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Addressing Reproductive Justice in Midwifery: Insights from Eastern Indonesia

Chahya Kharin Herbawani [1], *Ika Ayu Kristianingrum* [2]

[1] Program Study of Public Health, Faculty of Health Science, Universitas Pembangunan Nasional "Veteran" Jakarta, Depok, Indonesia

[2] Perkumpulan Samsara, Indonesia

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CORRESPONDING AUTHOR

Chahya Kharin Herbawani

Email: chahyakharin@upnvj.ac.id

ABSTRACT

Background: Reproductive justice highlights how social and structural inequalities shape reproductive autonomy. Midwives in rural settings such as Sorong, Southwest Papua, face barriers including limited service access and cultural stigma.

Purpose: This qualitative study aims to examine midwives' how midwives perceive and implement reproductive justice when responding to requests for assistance with unwanted pregnancy termination. **Methods:** This study employed a qualitative descriptive design using Focus Group Discussions (FGDs) conducted in Sorong, Southwest Papua, Indonesia. Fifteen midwives from rural and peri-urban health facilities participated. Data were analyzed using a qualitative descriptive approach to understand their dual roles as healthcare providers and advocates for women's reproductive rights.

Results: The findings show that midwives commonly engaged in initial consultation and counseling, with some relying on referral to specialists. Their responses were shaped by factors such as limited knowledge of regulations, lack of resources, cultural stigma, and restrictive policies. These challenges restrict their capacity to address reproductive justice issues effectively.

Conclusion: The study highlights the urgent need to integrate reproductive justice principles into midwifery education and training. Equipping midwives with knowledge, advocacy tools, and policy awareness may support their role in protecting women's reproductive rights in low-resource settings. This research adds to the understanding of reproductive justice and underscores the transformative potential of midwifery practice in advancing health equity in Sorong, Southwest Papua.

Keywords: Education; Midwives; Reproductive Justice; Eastern Indonesia

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INTRODUCTION (CHAPTER)

Reproductive justice is a comprehensive framework, complete physical, mental, spiritual, political, social, and economic wellbeing of women and girls, based on the full achievement and protection of women's human rights (1). Reproductive justice merges reproductive rights with social justice, addressing the intersecting structural inequalities that impede individuals' autonomy over their reproductive lives. Unlike the traditional reproductive rights paradigm, which primarily focuses on access to reproductive healthcare services, reproductive justice emphasizes the right to have children, not to have children, and to parent children in safe and supportive environments. This framework, first conceptualized by SisterSong Women of Color Reproductive Justice Collective, acknowledges the influence of socio-economic, cultural, and political factors in shaping reproductive health outcomes, particularly for marginalized populations (2). In this study, reproductive justice is operationalized through midwevis' attitudes, decision-making processes, and ethical considerations in responding to reproductive health situations.

Midwives, as frontline healthcare providers, are strategically positioned to advance reproductive justice, especially in underserved and marginalized communities. Their role extends beyond clinical care to encompass emotional, social, and advocacy support, aligning with the core principles of reproductive justice. However, despite their critical position, midwives often encounter systemic barriers such as inadequate resources, restrictive policies, and cultural stigmas that hinder their capacity to advocate effectively for reproductive justice (3). Adressing these intricate challenges requires an in-depth understanding of how midwives navigate their roles in practice.

In the context of rural settings such as Sorong, Southwest Papua, where socio-economic disparities and cultural complexities significantly impact reproductive health, the integration of reproductive justice into midwifery practice is particularly pertinent. This setting presents unique challenges, including limited access to reproductive health services, high maternal mortality rates, and deeply entrenched gender norms that restrict women's reproductive autonomy (4). However, there is limited evidence on how midwives perceive and implement reproductive justice within this specific context. Therefore, this study aims to examine how midwives perceive and implement reproductive justice when responding to requests for termination of unwanted pregnancy.

