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REFUGEE WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN INDONESIA

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Abstract: This article critically examines the protection of sexual and reproductive health rights (SRHR) of refugee women in Indonesia within the context of its status as a non-signatory to the 1951 Refugee Convention. While Indonesia has ratified key human rights instruments, the national legal framework—primarily Presidential Regulation No. 125/2016—fails to adequately guarantee access to maternal and reproductive healthcare for refugee women. Employing a non-doctrinal qualitative methodology, this study integrates normative legal analysis with empirical data derived from interviews with UN Refugee Agency (UNHCR) Indonesia and reports from international and civil society organizations. The article introduces a novel analytical framework by combining Availability, Accessibility, Acceptability, Affordability, Quality standards, ROAM health equity indicators, and feminist legal theory to assess Indonesia's obligations as a transit state. It argues that Indonesia operates under a model of "delegated humanitarianism," whereby state responsibility for refugee protection is effectively transferred to international organizations such as UNHCR and UN Migration Agency (IOM). This governance model produces structural inequalities, particularly for refugee women, whose reproductive health needs remain unaddressed due to gender-neutral regulatory approaches. Findings reveal systemic disparities in maternal healthcare access, discriminatory treatment in service delivery, and the absence of state-funded healthcare mechanisms for refugees. The article concludes by proposing an integrated legal and institutional reform model that emphasizes state accountability, gender-sensitive policy design, and multi-level coordination to ensure the fulfillment of SRHR for refugee women in transit contexts.

Artikel ini mengkaji secara kritis perlindungan hak kesehatan seksual dan reproduksi perempuan pengungsi di Indonesia dalam konteks statusnya sebagai negara yang tidak menandatangani Konvensi Pengungsi 1951. Meskipun Indonesia telah meratifikasi instrumen-instrumen hak asasi manusia utama, kerangka hukum nasional—terutama Peraturan Presiden No. 125/2016—gagal menjamin akses

yang memadai terhadap layanan kesehatan ibu dan reproduksi bagi perempuan pengungsi. Dengan menggunakan metodologi kualitatif non-doktrinal, studi ini mengintegrasikan analisis hukum normatif dengan data empiris yang diperoleh dari wawancara dengan UNHCR Indonesia serta laporan dari organisasi internasional dan masyarakat sipil. Artikel ini memperkenalkan kerangka kerja analitis baru dengan menggabungkan standar AAAQ (Ketersediaan, Aksesibilitas, Penerimaan, Keterjangkauan, Kualitas), indikator kesetaraan kesehatan ROAM, dan teori hukum feminis untuk menilai kewajiban Indonesia sebagai negara transit. Artikel ini berpendapat bahwa Indonesia beroperasi berdasarkan model "kemanusiaan yang didelegasikan," di mana tanggung jawab negara dalam perlindungan pengungsi secara efektif dialihkan kepada organisasi internasional seperti UNHCR dan IOM. Model tata kelola ini menimbulkan ketidaksetaraan struktural, terutama bagi perempuan pengungsi, yang kebutuhan kesehatan reproduksinya tetap tidak terpenuhi akibat pendekatan regulasi yang netral gender. Temuan-temuan menunjukkan adanya kesenjangan sistemik dalam akses layanan kesehatan ibu, perlakuan diskriminatif dalam penyediaan layanan, dan tidak adanya mekanisme layanan kesehatan yang didanai negara bagi pengungsi. Artikel ini diakhiri dengan mengusulkan model reformasi hukum dan kelembagaan terintegrasi yang menekankan akuntabilitas negara, perancangan kebijakan yang sensitif gender, dan koordinasi multi-tingkat untuk memastikan terpenuhinya HKSR bagi perempuan pengungsi dalam konteks transit.

Keywords: Maternal; Health; Refugee; Sexual and Reproductive Health; Woman.

INTRODUCTION

Despite Indonesia's ratification of core human rights treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the domestic legal framework governing refugees—primarily Presidential Regulation No. 125 of 2016—remains limited in scope and gender-neutral in formulation (Komnas HAM 2007). This regulatory approach fails to address the specific reproductive health needs of refugee women, thereby reproducing structural inequalities. Refugee women are the group most affected by conflict and humanitarian crises. The definition of refugee refers to foreigners who are in the territory of the Republic of Indonesia due to well-founded fear of persecution on the grounds of race, ethnicity, religion, nationality, membership of a particular social group, and political opinion, and who do not wish to seek protection from their country of origin and/or have been granted asylum seeker or refugee status by the United Nations (UN) through the United Nations High Commissioner for Refugees (UNHCR). For these reasons, refugee women fear persecution, which leads to a variety of types of exclusion and intersecting discrimination, including identity-based discrimination and spatial disadvantages (Khoo Ying Hooi 2023).

