women's health rights constitute an inseparable part of human rights that must be respected, protected, and fulfilled by the state. Women's health extends beyond biological or reproductive aspects and encompasses social, economic, cultural, political, and legal dimensions that influence women's overall quality of life. From a human rights perspective, women are entitled to access safe, quality, affordable, and non-discriminatory healthcare services. These rights include reproductive and sexual health rights, the right to health information, the right to make autonomous decisions regarding one's own body and reproductive life, and the right to be free from violence, stigma, and discriminatory practices that undermine women's dignity. Therefore, the fulfillment of women's health rights must be understood as part of broader efforts to achieve social justice, gender equality, and sustainable human development.

Indonesia has established a relatively progressive legal framework for the protection of women's health rights through constitutional guarantees in the 1945 Constitution of the Republic of Indonesia, Law No. 17 of 2023 concerning Health, and various implementing regulations. In addition, Indonesia has ratified several international human rights instruments, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which obligates the state to eliminate discrimination against women in healthcare access. These regulations demonstrate the state's recognition that women's health is a fundamental right deserving legal protection. Nevertheless, despite these progressive normative developments, implementation in practice continues to face significant obstacles, resulting in women's inability to fully enjoy substantive healthcare protection.

The challenges faced by women in accessing healthcare rights reveal a considerable gap between legal norms and social realities. Inequality in healthcare access remains a major issue, particularly for women living in underdeveloped, frontier, and remote areas, as well as women from economically marginalized groups, women with disabilities, Indigenous women, migrant women, and other vulnerable populations. Limited healthcare infrastructure, unequal distribution of healthcare personnel, high healthcare costs, and inadequate reproductive and mental healthcare services constitute serious barriers to the fulfillment of women's health rights. Furthermore, patriarchal culture and discriminatory social norms continue to restrict women's autonomy in making decisions regarding their bodies and reproductive health. Women are frequently positioned as objects of healthcare policy rather than as autonomous subjects possessing full rights over their own bodies and lives.

Women's health issues are also inseparable from the prevalence of gender-based violence. Sexual violence, child marriage, harmful practices targeting women's bodies, and discrimination in the workplace demonstrate that women remain vulnerable to violations of their health rights. High maternal mortality rates, cervical cancer cases, unintended pregnancies, unsafe abortions,

and the limited availability of recovery services for survivors of violence indicate that healthcare systems have not yet provided comprehensive protection for women. In many cases, women also encounter economic barriers that prevent them from accessing safe and quality healthcare services. Poverty functions as a structural factor that exacerbates women's health conditions, as many women are required to bear healthcare costs independently while simultaneously experiencing greater healthcare needs than men throughout their life cycle.

Within this context, a human right–based approach is essential to ensure that women's health is no longer viewed merely as a medical issue, but rather as a matter of justice and state responsibility. A human rights framework positions women as rights holders, while the state serves as the duty bearer obligated to respect, protect, and fulfill these rights. The state's responsibility extends beyond establishing formal legal protections; it must also ensure equal access, quality healthcare services, legal protection mechanisms, and the elimination of structural barriers that perpetuate discrimination in healthcare. From this perspective, the failure of the state to provide adequate healthcare services may constitute a violation of human rights.

The concept of intersectionality introduced by Kimberlé Crenshaw further demonstrates that women's experiences of healthcare inequality are not uniform. Women experience multiple forms of discrimination through the intersection of identities such as gender, social class, race, ethnicity, disability, and sexual orientation. Consequently, certain groups of women face greater vulnerability than others. Indigenous women, women with disabilities, impoverished women, and transgender women, for example, frequently experience marginalization within healthcare systems and are deprived of autonomy over their bodies and reproductive rights. The intersectionality framework emphasizes that the protection of women's health rights requires inclusive policies that are sensitive to the diversity of women's experiences. Healthcare policies cannot rely on universal approaches that ignore differing social conditions and vulnerabilities.