METHOD

This study used a qualitative descriptive design using Focus Group Discussions (FGDs) to explore the perspectives and roles of midwives in promoting reproductive justice within rural healthcare contexts. The Focus Group Discussions (FGDs) were conducted in Sorong, Southwest Papua (Papua Barat Daya), Indonesia, and involved 15 midwives from various rural and peri-urban health service settings. The activity was organized by Perkumpulan Samsara as a five-day workshop titled "*SRHR Bootcamp: Referral Series for Empathic and Stigma-Free Sexual and Reproductive Health Services for Midwives*". This bootcamp functioned not only as a platform for capacity building but also, incidentally, as a participatory setting for data collection.

Within the framework of the workshop, FGDs were integrated as a key method to elicit rich, experience-based narratives from the participants. The discussions were guided by a semi-structured discussion guide and aimed at capturing midwives' insights into their everyday roles as healthcare providers and their functions as community-level advocates for reproductive justice. The FGDs also explored specific case experiences in which midwives had to make clinical and ethical decisions related to women's sexual and reproductive health. These cases included, but were not limited to, situations involving adolescent pregnancy, access to contraception, stigma around abortion, and gender-based violence. All FGDs were

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conducted in Bahasa Indonesia and facilitated by trained moderators with experience in qualitative research and reproductive health.

The researchers were actively involved in the design, facilitation, and implementation of the bootcamp. This dual role provided valuable contextual understanding of the learning process but may also have influenced participant responses during data collection. Participants may have perceived the researchers as instructors, facilitators, or evaluators, which could have created power dynamics affecting the openness of their responses. To minimize this influence, participants were informed that their contributions would be treated confidentially, used solely for research purposes, and would not affect their participation or standing within the bootcamp. Throughout the study, the research team engaged in ongoing reflection regarding how their roles, assumptions, and interactions with participants might shape both the collection and interpretation of data.

Participants were encouraged to reflect on and discuss the challenges they face in advocating for women's health rights, particularly in the context of resource-limited, culturally diverse, and remote rural settings. Topics included structural limitations such as lack of referral services, limited clinical infrastructure, community stigma around reproductive health issues, and the absence of clear policy guidelines. The FGDs provided a platform to not only surface these barriers but also to share local strategies and support mechanisms that midwives utilize in addressing these challenges. Participant responses were recorded through discussion notes and session documentation generated throughout the bootcamp. Data were transcribed and analyzed using manual thematic analysis. The analytical process involved familiarization with the data, identification of initial codes, grouping of codes into themes, and refinement of themes through discussion among the research team.

This study has several limitations. The relatively small sample size and specific bootcamp context may limit the transferability of the findings. Participant responses may also have been influenced by social desirability bias and the collaborative workshop environment. In addition, the study relied primarily on participant-generated data without extensive triangulation through independent observations, external assessments, or longitudinal follow-up. Future research should involve larger and more diverse samples, multiple data sources, and longer-term evaluation of learning outcomes.

This study originated as a community service activity and formal institutional ethical approval was not obtained prior to data collection. Nonetheless, ethical principles were upheld throughout: participation was voluntary, all participants provided verbal informed consent prior to the FGDs, and confidentiality was maintained throughout the study.

RESULTS AND DISCUSSION

RESULTS

The findings of this study reveal several key themes that illuminate the complex roles midwives play in advancing reproductive justice within the context of Sorong, Southwest Papua, Indonesia.