By nature, women experience phases or periods that require them to conceive and give birth. Globally, an average of 4.5-5% of women in every population conceive and require intensive care and obstetric services (UNHCR 2021). It is not uncommon for pregnant women to require special treatment for the safety of the *fetus* and the mother. Such conditions tend to be difficult for women who are not in stable conditions, such as refugees. They face multiple layers of vulnerability; when they need health services, they are usually not prioritized (BBC News Indonesia 2023). This situation is exacerbated by the more complex problems faced by refugee women due to biological, psychological, and economic conditions (Paul and Butola 2024). They must deal with menstruation, pregnancy, childbirth, postpartum, breastfeeding, and *postnatal* care (Hanani 2014). These cycles require health services that are difficult to access during times of crisis, namely during transit in Indonesia (Larrea-Schiavon et al. 2022). As a result, the risks they face are greater than those faced by women who are not experiencing a crisis (Melanie Gibson-Helm et al. 2014).

In the Indonesian context, the main cause cited as justification is the absence of institutions or agencies responsible under the law. As a result, their complaints tend not to be followed up on due to operational constraints (IDN Times 2023). Indonesia only has Presidential Regulation Number 125 of 2016, which regulates the handling of refugees entering Indonesian jurisdiction. Substantively, this regulation does not address the technical issues of meeting the health needs of female refugees. It only stipulates that pregnant female refugees are allowed to stay outside refugee camps, with funding guaranteed by international organizations, in this case, the International Organization for Migration (IOM) and/or UNHCR (Presidential Regulation Number 125 of 2016 on Handling Refugees from Abroad 2016). Research by Melov et al identified that pregnant women exposed to global migration issues do not have the same access as women in general. In fact, significant differences are apparent in high-income countries (Melov et al. 2025). Research by Sampson et al found that one pregnant refugee had to isolate herself in a hotel room (refugee shelter) and was under social pressure because the Indonesian state did not recognize her pregnancy. She depended on her family for support because her husband was not allowed to work (Sampson et al. 2016). Research by Yuliandri et al. mentioned that sick refugees in Medan could access health facilities such as hospitals and community health centres. The study did not specify how refugees accessed these facilities, whether they were free or paid (Reni Yuliandari et al. 2024). Anjasmara et al found that health services were accessible to refugees with financial assistance if the hospital or health centre collaborated with IOM (Ananda Andika Anjasmara et al. 2021). There are fundamental problems for refugees who become pregnant while in transit in Indonesia.

Previous studies have discussed the difficulties in protecting refugees in various aspects in general, as explained by Savitri and Brown, who highlight the multidimensional basic rights that have not been fulfilled in Indonesia (Savitri Taylor and Brynna Rafferty-Brown 2010). Health issues for female refugees have also been discussed by Camelia et al. in relation to integration and resettlement efforts (Camelia et al. 2025). The National Human Rights

Commission has also highlighted the experiences of women in refugee camps in relation to reproductive health rights, but with a focus on internally displaced persons.

The protection of refugee women's sexual and reproductive health rights (SRHR) remains a critical yet underexplored issue in transit countries. Indonesia, while not a party to the 1951 Refugee Convention, hosts thousands of refugees for prolonged periods, often exceeding five years. During this time, refugee women experience layered vulnerabilities arising from legal uncertainty, socio-economic marginalization, and gender-specific health needs. Existing scholarship has largely focused on refugee protection in destination or resettlement countries, with limited attention to transit states such as Indonesia. Moreover, studies on refugee health tend to adopt descriptive or policy-oriented approaches without integrating critical legal theory and health equity frameworks. This article addresses these gaps by offering a novel interdisciplinary analysis that combines international human rights law, feminist legal theory, and public health frameworks, particularly the AAAQ standards and ROAM indicators. This article argues that Indonesia's refugee governance reflects a model of "delegated humanitarianism," in which the state informally transfers its obligations to international organizations such as UNHCR and IOM. While this model enables short-term humanitarian responses, it structurally undermines the fulfillment of SRHR for refugee women by obscuring state accountability and perpetuating gender-blind policy design.

Accordingly, this study seeks to answer two central questions: (1) What are Indonesia's normative obligations regarding the SRHR of refugee women under international human rights law? and (2) How are these obligations implemented in practice, particularly in relation to maternal healthcare services? By addressing these questions, this article contributes to the development of a more accountable and gender-responsive framework for refugee protection in transit contexts.