In addition, the concept of reproductive justice constitutes an important framework for strengthening the protection of women's health rights. Reproductive justice not only emphasizes the right to access reproductive healthcare services, but also the right of women to live within social, economic, and political conditions that enable them to exercise these rights freely and with dignity. Accordingly, the protection of women's health rights must encompass poverty reduction, improved education, social protection, economic empowerment, and the elimination of stigma and gender-based discrimination. The state must ensure that women have access to comprehensive sexuality education, accurate health information, mental healthcare services, protection from gender-based violence, and safe and quality reproductive healthcare services.

Ultimately, the protection of women's health rights requires the transformation of healthcare systems into systems that are more equitable, inclusive, and grounded in human rights principles. Governments must strengthen gender-responsive healthcare policies, improve equitable healthcare access, enhance healthcare infrastructure and human resources, and ensure the effective implementation of healthcare regulations at both national and local levels. In addition, broader social and cultural transformation is necessary to eliminate patriarchal norms and discriminatory practices that continue to restrict women's full enjoyment of their health rights. Collaboration among governments, healthcare institutions, educational institutions, civil society organizations, and communities is essential in creating healthcare systems capable of guaranteeing equality, dignity, and justice for all women. Thus, the fulfillment of women's health rights should be recognized not only as an indicator of successful national health development, but also as a reflection of the state's commitment to human rights protection and substantive social justice.

REFERENCES

Andayani, Q., Koesbardiati, T., Sujoso, A. D., & Laksono, A. D. (2021). The Barrier to Access Health Insurance for Maternity Care: Case Study of Female Workers in Indonesia. *Medico-Legal Update*, *21*(2). https://doi.org/10.37506/mlu.v21i2.2802

Andriani, H., Rachmadani, S. D., Natasha, V., & Saptari, A. (2022). Continuum of Care in Maternal, Newborn and Child Health in Indonesia: Evidence from the Indonesia Demographic and Health Survey. *Journal of Public Health Research*, *11*(4), 22799036221127620. https://doi.org/10.1177/22799036221127619

Antara. (2024). *Memberdayakan Perempuan di wilayah 3T*. https://www.antaranews.com/berita/5283877/memberdayakan-perempuan-di-wilayah-3t

Ara, I., Maqbool, M., & Gani, I. (2022). Reproductive Health of Women: implications and attributes. *International Journal of Current Research in Physiology and Pharmacology*, *6*(3), 8–18. https://doi.org/10.5281/zenodo.7384716

Ashraf, G. Y. (2025). Feminist Theories and Their Impact on Gender Studies. In *Thriving Concepts in Women's and Gender Studies* (pp. 373–395). Apple Academic Press. https://doi.org/10.1201/9781003611028

Aulia, N., Yunita, ;, & Desmawati. (2022). Pembaharuan Hukum Perlindungan Hak atas Kesehatan Reproduksi Perempuan Di Indonesia. *Jurnal Hukum & Pembangunan*, *52*(1), 14–38. https://doi.org/10.21143/jhp.vol52.no1.3322

Badan Kebijakan Pembangunan Kesehatan. (2024). Indonesia Darurat Maldistribusi: Solusi Kontekstual untuk Pemerataan Tenaga Medis dan Tenaga Kesehatan.(Policy Brief 2024). *Tim Perencanaan Dan Pendayagunaan Tenaga Medis Dan Tenaga Kesehatan*.

Badan Legislasi DPR. (2023). Naskah Akademik Rancangan Undang-Undang Tentang Kesehatan. In *DPR RI*.

Bartlett, K. T. (2018). Feminist Legal Methods [1990]. In *Feminist legal theory* (pp. 370–403). Routledge.

Beninger, C. (2021). Reproductive Rights, UN Sustainable Development Goals and International Human Rights Law. In *Gender Equality* (pp. 1013–1025). Springer. https://doi.org/10.1007/978-3-319-95687-9_48

Borchelt, G. (2018). The Impact Poverty Has on Women's Health. *Human Rights*, *43*(3), 16–19. https://www.proquest.com/docview/2159626045

Brown, R., Kismödi, E., Khosla, R., Malla, S., Asuagbor, L., Andión-Ibanez, X., & Gruskin, S. (2019). A Sexual and Reproductive Health and Rights Journey: from Cairo to the Present. *Sexual and Reproductive Health Matters*, *27*(1), 326–328. https://doi.org/10.1080/26410397.2019.1676543