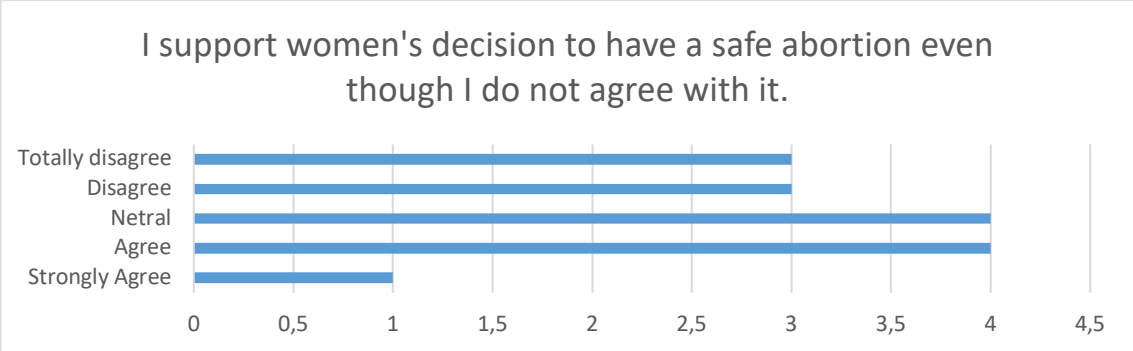

Figure 1. Midwive's support to women's decision to have a safe abortion

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This study investigated attitudes towards abortion among 15 midwives. Figure 1 presents the distribution of responses to the statement, "I support women's decision to have a safe abortion even though I do not agree with it." The data indicate a nuanced perspective among the respondents. While a minority "Totally disagree" (approximately 20%) or "Disagree" (around 20%) with the statement, a substantial portion expressed support. Notably, 26.7% "Agree" and 6.7% "Strongly Agree," suggesting a prevailing sentiment of supporting a woman's decision for a safe abortion, even if personal moral reservations exist. A significant number of respondents (approximately 26.7%) remained "Neutral," indicating a diversity of opinions or possibly a reluctance to take a definitive stance.

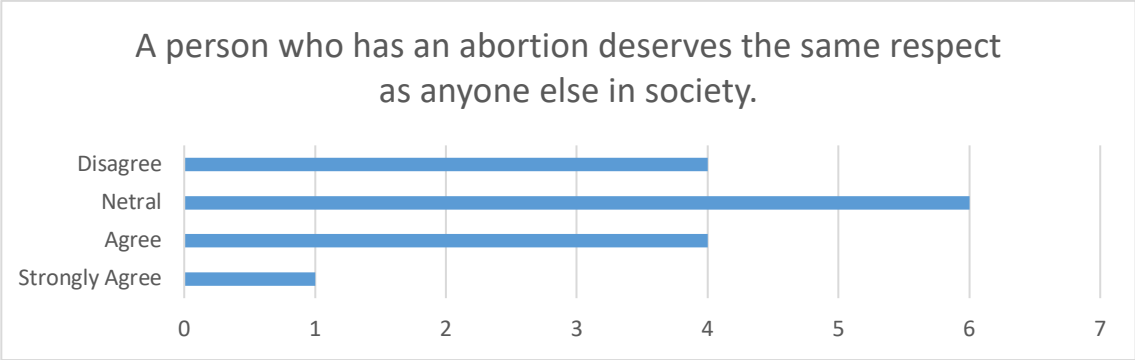

Figure 2. Midwive's perspective about respect to a person who has an abortion

Figure 2 illustrates the responses to the statement, "A person who has an abortion deserves the same respect as anyone else in society." The findings reveal a strong consensus among the respondents regarding the equal respect for individuals who have undergone an abortion. A very small percentage "Disagree" (around 26.7%) or are "Neutral" (around 40%). Conversely, a substantial majority "Agree" (approximately 26.7%) or "Strongly Agree" (around 6.7%) with the statement, underscoring a widely held belief that undergoing an abortion should not diminish an individual's societal respect. These results suggest a compassionate and non-judgmental stance towards women who have had abortions within the surveyed group.

Through the Focus Group Discussions (FGDs) involving 15 midwives working across rural and peri-urban healthcare settings, insights were gained into their responses when approached by someone seeking assistance in terminating an unwanted pregnancy. The open-ended nature of the question allowed for diverse perspectives, revealing a strong emphasis on professional ethics, patient safety, religious considerations, and the importance of comprehensive medical consultation. The discussion data were reviewed and organized to identify common issues and responses, which were subsequently grouped into key themes.

These themes include: (1) initial consultation and situational assessment, (2) referral to obstetrician-gynecologists, (3) counseling and educational interventions, (4) maternal safety and awareness of legal frameworks, and (5) moral and religious considerations. Together, these themes illustrate the ways in which midwives perceive and implement reproductive justice within their professional roles.

Initial Consultation and Situational Assessment

A dominant theme across the responses is the prioritization of initial consultation and contextual assessment. The majority of participants indicated that their immediate response would be to engage the individual in a dialogical process to better understand their situation, motivations, and the medical or psychological risks involved. Illustrative responses included: "*Pendekatan terlebih dahulu dengan konsultasi*." ("*Approach first with consultation.")* and "*Menanyakan apa masalahnya*." ("*Ask what the problem is*."). This underscores a commitment to informed decision-making and patient well-being, ensuring that any subsequent actions are based on a thorough understanding of the circumstances.