RESEARCH METHOD

This study employs a non-doctrinal qualitative research design that integrates normative legal analysis with empirical inquiry. The normative component examines Indonesia's obligations under international human rights law, focusing on ICESCR, CEDAW, ICCPR, and CRC, as well as their interpretative frameworks such as General Comments and General Recommendations. This analysis is complemented by a critical feminist legal perspective to assess how ostensibly gender-neutral regulations produce substantive inequalities. The empirical component is based on a semi-structured interview conducted with a representative of the United Nations High Commissioner for Refugees (UNHCR) Indonesia on March 13, 2024. The interview aimed to explore institutional practices, coordination mechanisms, and challenges in delivering reproductive health services to refugee women. Data were analyzed using thematic analysis to identify recurring patterns related to access, discrimination, and institutional constraints. Secondary data were collected from official reports issued by UNHCR, SUAKA, OHCHR, and relevant non-governmental organizations, as well as academic literature on refugee law and maternal health. To enhance analytical robustness,

this study adopts the AAAQ framework (availability, accessibility, acceptability, affordability, and quality) and the ROAM health equity indicators as evaluative tools. This methodological triangulation allows for a comprehensive assessment of both the normative commitments and practical realities of SRHR protection for refugee women in Indonesia. However, the study acknowledges limitations, particularly the absence of direct interviews with refugee women, which may constrain the depth of experiential insights.

RESULT AND DISCUSSION

Indonesia's Obligations towards Refugee Women's Rights to Sexual and Reproductive Health

Normatively, Indonesia is not a party to the Convention relating to the Status of Refugees and its Protocol. It raises the question of why Indonesia is responsible for providing health services to refugees. In addition to being a global public good (Alexander Betts 2009), Indonesia has a fundamental responsibility to temporarily protect refugees based on general principles of law, customary international law, and other human rights treaties. Indonesia acts as a 'transit country', with transit periods that tend to be long (on average, more than five years of residence) (Graeme Hugo et al. 2017). During this period, Indonesia is responsible for respecting, protecting, and fulfilling the rights of refugees. For details, the Table below shows Indonesia's obligations to fulfil the rights of refugees while they are in Indonesia. For details, the Table below shows the Indonesian obligation to fulfil the refugee rights while they are in Indonesia.

Table 1 International Framework to Protect Refugee Women 's Reproductive Health

No	Treaty Name	Article	Legal Substance	Ratification Status
1	International Covenant on Civil and Political Rights (ICCPR)	Article 6, Article 23 section 1-4	- Right to live - Right to men and women of marriage and found a family, with full consent, and ensure equality rights	Accession on 23 February 2006
2	International Covenant on Economic, Social, and Cultural Rights (ICESCR)	Article 10 section 2, Article 12 section 1 Article 12 section 2a Article 12 section 2d	- Special protection for mothers during, before, and after childbirth (include paid leave and social security) - Right to enjoy the highest attainable standard of physical and mental health. - Reduction stillbirth-rate and of infant mortality - Assure to all medical service and medical attention	Accession on 23 February 2006
3	Convention on the Elimination of All Forms of	Article 10h Article 12 section 1-2	- Obligation to take measures to eliminate discrimination in order to ensure access to specific educational	Ratification on 13 September 1984

	Discrimination Against Women (CEDAW)	Article 14 section 2b	information to ensure the health and well-being of families - Eliminate discrimination in the field of health care - Access to adequate health care facilities, including information, counseling and services	
4	Convention on the Rights of the Child (CRC)	Article 24 section 2d	facilities for the treatment of illness and rehabilitation of health and to ensure appropriate pre-natal and post-natal health care for mothers	Ratification on 5 September 1990

(Source: processed data)

The ICCPR contains provisions on family rights and unity, which General Comment Number 36, adopted by the Human Rights Committee (HRC), interprets as meaning that the right to life cannot be diminished and prohibits violence against pregnant women and legitimizes the right of women to have an abortion if the pregnancy causes physical or psychological pain (Human Rights Committee 2019). A competent health professional must perform the abortion. In addition, the state is also obliged to provide maternal health services consisting of prenatal, postnatal, and post-abortion services, along with preventive measures to ensure that access to health information is available to everyone (Wang Bing 2004).