Brysk, A. (2023). Pandemic Patriarchy: The Impact of a Global Health Crisis on Women's Rights. *Rights at Stake and the COVID-19 Pandemic: Two Special Issues of the Journal of Human Rights*, *21*(3), 138. https://doi.org/10.1080/14754835.2022.2071105

Bustreo, F., Germann, S., & Gilmore, K. (2022). Respecting, Protecting, and Fulfilling the Health and Human Rights of Youth in Digital Spaces. *The Lancet Child & Adolescent Health*, *6*(2), 75–76. https://doi.org/10.1016/S2352-4642(21)00372-2

Carneiro, M. M. (2024). Women's Health in 2024: Change Now for Tomorrow Will Be Too Late. *Women & Health*, *64*(1), 1–4. https://doi.org/10.1080/03630242.2024.2292320

Cini, K. I., Wulan, N. R., Dumuid, D., Triputri, A. N., Abbsar, I., Li, L., Priambodo, D. A., Sameve, G. E., Camellia, A., & Francis, K. L. (2023). Towards Responsive Policy and Actions to Address non-Communicable Disease Risks amongst Adolescents in Indonesia: Insights from Key Stakeholders. *The Lancet Regional Health-Southeast Asia*, *18*, 100260. https://doi.org/10.1016/j.lansea.2023.100260

Cook, R. J. (2020). International Human Rights and Women's Reproductive Health. In S. Sherwin & B. Parish (Eds.), *Women, Medicine, Ethics and the Law* (pp. 37–50). Routledge. https://doi.org/10.4324/9781003073789-3

Cook, R. J., & Ngwena, C. G. (2006). Women's Access to Health Care: the Legal Framework. *International Journal of Gynecology & Obstetrics*, *94*(3), 216–225. https://doi.org/10.1016/j.ijgo.2006.04.009

Coomans, F. (2011). The Extraterritorial Scope of the International Covenant on Economic, Social and Cultural Rights in the Work of the United Nations Committee on Economic, Social and Cultural Rights. *Human Rights Law Review*, *11*(1), 1–35. https://doi.org/10.1093/hrlr/ngq055

Crenshaw, K. (2013a). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. In *Feminist Legal Theories* (pp. 23–51). Routledge. https://doi.org/10.1093/oso/9780198782063.003.0016

Crenshaw, K. (2013b). Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color. In *The Public Nature of Private Violence* (pp. 93–118). Routledge. https://doi.org/10.2307/1229039

Crenshaw, K. (2019). Difference Through Intersectionality 1. In *Dalit Feminist Theory* (pp. 139–149). Routledge India.

Direktorat Jenderal Sumber Daya Manusia Kesehatan Kemenkes RI. (2025). *Press Release Peresmian MARCH Project*. https://ditjen-sdmk.kemkes.go.id/pos/berita/press-release-peresmian-march-project

Direktorat Pelaporan dan Statistik Kementerian Kependudukan dan Pembangunan Keluarga. (2024). *Indikator Kinerja Utama (IKU) BKKBN*.

Eger, H., Chacko, S., El-Gamal, S., Gerlinger, T., Kaasch, A., Meudec, M., Munshi, S., Naghipour, A., Rhule, E., & Sandhya, Y. K. (2024). Towards a Feminist Global Health Policy: Power, Intersectionality, and Transformation. *PLOS Global Public Health*, *4*(3), e0002959. https://doi.org/10.1371/journal.pgph.0002959

Erdman, J. N., & Cook, R. J. (2006). Women's Rights to Reproductive and Sexual Health in a Global Context. *Journal of Obstetrics and Gynaecology Canada*, *28*(11), 991–997. https://doi.org/10.1016/S1701-2163(16)32295-2

Fredman, S. (2016). Women and Poverty–A Human Rights Approach'(2016). *African Journal of International and Comparative Law*, *24*(4), 494. https://doi.org/10.3366/ajicl.2016.0170

Freeman, M. (2022). *Human Rights*. John Wiley & Sons.