Referral to Obstetrician-Gynecologists

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Another recurring pattern is the decision to refer clients to specialists, particularly obstetrician-gynecologists (ObGyns). This referral behavior appears to reflect a combination of legal compliance and perceived professional boundaries, as abortion services are generally understood to fall under the authority of licensed medical doctors in Indonesia. For example, one respondent stated, "*Saya menyarankan untuk mengunjungi dokter spesialis." ("I suggest visiting a specialist.")* while another explained: "*Kalau pribadi saya, abortus dilarang bagi agama dan yang bisa melakukan itu hanya dokter, dan itu pun kalau ada indikasi.*" ("Personally, I believe abortion is forbidden by religion, and only doctors can perform it, and even then, only if there are indications."). However, it is important to note that obstetrician are not always available or easily accessible in many of the respondents' practice areas, especially in rural settings. In some cases, referral may also function as a way to distance oneself from direct involvement in ethically sensitive situations, particularly when personal or religious objections are present.

Counseling and Educational Interventions

Most respondents emphasized their role in providing counseling and education when responding to abortion requests. However, the nature of this counseling varied. Some responses reflected directive counseling, where midwives actively discouraged abortion, as illustrated by statements such as "*Memberikan konseling agar tidak melakukannya karena sangat bahaya.*" ("*Providing counseling not to do it because it is very dangerous.*"). In contrast, other responses suggested a more informational approach, such as "*Saya memberi pengetahuan*." ("*I provide knowledge.")* indicating an effort to provide knowledge without explicitly directing decisions. This variation highlights differing interpretations of the midwife's role, ranging from guiding patient choices to supporting informed decision-making.

Maternal Safety and Lack of Legal Awareness

Although not always explicitly stated, many responses revealed an implicit concern for the health and safety of both the mother and the fetus. Warnings about the dangers of abortion, such as "*sangat bahaya*" ("*Very dangerous"*) and references to the need for medical evaluation, "*Apakah bermasalah atau tidak*" ("*Is it problematic or not*"), indicate a genuine commitment to protecting maternal and fetal well-being.

Moreover, several midwives expressed a firm refusal to assist in abortion procedures when no clear medical or legal justification was present. However, this stance may also reflect a lack of awareness regarding existing regulations and medical indications under which abortion is legally permitted in Indonesia. This highlights the need for enhanced education and training for midwives on reproductive health laws and safe abortion guidelines to ensure informed and legally compliant decision-making.

Moral and Religious Considerations

Another emergent theme pertains to the moral and religious objections voiced by several respondents. Responses such as "*Abortus dilarang bagi agama.*" ("*Abortion is prohibited by religion*") and "*Sebagai bidan saya menyampaikan bahwa aborsi adalah dosa besar*" ("*As a midwife, I convey that abortion is a major sin.*") suggest that personal religious beliefs play a significant role in shaping midwives' responses. These beliefs often intersect with professional responsibilities, creating tensions between personal values and the ethical obligation to provide patient-centered care. A number of midwives took a firm stance against assisting in abortion, as reflected in statements like statements such as "*Saya tidak akan membantu untuk melakukan aborsi dengan alasan yang tidak pantas*" ("*I will not help perform an abortion for an inappropriate reason*") and "*Saya tidak bisa membantu*" ("*I cannot help*") suggesting a form of conscientious objection. While such positions may be grounded in personal or religious convictions, they may also influence access to care, particularly in settings where alternative services are limited.

DISCUSSION

The present study provides important insights into the intersection of midwifery practice and reproductive justice within the context of Sorong, Southwest Papua. The findings underscore the crucial

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role described by participants that midwives play not only as primary healthcare providers but also as frontline advocates for women's sexual and reproductive health and rights (SRHR), especially in regions where access to health services and legal protections are limited. This dual role of midwives, clinical and advocacy-based, resonates with global frameworks that recognize midwives as key actors in the realization of reproductive justice (2,5). The data from both surveys and Focus Group Discussions (FGDs) reveal a complex interplay between professional ethics, personal beliefs, legal awareness, and healthcare system limitations. These findings resonate with global debates on abortion care, conscientious objection, and the critical role of midwives in reproductive health services (6,7).