Article 3 of the ICESCR stipulates that everyone has the same right to enjoy all economic, social, and cultural rights, one of which is the right to health. This right is implemented based on the prohibition of discrimination, which is the different treatment of a person or group of people based on status, race, skin colour, gender, language, religion, political opinion and others, nationality, wealth, birth and other statuses such as age, ethnicity, disability, marital status, refugee or migrant status (Committee on Economic, Social, and Cultural Rights 2005). The right to health, as stipulated in Article 12 of this Covenant, refers to mental and physical health. States are required to ensure equality in health services, including preventive, curative, and rehabilitative processes. Everyone should have optimal access to health services (Camelia et al. 2025).

These health services are based on the AAAAQ indicators in order to provide access to sexual and reproductive health, namely: i) availability, the availability of a number of facilities, services, goods, and health programs to provide sexual and reproductive health services as widely as possible to the community; ii) accessibility, health facilities, goods, information, and services related to sexual and reproductive health care are accessible to all individuals and groups without discrimination and free of barriers, including physical accessibility and information accessibility; iii) affordability, sexual and reproductive health services must be affordable for everyone; iv) acceptability, respect for culture, minorities, society, communities, and sensitivity to gender, age, disability, sexual diversity, and life cycle requirements, but this does not justify the refusal to provide facilities, goods, information, and services; v) quality, the provision of quality services in terms of medical personnel, medicines, technology and

innovation, and other service support (Committee on Economic, Social and Cultural Rights 2016).

General Recommendation Number 35 of the CEDAW Committee explains that legislatively, countries are mandated to adopt women's rights to non-discrimination into legislation. This includes harmonizing regulations such as customary law, religious values, state law, administrative law, and regulations related to procedures so that they are in line with the protection of gender-based violence (Committee on the Elimination of Discrimination against Women 2017). Executively, states are mandated to design focused public policies, develop and implement monitoring mechanisms, and establish and/or fund competent national courts. In addition, states must provide accessible, affordable, and adequate services to protect women from gender-based violence, including reparations for all victims, including mental, sexual, and reproductive health services. Judicially, the state is mandated to ensure that all legal procedures in cases of gender-based violence against women are impartial, fair, and free from gender stereotypes or discriminatory interpretations of the law (Committee on the Elimination of Discrimination against Women 2017).

Article 12, paragraph (1) of CEDAW requires countries to report on critical issues related to health that affect women in their countries, including data on health regulations, plans and policies based on scientific research, ethics and assessments of health needs and women based on religion, tradition and culture (Committee on the Elimination of Discrimination 1999). General Recommendation Number 24 directs States to take steps to eliminate discrimination against women, considering it inappropriate if the health care system does not have services to prevent, detect, and treat diseases specific to women. It is discriminatory for a country to refuse to provide reproductive health services to women legally. For example, if a health care provider refuses to perform such services for legitimate reasons, steps must be taken to ensure that women are referred to alternative health care services (Committee on the Elimination of Discrimination 1999). Fair access to health services is also articulated as a human right under the CRC. Reproductive health services play a special role in improving maternal health, including maternal and newborn health, family planning, prevention of unsafe abortions, control of sexually transmitted infections, and promotion of sexual health (Committee on the Rights of the Child 2013).

All of these binding regulations have not yet been able to address issues related to the protection of refugee women in Indonesia. This is inextricably linked to social norms that subordinate women. Solihah et al. identified that the implementation of norms within CEDAW provisions is heavily dependent on Indonesia's patriarchal culture; these norms, which tend to be disadvantageous to women due to the lack of female representation in parliament, result in many women facing structural challenges in accessing health services. Moreover, the stigma attached to women as individuals who need to be "protected" intertwines with the impact on women's ability to choose regarding abortion and childfree lifestyles. Women's autonomy seems to be tied to men's voting rights. Additionally, the influence of interpretations of religious and traditional norms (cultural relativism) often

prevents women from accessing medical care in accordance with legal provisions. Traditionally, alternative practices have served as a shortcut for women's reproductive health care (Siti Maratus Solihah et al. 2024).

Indonesia is a signatory to various treaties that guarantee the protection of women refugees. As part of the international community, Indonesia does not want to violate international agreements. However, on the other hand, it does not yet have the capacity to protect refugees within its territory (Arie Afriansyah 2018). The lack of political will in handling refugees is also clearly reflected in regulations and practices. In fact, implementing international provisions ratified by a country requires follow-up in the form of established regulations and technical provisions that can be applied (Acconci 2024). The HRC notes that the inaction of various actors, both state and non-state, often hampers female refugees' access to reproductive health. State actors, in particular, rely solely on Presidential Regulation 125/2016, which does not adequately address the basic rights of refugees, demonstrating a weak commitment to refugee protection. Refugees are considered aliens, even though they need the state to fulfil their basic rights. In fact, the limited access to maternal healthcare among refugee women is not merely a logistical issue but reflects a structural consequence of Indonesia's delegated humanitarian governance model. By positioning international organizations as primary service providers, the state effectively externalizes its human rights obligations, resulting in fragmented service delivery and the absence of enforceable entitlements.