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford university press. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001

Grugel, J., Masefield, S. C., & Msosa, A. (2024). The Human Right to Health, Inclusion and Essential Health Care Packages in Low Income Countries:"Health for all" in Malawi. *International Journal of Human Rights in Healthcare*, *17*(1), 75–86. https://doi.org/10.1108/IJHRH-09-2021-0178

Hardaningtyas, D., Indriastuti, & Suprayoga. (2025). Psychological Policy For Women: A Strategy Towards Gender Equity in Indonesia. *Politico*, *25*(2), 143–159. https://ejurnal.unmuhjember.ac.id/index.php/POLITICO/article/view/4522.

Hardiyanti, M., Natalis, A., & Indreswari, T. L. (2025). When the Body Says No: Legal Protection for Women Survivors of Vaginismus in Marriage in Indonesia. *Iranian Journal of Public Health*, *54*(12), 2784–2786. https://doi.org/10.18502/ijph.v54i12.20852

Harry, M., Saifullah, S., Jundiani, J., & Fajarani, M. (2024). Examining the Provision of Legal and Religious Education to Islamic Families to Safeguard the Rights and Well-Being of Women and Children: A Case Study Conducted in Malang Regency, East Java. *Samarah: Jurnal Hukum Keluarga Dan Hukum Islam*, *8*(3), 1526–1546. https://doi.org/10.22373/sjhk.v8i3.19566

Hasibuan, S. R. (2026). Behavioral Determinants of Retention in Indonesia's National Health Insurance: a Retrospective Cohort Study of Informal Workers. *Berita Kedokteran Masyarakat*, *42*(3), e28542–e28542. https://doi.org/10.22146/bkm.v42i03.28542

Hellum, A. (2021). CEDAW and Global Standards for Women's Rights: The Convention's Actual and Potential Influence as an Accountability Mechanism for Gender-Sensitive Legislation. In *International Women's Rights Law and Gender Equality* (pp. 169–187). Routledge.

Hill, B. J. (2009). Reproductive Rights as Health Care Rights. *Columbia Journal of Gender and Law*, *18*(2), 9–30. https://doi.org/10.7916/cjgl.v18i2.2570

Howard, L. M., Wilson, C. A., Reilly, T. J., Moss, K. M., Mishra, G. D., Coupland-Smith, E., Riecher-Rössler, A., Seedat, S., Smith, S., & Steinberg, J. R. (2025). Women's Reproductive Mental Health: Currently Available Evidence and Future Directions for Research, Clinical Practice and Health Policy. *World Psychiatry*, *24*(2), 196–215. https://doi.org/10.1002/wps.21305

Hunter, R. (2019). Feminist Approaches to Socio-Legal Studies. In *Routledge handbook of socio-legal theory and methods* (pp. 260–272). Routledge.

Huzaimah, A., Abdillah, M., Laila, N. Q., Tamudin, M., & Astuti, T. M. P. (2023). Disregarding the Reproductive Rights of Women in Child Marriage in Indonesia. *Samarah: Jurnal Hukum Keluarga Dan Hukum Islam*, *7*(2), 1097–1120. https://doi.org/10.22373/sjhk.v7i2.17392

Indraswari, D. L. (2023). *Masih Timpangnya Distribusi Tenaga Kesehatan di Indonesia*. https://www.kompas.id/artikel/masih-timpangnya-distribusi-tenaga-kesehatan-di-indonesia

Kasuma, I., & Irianto, S. (2023). CEDAW Convention and Engendering Faculty of Law's Curriculum Reinforcement: A Lesson Learnt from Indonesia. *Indonesian Journal of International Law*, *20*(2), 1. https://doi.org/10.17304/ijil.vol20.2.1

Kementerian Pemberdayaan Perempuan dan Perlindungan Anak. (2026). *Menteri PPPA : Pemerintah Perkuat Sistem Layanan Kesehatan Responsif Gender, Pastikan Tak Ada Perempuan yang Tertinggal*. https://www.kemenpppa.go.id/siaran-pers/menteri-pppa-pemerintah-perkuat-sistem-layanan-kesehatan-responsif-gender-pastikan-tak-ada-perempuan-yang-tertinggal