One of the findings of this study is that some midwives expressed support for a woman's decision to undergo a safe abortion, even if they personally disagreed with the practice. This highlights an important ethical stance wherein professional responsibilities are acknowledged despite individual moral reservations. As identified by (8), healthcare providers often navigate complex moral terrain where personal values and professional duties may conflict. The ability of midwives to support women's choices, even when personally conflicted, reflects an ethically grounded approach that prioritizes patient autonomy, a central principle in bioethics (9).

The findings also reveal a dominant narrative emphasizing the importance of respectful treatment towards individuals who have undergone abortion. This is a critical insight, especially in socio-cultural contexts where abortion is highly stigmatized (10). By affirming that women deserve equal respect regardless of their reproductive choices, this may indicate a potential role in reducing abortion-related stigma and promoting reproductive justice. The World Health Organization emphasizes the importance of respectful, non-judgmental, and person-centered care in abortion services, and the findings of this study align with those global standards (7).

However, the FGDs uncovered several barriers to equitable and safe abortion care. Midwives frequently cited the need to refer clients to obstetrician-gynecologists, acknowledging both legal constraints and professional boundaries. According to Indonesian Law No. 36 of 2009 on Health and Government Regulation No. 61 of 2014, abortion is legally permissible under specific circumstances, such as rape, fetal anomalies, or risks to maternal health. Yet, the lack of access to specialists in rural areas presents a significant obstacle to timely and safe abortion services. This geographical disparity echoes global findings, where structural limitations in healthcare delivery systems compromise access to legal abortion (11,12). This aligns with findings in this study, where several participants demonstrated varying levels of understanding of legal provisions.

The tendency among midwives to emphasize counseling and educational interventions also reveals valuable insights. While this indicates a protective stance that seeks to inform women of the risks involved in abortion, some responses suggest a more directive approach, as reflected in participant statements discouraging abortion, potentially directing women away from abortion rather than supporting autonomous decision-making. Studies have documented similar patterns in other settings, where counseling can become prescriptive rather than empowering (13). It may be beneficial for midwives to receive training in non-directive counseling techniques to ensure that women are not subtly coerced or misinformed, particularly when abortion is legally permissible and medically necessary.

Another prominent theme is the invocation of moral and religious objections to abortion. While conscientious objection is legally recognized in many countries, its practice must be balanced with the obligation to ensure patient access to lawful medical services (6). The data indicate that midwives who refused to assist in abortion procedures often did so based on religious grounds, labeling abortion as a "*Dosa besar*" ("*Major sin*"). While such moral frameworks are deeply embedded in personal identity, they can create challenges in ensuring access to carewhen they obstruct women's access to time-sensitive care. If healthcare providers refuse to participate in abortion services, they are required to promptly refer the patient to ensure that women do not experience delays or denials of legally permitted services (7,14).

Importantly, several midwives demonstrated limited awareness of the specific conditions under which abortion is legally allowed in Indonesia. This knowledge gap may influence how midwives interpret and apply existing regulations in practice of patient rights and increase the risk of unsafe abortions, which remain a major cause of maternal morbidity and mortality in many developing countries (15). Strengthening midwives' education on reproductive health law, safe abortion protocols, and ethical care practices is thus

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essential to bridge this gap. Similar recommendations have been emphasized by international research which links provider education to improved reproductive health outcomes (7,16).

The study also reflects broader themes of medical paternalism and provider-centered decision-making that persist in many healthcare systems. While concern for patient safety is laudable, overly protective attitudes that limit women's reproductive choices may perpetuate disempowerment. Reproductive justice frameworks advocate for the right of all individuals to make informed choices about their reproductive lives without coercion, discrimination, or violence (2). Midwives, as frontline providers, must be supported in adopting this rights-based perspective through continuing professional development and supportive policy environments.