The problems inherent in Presidential Regulation 125/2016 are not limited to this. The nomenclature "refugees from abroad" used in this regulation is actually inconsistent with international regulations. Globally, this nomenclature is not recognized; only the term "refugee" is used, which receives international protection. The impact is a restriction on the universal definition of who is entitled to refugee status as regulated in the 1951 Refugee Convention because it covers new forms of refugees that will emerge (Sigit Riyanto 2024). Rhode's critical feminist theory views that law often gender-neutral and it cause disadvantages for women. It does not contribute to substantive equality (K. Bartlett 2018).

As stated in Article 26, Section 5 of Presidential Regulation 125/2016, basic needs are limited to health and sanitation services, which are still general and broad in nature, while reproductive health services are a matter that needs to be specifically regulated. The same policy will have different impacts on women and men, especially from certain groups (Jana 2025). The health services referred to in this provision are also vague, whether they are basic health services, advanced health services, or other health services. The identified bias is not explained in other or technical regulations. These ambiguities are used as a basis for various actors to neglect refugees (Afriansyah and Zulfa 2018). In fact, when they left their home countries, they left their lives, homes, possessions, and families behind in order to obtain international protection (Sigit Riyanto 2025). Such conditions show that women are often victims of political and socio-economic structures that oppress them (Jana 2025).

In the provisions in question, basic needs are explicitly mentioned as the responsibility of 'international organizations' (Presidential Regulation Number 125 of 2016 on Handling Refugees from Abroad 2016) does not mention the government or the Ministry of Health jointly providing access to reproductive health for refugees while in Indonesia. However, Article 12, paragraph (1) of CEDAW states that action is needed from the state, at the regulatory, policy, and technical levels, to fulfil the right to health for women within its territory. This *de jure* issue certainly has a direct impact on refugee women who become pregnant while in Indonesia.

Several efforts have been made, such as cooperation between the IOM and government hospitals, to provide health services to refugees. However, implementation continues to face challenges, such as hospitals prioritizing Indonesian citizens over refugees (Fernando et al. 2025). In women's health, neglecting issues of difference and neglecting women and not addressing the root causes of women's inequality are forms of discrimination and subordination (Hankivsky 2012). Rhode's critical feminist theory explains that ignoring the differences in women's needs—particularly biological ones—indicates that there is an invisibility of women's specific needs that cannot be met without regulations and institutional efforts. Rhode also argues that regulations that tend to be formalistic will fall short of substantive equality, lead to systemic discrimination, act as a double-edged sword for women in the direction of gender-unequal social transformation, and marginalize women's lived experiences in regulations at the policymaking level (Julia T Wood 2014). Various implementations of these regulations on pregnant refugee women are described in the following sub-chapter. The vulnerable experiences of pregnant refugee women can be taken into consideration in updating regulations in Indonesia to make them more accommodating.

Tragic Implications for Refugee Women's Pregnancies in Indonesia

There were 7,803 refugees and 4,205 asylum seekers in Indonesia according to the UNHCR as of December 2024. Of the 12,008 individuals recorded, 71% are male and 29% are female refugee adults (UNHCR 2025). Refugee women staying for a long time and experience multiple vulnerabilities such as access to reproductive health services. Reproductive health services for refugee women are a basic need that they may not necessarily have access to. There are several specificities regarding health care for refugees who become pregnant in another country (Pangas et al. 2019). Maternal care recommended by the World Health Organization (WHO) in 2025 includes antenatal care, intrapartum care, postnatal care, breastfeeding, prevention of maternal health complications, and improving maternal health and well-being (WHO 2025). Social services and support during pregnancy are key to safe childbirth and maternal health after delivery. The WHO recommends that pregnant women receive at least eight antenatal care visits during pregnancy and up to 42 days after delivery. These services should be provided to all pregnant women, including refugee women (WHO Regional Office for Europe, 2018).