Kismödi, E., Corona, E., Maticka-Tyndale, E., Rubio-Aurioles, E., & Coleman, E. (2017). Sexual Rights as Human Rights: A Guide for the WAS Declaration of Sexual Rights. *International Journal of Sexual Health*, *29*(sup1), 1–92. https://doi.org/10.1080/19317611.2017.1353865

Komnas Perempuan. (2019). *Angka Kematian Ibu: Penghilangan Hak Hidup Perempuan di Tengah Pergulatan*. https://komnasperempuan.go.id/file-manager/frontend/Risalah Kebijakan Angka Kematian Ibu?ref=%3D%3D

Komnas Perempuan. (2025a). *Komnas Perempuan: Negara Jangan Abai Hak Kesehatan dan Kesentosaan Perempuan* (Issue November). https://komnasperempuan.go.id/siaran-pers-detail/siaran-pers-komnas-perempuan-memperingati-hari-kesehatan-nasional

Komnas Perempuan. (2025b). *Pemenuhan Hak Kesehatan Reproduksi Perempuan Pekerja: Laporan Pendokumentasian Situasi di Sektor Umum, Sektor Industri, dan Aparatur Sipil Negara*. https://komnasperempuan.go.id/pengembangan-pengetahuan-detail/pemenuhan-hak-kesehatan-reproduksi-perempuan-pekerja-laporan-pendokumentasian-situasi-di-sektor-umum-sektor-industri-dan-aparatur-sipil-negara

Komnas Perempuan. (2026). *Perkuat Peran Bidan: Untuk Hentikan Kematian Ibu dan Optimalisasi Layanan Kesehatan terhadap Perempuan*. 2. https://komnasperempuan.go.id/siaran-pers-detail/siaran-pers-komnas-perempuan-memperingati-hari-bidan-internasional-2026

Krahn, G. L., Robinson, A., Murray, A. J., Havercamp, S. M., Havercamp, S., Andridge, R., Arnold, L. E., Barnhill, J., Bodle, S., & Boerner, E. (2021). It's Time to Reconsider How we Define Health: Perspective from Disability and Chronic Condition. *Disability and Health Journal*, *14*(4), 101129. https://doi.org/10.1016/j.dhjo.2021.101129

Krisnalita, L. Y. (2018). Perempuan, HAM dan Permasalahannya di Indonesia. *Binamulia Hukum*, *7*(1), 71–81. https://doi.org/10.37893/jbh.v7i1.15

Langer, A., Meleis, A., Knaul, F. M., Atun, R., Aran, M., Arreola-Ornelas, H., Bhutta, Z. A., Binagwaho, A., Bonita, R., & Caglia, J. M. (2015). Women and Health: The Key for Sustainable Development. *The Lancet*, *386*(9999), 1165–1210. https://doi.org/10.1016/S0140-6736(15)60497-4

Liyanto, E., Nuryana, D., Cahyani, R. A., Utomo, B., & Magnani, R. (2022). How well are Indonesia's Urban Poor being Provided Access to Quality Reproductive Health Services? *PLOS ONE*, *17*(4), 1–18. https://doi.org/10.1371/journal.pone.0265843

Loza, Y. (2022). Women's Bodies and Lives as Symbols of Patriarchal Codes: Honor Killings. *Social Science Information*, *61*(4), 371–389. https://doi.org/10.1177/05390184221129227

Lwamba, E., Shisler, S., Ridlehoover, W., Kupfer, M., Tshabalala, N., Nduku, P., Langer, L., Grant, S., Sonnenfeld, A., & Anda, D. (2022). Strengthening Women's Empowerment and Gender Equality in Fragile Contexts Towards Peaceful and Inclusive Societies: A Systematic Review and Meta-Analysis. *Campbell Systematic Reviews*, *18*(1), e1214. https://doi.org/10.1002/cl2.1214

Mann, J. M., Gostin, L., Gruskin, S., Brennan, T., Lazzarini, Z., & Fineberg, H. V. (1994). Health and Human Rights. *Health and Human Rights*, *1*(1), 6–23. https://doi.org/10.2307/4065260