Within the framework of health services in Indonesia, the minimum antenatal care indicators according to the Ministry of Health consist of, i) first visit (K1), which is the first contact between the pregnant woman and health workers to obtain integrated and comprehensive services in accordance with minimum standards before the eighth week, ii) visits to-4 (K4), which is integrated and comprehensive services at least four times during pregnancy, with more than four examinations recommended if there are complaints, illnesses, or pregnancy disorders, iii) visit 6 (K6), which is services by health workers six times and more if related to the treatment of obstetric complications, infectious diseases, and nutritional problems during pregnancy, childbirth, and the postpartum period (Kementerian Kesehatan RI 2020).vThe standard for each antenatal checkup consists of weighing and measuring height, measuring blood pressure, assessing nutritional status, measuring fundal height, determining fetal presentation and fetal heart rate, screening for tetanus immunization and administering tetanus immunization if necessary, administering iron tablets, conducting laboratory tests, case management, and counselling (including effective communication, information, and education). A balanced diet for pregnant women consists of consuming a greater variety of foods, including protein, iron, folic acid, vitamins, calcium, and iodine, limiting consumption of foods high in salt, drinking more water, and limiting caffeine consumption (Kementerian Kesehatan RI 2020).

The Reproductive Outcomes and Migration (ROAM) identifies health equity indicators, consisting of the following indicators (WHO Regional Office for Europe 2018):

Table 2 ROAM indicators for health equity

No	Indicator	Examining the indicator
1	in health status (outcomes)	how healthy different populations?
2	in access to health care services	how easily can different populations access health services? How often do they access them?
3	in delivery of health care services	how fairly are healthcare services accessed and delivered to different populations?
4	in health care policy/financing	how fairly is the budget for health services allocated to different populations? Do health-related policies have an impact on different populations?

(Source: Lang C et all, 2008)

These indicators serve as benchmarks for assessing whether a country's health services are accessible to refugees or vulnerable groups within that country. These indicators can also illustrate specific problems that arise in terms of access to care for mothers and newborns who are refugees. The risks of pregnancy in women are generally influenced by several factors, including the mother's medical condition, high-risk pregnancy, psychological factors, and socio-economic conditions (Kringeland et al. 2010). Such risks occur in Indonesia, based on the SUAKA Report for the UPR, where mental disorders caused by living in uncertainty for more than a decade are accompanied by an increase in SGBV against refugee women (SUAKA Indonesia et al. 2022). In Australia, it has been noted that the largest contributors

to the increased risk of death among pregnant refugees are refugee status, socio-economic injustice, diabetes, gestational hypertension, premature birth, obstetric complications such as haemorrhagic sepsis, preeclampsia, eclampsia, and other circulatory conditions during pregnancy and childbirth (Yeshitila et al. 2025).

Childbirth can have tragic consequences, and emergency procedures are sometimes necessary. Therefore, the freedom of pregnant women to choose childbirth procedures and infant care is vital for both. Of course, these choices are based on adequate information from quality health services. Research by Kringeland et al states that failure in childbirth can be influenced by health workers, such as a lack of support during childbirth, unexpected medical problems, and the mother's emotional condition. The delivery process is closely linked to the mother's mental state, who often feels trapped in an unavoidable, unknown, and uncontrollable situation, experiencing general anxiety, low self-esteem, depression, dissatisfaction with healthcare services, and a lack of support. Therefore, during delivery, healthcare workers have a responsibility to contribute to optimal antenatal care and structure (Kringeland et al. 2010).

The above explanation is a cause-and-effect factor that pregnant women must pay attention to. The condition of pregnant women is exacerbated by their vulnerability due to migration issues. They are at risk of not being able to access maternal health services, including health workers who assist with their deliveries (Kusuma et al. 2013). The following are the results of an assessment of ROAM's health equity indicators based on findings from in-depth interviews and various reports from various state and non-state institutions in Indonesia. The assessment results are presented in Table 3.

Table 3 ROAM's health equity indicators in the context of Indonesia

No	Indicator	Assessment on maternal care for refugee women
1	in health status (outcomes)	There are differences in health of pregnant women between refugees and Indonesian
2	in access to health care services	Refugee women have difficult accessing decent maternal care in primary and health services. They usually wait for IOM support for accessing health services
3	in delivery of health care services	There is difference treatment between refugees and Indonesian
4	in health care policy/financing	There is difference treatment in terms of health services budget. There are no comprehensive policies related to health services

(Source: processed data)

First, there are differences in the health status of refugees during their waiting period in Indonesia, especially for pregnant women. Pregnant refugee women often do not have access to maternal care as recommended by the WHO and the Ministry of Health. This results in additional physical and psychological burdens (Lintang Kinasih Wijayani, March 13, 2024). The condition of female refugees, as reported in the 2023 CATAHU report by the

National Commission on Violence Against Women, states that a pregnant refugee in her ninth month was detained at the Class I Immigration Office at Soekarno Hatta Airport upon entering Indonesia, suffering from pain and swelling throughout her body. The victim was a victim of domestic violence by her husband, who was also a refugee, and was taken out of Indonesia. The victim returned to Indonesia to seek protection from the Indonesian government, but her detention at the immigration detention centre resulted in the victim's SRHR not being fulfilled. During her detention, the victim was not given access to reproductive health services, nor was she provided with the logistical needs of pregnant women (Komnas Perempuan 2023).