Minichiello, V., Scott, J., Grov, C., & Patel, V. (2023). The Role of Social Science in Shaping the Sexually Transmitted Diseases (STI) Discourse. In P. Liamputtong (Ed.), *Handbook of Social Sciences and Global Public Health* (pp. 1151–1167). Springer International Publishing.

https://doi.org/10.1007/978-3-031-25110-8_76

Murdijana, D., Hodijah, S. N., & Mukarramah, E. (2019). *Kertas Kebijakan Pengabaian Hak Reproduksi Dan Seksual: Ancaman Bagi Keselamatan Dan Hak Hidup Perempuan Dan Anak Perempuan Indonesia* (p. 2). Komisi Nasional Anti Kekerasan Terhadap Perempuan (KOMNAS PEREMPUAN).

Nabila, Z., & Budhiartie, A. (2025). Hak Asasi Manusia Terhadap Kekerasan Pada Perempuan Dalam Peraturan Perundang-Undangan Di Indonesia. *Juris Humanity: Jurnal Riset Dan Kajian Hukum Hak Asasi Manusia*, *4*(1), 54–69. https://doi.org/10.37631/jrkhm.v4i1.78

Nampewo, Z., Mike, J. H., & Wolff, J. (2022). Respecting, Protecting and Fulfilling the Human Right to Health. *International Journal for Equity in Health*, *21*(1), 36. https://doi.org/10.1186/s12939-022-01634-3

Natalis, A. (2025). Power, Law, and the Semiotics of Marginalisation: Rethinking Prostitution, Health Risk, and Legal Discourse in Indonesia. *International Journal for the Semiotics of Law-Revue Internationale de Sémiotique Juridique*, 1–31. https://doi.org/10.1007/s11196-025-10310-y

Natalis, A. (2026a). Condom Use in Indonesia: Interplay With Societal Norms and Human Rights. *Journal of Medicine, Surgery, and Public Health*, 100225. https://doi.org/10.1016/j.glmedi.2026.100225

Natalis, A. (2026b). Human Rights and HIV Prevention: Re-Thinking Prostitution Policies in Indonesia. *HIV & AIDS Review*. https://doi.org/10.5114/hivar/217455

Natalis, A., Hardiyanti, M., & Sembiring, A. F. (2026). Sexuality, Privacy, and Human Rights: Rethinking the Criminalisation of Consensual Relationships in Indonesia. *Cosmopolitan Civil Societies: An Interdisciplinary Journal*, *18*(1), 77–93. https://doi.org/10.5130/ccs.v18.i1.10154

Nayyar, R., & Agarwal, S. (2022). Strategies for Optimising Doctor Numbers in Western Pacific and Asian Countries: The Path Travelled. *South-East Asian Journal of Medical Education*, *16*(1), 11–18. https://doi.org/10.4038/seajme.v16i1.399

Nunes, R. (2021). *Healthcare as a Universal Human Right: Sustainability in Global Health*. Taylor & Francis. https://doi.org/10.4324/9781003241065

Ojong, S. A., Temmerman, M., Khosla, R., & Bustreo, F. (2024). Women's Health and Rights in the Twenty-First Century. *Nature Medicine*, *30*(6), 1547–1555. https://doi.org/10.1038/s41591-024-03036-0

Onie, F. H. (2024). *Women's Right in the International Instruments: A Legal Study*. Department of Law and Justice.

Orta, L. C. G. (2025). The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW): From its Radical Preamble to its Contemporary Intersectional Approach. *Women's History Review*, *34*(1), 79–92. https://doi.org/10.1080/09612025.2023.2277490

Ouahid, H., Sebbani, M., Cherkaoui, M., Amine, M., & Adarmouch, L. (2025). The Influence of Gender Norms on Women's Sexual and Reproductive Health Outcomes: a Systematic Review. *BMC Women's Health*, *25*(1), 224. https://doi.org/10.1186/s12905-025-03768-2

Paes, F., & Geraldes, A. (2021). Convention on the Elimination of All Forms of Discrimination against Women. In *Gender Equality* (pp. 124–134). Springer. https://doi.org/10.1007/978-3-

319-95687-9_39

Patterson, D. (2024). Human Rights-Based Approaches and the Right to Health: A Systematic Literature Review. *Journal of Human Rights Practice*, *16*(2), 603–623. https://doi.org/10.1093/jhuman/huad063

Pillai, A. V, & Kostruba, A. (2021). Women's Reproductive Rights and their Scope under International Legal Frameworks. *Entrepreneurship, Economy and Law*, *8*, 18–28. https://doi.org/10.32849/2663-5313/2021.8.03

Pound, R. (2017). *Social Control Through Law*. Routledge.

Qibtiyah, A., Andeska, W., & Salsabila, A. (2025). Islamic Jurisprudence on Women Reproductive Health (Indonesian Review). *Indonesian Journal of Islamic Economic Law*, *2*(1), 69–82. https://doi.org/10.23917/ijoel.v2i1.6957

Rahman, F. F. (2024). Indonesia's Healthcare Landscape: Embracing Innovation in the new Health Regime. *Current Medical Research and Opinion*, *40*(6), 929–933. https://doi.org/10.1080/03007995.2024.2349732

Ramelan, R., Rochmiyatun, S., & Armasito, A. (2025). Women's Reproductive Rights in the Stunting Prevention Policy by the Government of Indonesia. *Hakamain: Journal of Sharia and Law Studies*, *4*(1), 189–200. https://doi.org/10.57255/hakamain.v4i1.1341

Rayyan, R., Zarzani, T. R., & Simarmata, M. (2025). Efforts to Fulfill and Ensure Legal Protection of Patients' Rights in Healthcare Services. *Proceedings of International Conference on Islamic Community Studies*, 4034–4045. https://proceeding.pancabudi.ac.id/index.php/ICIE/article/view/1001

Riana, E., Susanti, T., Ananda, N. R., & Anisa, R. (2021). Pendampingan Ibu Hamil Di Era Pandemi Covid-19 Dalam Upaya Peningkatan Cakupan Pelayanan Ibu Hamil Di Puskesmas Karya Mulia Pontianak. *Selaparang*, *4*(2), 122–126. https://doi.org/10.31764/jpmb.v4i2.4066

Rosdianti, Y., & Limbong, R. J. (2021). Hak-hak Disabilitas di Simpang Jalan: Menyoal Pelindungan Hak Atas Kesehatan di Tengah Pandemi COVID-19. *Masyarakat Indonesia*, *47*(1), 13–30. https://doi.org/10.14203/jmi.v47i1.939

Schaaf, M., & Khosla, R. (2021). Necessary but not Sufficient: a Scoping Review of Legal Accountability for Sexual and Reproductive Health in Low-Income and Middle-Income Countries. *BMJ Global Health*, *6*(7). https://doi.org/10.1136/bmjgh-2021-006033

Sellin, J. A. (2015). Does one size fit all? Patents, the Right to Health and Access to Medicines. *Netherlands International Law Review*, *62*(3), 445–473. https://doi.org/10.1007/s40802-015-0047-5

Shafira, C. N., Mulyani, R., Salsabila, N., & Riswan, M. (2025). Pemetaan Visual Ketersediaan Sarana Kesehatan di Desa/Kelurahan per Provinsi di Indonesia Tahun 2024 Menggunakan Analisis Biplot. *South East Asian Management Concern*, *3*(1), 1–5. https://doi.org/10.61761/seamac.3.1.1-5

Shai, A., Koffler, S., & Hashiloni-Dolev, Y. (2021). Feminism, Gender Medicine and Beyond: a Feminist Analysis of "Gender Medicine". *International Journal for Equity in Health*, *20*(1), 177. https://doi.org/10.1186/s12939-021-01511-5

Smith, S. G., & Sinkford, J. C. (2022). Gender Equality in the 21st Century: Overcoming Barriers to Women's Leadership in Global Health. *Journal of Dental Education*, *86*(9), 1144–1173.

https://doi.org/10.1002/jdd.13059

Sofokleous, A. (2020). The Right to Health Equity and how this could be Applied to Improve Women's Access to Health Care Services. *Bio-Juria Βιο-Νομικά*, *1*(2), 24–34. https://ejournals.lib.auth.gr/bionomika/article/view/7575