Efforts can only be made by telephone with UNHCR, and no access is given to meet in person. In addition, Komnas Perempuan (National Commission on Violence against Women) has attempted to meet with the victims in person. However, access to visit them has not been granted until the victims were forcibly returned to their country of origin. The victims were victims of multiple forms of violence, namely domestic violence and inhumane treatment while in detention in the form of restricted communication, violations of reproductive health rights, and forced repatriation to their country of origin (Komnas Perempuan 2023). The health condition of these pregnant refugees was not taken into consideration by the authorities in treating them humanely. Administrative matters were more important than the health condition of the refugee woman. This case illustrates that language barriers, lack of social support, and unfamiliarity with health services have an impact on pregnant refugees (Asbjornsen et al. 2025). Dang argues that language barriers are directly integrated with the effectiveness of health services, particularly in relation to communication with health workers (Dang 2025).

Second, female refugees in Indonesia experience difficulties in accessing maternal care compared to Indonesian citizens. They also do not have regular access to health services, which contributes to the prevalence of emergencies (Solmaz et al. 2025). In its findings for the 2022 Universal Periodic Review, Komnas Perempuan noted that refugees do not have equal access to adequate health services due to economic and administrative reasons, as well as limited legal protection for those in unregistered marriages. This is confirmed in the 2024 UNHCR Annual Report, which states that all refugees have limited access to Puskesmas (community health centres) for primary services, which are fee-based. Economic challenges are a particular burden for them in accessing services because they are prohibited from working while in Indonesia. As a result, primary services are only available through donations from non-governmental organization secondary and tertiary services are provided by the Jesuit Refugee Service (JRS) and the Cita Wadah Swadaya Foundation (YCWS). As of 2024, they have helped 24 refugees access neonatal services and 12 access maternal services (UNHCR 2025).

Family planning services include the right to decide not to have children, to have children, and to determine the spacing between children. Contraceptive services are needed for refugee women to fulfil their rights. Contraception in this case applies to long-term and

short-term contraception as well as the provision of condoms on a regular basis and at certain times. In practice, refugee women living independently can only access these services at their own expense, meaning they must purchase them themselves at pharmacies or hospitals. Their economic conditions greatly determine whether refugees can access these services or not, so it is not uncommon for this basic need to go unmet, resulting in refugee women experiencing unwanted pregnancies (Lintang Kinasih Wijayani 2024). Globally, over the past decade, according to the Centre for Reproductive Rights, the greatest challenge for refugee women has been unwanted pregnancies (Jana 2025).

Third, there is a different treatment for female refugees accessing health services in Indonesia. Female refugees living in refugee camps tend to receive better contraceptive services than refugees living independently. Refugee camps provide regular contraceptive services every 3-6 months (Dwita Aryani, March 13, 2024). This is certainly a positive step towards fulfilling family planning services for refugee women. However, contraceptive services are often needed not only periodically, but sometimes for a specific period of time. When refugee women need contraceptive services, they cannot freely access these services due to their limited freedom of movement and relocation. They can only wait for the UNHCR to provide these services (Dwita Aryani, March 13, 2024).

An independent report by Thomas Andrews, the UN Special Rapporteur on human rights in Myanmar, reported that while in Pidie Regency, Aceh, female refugees from Myanmar faced vulnerability during their displacement. More than 20 people died on the boat, and their bodies had to be thrown into the sea. In addition, inadequate food and clean water supplies forced them to drink seawater. Many young women became pregnant as a result of rape during the conflict, and women were trafficked for child marriage, with the buyers waiting for them in Malaysia (OHCHR 2023).

For refugee women living independently, if they have to give birth at a hospital or health centre, they must pay the delivery costs in advance. UNHCR will reimburse these costs if an assessment of the refugee shows that she is eligible for delivery assistance. Only 1,273 vulnerable refugees from 430 households receive monthly allowances and financial assistance from UNHCR, which is sent through the post office in the area where the refugees live. Meanwhile, refugees who are deemed not to meet the vulnerability criteria through assessment are not provided with financial assistance by UNHCR and must therefore cover their own access to sexual and reproductive health services, including during childbirth and postnatal care (Lintang Kinasih Wijayani 2024).