Souza, J. P., Day, L. T., Rezende-Gomes, A. C., Zhang, J., Mori, R., Baguiya, A., Jayaratne, K., Osoti, A., Vogel, J. P., & Campbell, O. (2024). A Global Analysis of the Determinants of Maternal health and transitions in maternal mortality. *The Lancet Global Health*, *12*(2), e306–e316. https://doi.org/10.1016/S2214-109X(23)00468-0

Suhartono, D., & Irianto, S. (2026). Legal Protection for Patient Safety in Indonesia's National Health Insurance System: Urging Regulatory Reform. *Perinatal Journal*, *34*(1). https://doi.org/10.57239/prn.26.03410033

Sutton, M. Y., Anachebe, N. F., Lee, R., & Skanes, H. (2021). Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020. *Obstetrics & Gynecology*, *137*(2), 225–233. https://doi.org/10.1097/AOG.0000000000004224

Temmerman, M. (2015). Women's Health Priorities and Interventions. *BMJ: British Medical Journal*, *351*, h4147. https://doi.org/10.1136/bmj.h4147

Triantono, Purwanti, A., Rochaeti, N., & Natalis, A. (2025). When the Law Fails the Victim: Deconstructing the Criminalization of Abortion for Rape Survivors in Indonesia. *International Journal for the Semiotics of Law-Revue Internationale de Sémiotique Juridique*, *38*(7), 2445–2469. https://doi.org/10.1007/s11196-025-10279-8

Udiana, G. K., & Pramana, I. B. N. T. (2025). Legal Protection of Patients in Indonesia's National Health Insurance (JKN) Era: a Comprehensive Review of Regulatory Framework and Hospital Practice. *Jurnal Dharmaputra Hukum Kesehatan*, *1*(2), 21–26. https://dmedlaw.org/index.php/dmlj/article/view/7

Vijeyarasa, R. (2021). Quantifying CEDAW: Concrete tools for Enhancing Accountability for Women's Rights. *Harvard Human Rights Journal*, *34*(1), 37–80. https://doi.org/10.3316/informit.T2025013100018791678872703

Wahyuni, S., & Ferial, L. (2023). Pemeriksaan Puskesmas di Daerah Terpencil terhadap Fasilitas Kesehatan. *Jurnal of Baja Health Science*, *3*(01), 91–108. https://doi.org/10.47080/joubahs.v3i01.2487

World Health Organization. (2022). *Protect the Promise: 2022 Progress Report on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)*. World Health Organization.

World Health Organization. (2025). *Report of the Eleventh Meeting of the WHO Strategic and Technical Advisory Group of Experts for Maternal, Newborn, Child, and Adolescent Health and Nutrition, 10-12 June 2025*. World Health Organization. https://iris.who.int/items/3c314316-6197-40e1-99f7-bef7729010e0

Yuliartini, N. P. R., Hartana, H., Kbarek, L. N., & Monteiro, S. (2025). From Retribution to Restoration: Human Rights-Based Legal Protection for Women Victims of Sexual Violence. *Jurnal Media Hukum*, *32*(2), 281–300. https://doi.org/10.18196/jmh.v32i2.26214

Yundianto, D., Khatami, M., Maharani, W., Mutmainah, I., Nawwaf, M. N., & Vaľko, M. (2026). Exploring Sexual Health and Well-Being in Rural Areas: A Systematic Literature Review with Case Study from Indonesia. *International Journal of Sexual Health*, 1–21.

https://doi.org/10.1080/19317611.2025.2604836

Zampas, C. (2013). Legal and Ethical Standards for Protecting Women's Human Rights and the Practice of Conscientious Objection in Reproductive Healthcare Settings. *International Journal of Gynecology & Obstetrics*, *123*(S3), S63–S65. https://doi.org/10.1016/S0020-7292(13)60005-3

Zampas, C., & Nihlén, Å. (2025). The State of International Human Rights Law on Sexual and Reproductive Health: An Overview. *Health and Human Rights*, *27*(2), 291. https://www.hhrjournal.org/2025/11/24/the-state-of-international-human-rights-law-on-sexual-and-reproductive-health-an-overview/