For refugee women living in refugee camps, when they give birth, they are usually only allowed to give birth in hospitals and are immediately transferred to refugee camps for recovery. One case was found where a refugee woman, after giving birth, had to be treated in the basement of the refugee camp, which was not a suitable place for recovery (Dwita Aryani, March 13, 2024). Difficulties with a healthy environment, such as clean oxygen, dirty beds, and the absence of nurses who could provide medical care, were situations she had to face after giving birth. Government regulations on reproductive health do not contain strict

sanctions related to violations of reproductive health services. In addition, they only focus on pregnant women in terms of reproductive health regulations and do not describe the coordination between ministries/agencies and international organizations providing services to refugee women after giving birth.

Fourth, as explained earlier, refugee access maternal care depending on funding from IOM or UNHCR while in Indonesia. There is no government budget related to maternal care for refugees in Indonesia. Several non-governmental organizations participate in helping Indonesian refugees, but they do not significantly target all refugees in Indonesia. Examples include the Cita Wadah Swadaya Foundation (YCWS) and Jesuit Refugee Service (JRS) in 2024, MER-C in 2024, Dompet Dhuafa and IDI in 2017 in Makassar, and Rumah Baca Aneuk Nanggroe (Ruman-Aceh). The impact is that there is no special place for babies and mothers to stay. As happened in Lhokseumawe, mothers and their babies were forced to live with other refugees in a shelter with 471 other refugees (Agus Setyadi 2024). In an in-depth interview with UNHCR, the Indonesian government contributed to the provision of hospitals and primary health services on the condition that they had received funding or established cooperation with UNHCR or IOM. In several reports, there is no record of Indonesia providing a special budget for pregnant refugee women.

This situation creates a dilemma for both refugees and health workers. Refugees are dependent on external funding because they are not allowed to work during their transit period in Indonesia. They are unable to support themselves because they do not have the opportunity to earn a living. On the other hand, the lack of skills among refugees is also an obstacle to earning a living while in Indonesia. It is not uncommon for them to be included in local activities by the surrounding community, based on humanity grounds. The dilemma for health workers is that they are unable to provide services if they do not have a basis for cooperation with donors from international organization can not act outside the SOPs of hospitals and primary health services. There needs to be a regulatory and policy framework from the Ministry of Health in order to take action. It is not uncommon for health workers to refuse refugees who come to health services.

The issues surrounding refugees require action that reflects lack of political will of the government. One of the efforts that the government can take, if it is unwilling to commit to the refugee convention, is to revise Presidential Regulation 125/2016. The revision must contain legal substance that protects pregnant women, which the competent authorities can technically apply. Given the absence of a responsible institution and the overlap of authorities, regulations are needed that explicitly specify the institution responsible for protecting pregnant refugees (UNHCR, 2024.). This paper argues that institutional strengthening related to the provision of maternal services can be implemented through coordination between the Ministry of Law and Human Rights, the Coordinating Ministry for Political, Legal, and Security Affairs, and the Ministry of Health at the central level. In addition, there should be direct coordination between the Ministry of Health and international organisation (UNHCR and IOM) in providing maternal care facilities (Leah

Bassel 2014). This coordination can be achieved through various means, such as consortia, inter-agency working groups, and inter-agency field manuals (Laurel Schreck 2000). At the regional level, local governments, through their health offices, in coordination with UNHCR and IOM, need to be involved in efforts to optimize external care for refugee women in Indonesia.

CONCLUSION

This article demonstrates that Indonesia's current approach to refugee governance, characterized as delegated humanitarianism, fundamentally limits the protection of sexual and reproductive health rights of refugee women. While Indonesia is normatively bound by international human rights instruments such as ICESCR and CEDAW, these obligations are not adequately translated into domestic legal and institutional frameworks. The reliance on Presidential Regulation No. 125 of 2016, which lacks gender-sensitive provisions and clear institutional mandates, results in fragmented service delivery and systemic inequalities. The application of the AAAQ and ROAM frameworks reveals significant disparities in access, quality, and financing of maternal healthcare services between refugee and non-refugee populations. From a theoretical perspective, this study confirms feminist legal critiques that gender-neutral laws often obscure structural discrimination. In practice, refugee women's reproductive health needs remain marginalized due to the absence of enforceable rights and state accountability. To address these challenges, this article proposes an integrated reform model that emphasizes legal revision, institutional coordination, and state-led financing mechanisms. Strengthening Indonesia's commitment to protecting refugee women's SRHR is not only a legal obligation but also a necessary step toward achieving substantive gender equality in humanitarian governance. [*W*]

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