Midwives as Agents of Reproductive Justice

Reproductive justice, as conceptualized by the SisterSong Women of Color Reproductive Justice Collective, integrates reproductive rights with broader social justice concerns. It encompasses the right to have children, the right not to have children, and the right to parent children in safe and healthy environments (2). This framework moves beyond the limited perspective of individual reproductive choice and emphasizes the structural determinants, economic, social, political, and cultural, that shape reproductive autonomy.

Midwives in this study exhibited limited understanding of these broader determinants of reproductive health. While many participants shared narrative accounts that reflected their dedication to client-centered care, particularly when addressing complex issues such as adolescent pregnancy, abortion, and gender-based violence, their efforts were often constrained by limited authority, regulatory frameworks, and systemic capacity. Prior studies have demonstrated that when midwives are adequately empowered, they occupy a critical role in delivering respectful maternity care, supporting informed reproductive decision-making, and advocating for equity within health systems (17,18).

Structural Constraints to Practicing Reproductive Justice

Despite demonstrating a strong commitment to client-centered care, midwives in this study identified several structural barriers that significantly hindered their ability to implement reproductive justice principles in practice. Among the most prominent challenges were limited access to and understanding of the current regulatory frameworks, particularly concerning abortion and contraception. This finding is particularly significant given Indonesia’s complex and often ambiguous legal landscape surrounding reproductive health services. The inadequate dissemination of updated national health regulations to frontline healthcare providers remains a persistent challenge in many low- and middle-income countries (LMICs), where policy knowledge often fails to reach the grassroots level of healthcare delivery (19). This is reflected in participants’ accounts in this study, which demonstrated varying levels of understanding of existing regulations.

Another critical barrier frequently cited by participants was the inadequacy of referral systems, particularly in remote and island regions. Midwives noted that obstetricians were not always readily available for consultation or service provision, thereby complicating timely access to medically indicated procedures, including legal abortion. These systemic weaknesses align with broader evidence highlighting the disparities in healthcare infrastructure across rural Indonesia and similar LMIC contexts, where workforce shortages, unequal distribution of services, and insufficient governmental investment in primary healthcare are widely documented (20).

Cultural stigma also emerged as a persistent and influential factor shaping midwives’ practice environments. Participants described facing strong community resistance when addressing sensitive topics such as comprehensive sexual education, contraceptive access for adolescents, and the provision of information regarding safe abortion. These accounts are consistent with global literature suggesting that stigma, deeply entrenched in patriarchal social norms, religious conservatism, and systemic gender inequality, significantly impedes midwives’ capacity to provide holistic reproductive care (10,21). Even in cases where midwives were personally open to discussing these issues, their ability to do so was constrained by fears of social reprisal or professional censure, underscoring the powerful influence of cultural taboos in shaping provider behavior.

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In essence, the reluctance to engage in open dialogue about reproductive rights is not necessarily indicative of provider apathy or opposition but often reflects the broader socio-political conditions in which midwives operate. In conservative settings such as rural and peri-urban Eastern Indonesia, social sanctions, including shaming, professional isolation, and even threats of violence, can severely limit healthcare workers' autonomy and willingness to advocate for reproductive justice. This further reinforces the need for systemic reforms that prioritize legal clarity, community education, and provider protection to create an enabling environment for midwives to uphold reproductive rights.

Importance of Capacity Building and Policy Reform

One of the most compelling implications of this study is the urgent need to incorporate reproductive justice frameworks into midwifery education and in-service training. Several participants expressed a desire for greater clarity and confidence in navigating ethically and legally complex situations. Global evidence supports the idea that integrating rights-based and culturally sensitive content into professional training can enhance midwives' ability to advocate for and deliver comprehensive care (22,23).

Furthermore, policy-level changes are needed to support midwives' roles as advocates. This includes clearer legal guidelines on reproductive health interventions, protection from professional backlash, and institutional support for midwives who work in high-stigma environments. Evidence from other LMICs suggests that when midwives are supported through enabling policy environments, they can significantly reduce maternal and neonatal morbidity and mortality while promoting equity in access to care (24,25).

Community-Based Approaches and Participatory Engagement

An important methodological strength of this study was its integration within a community service model, particularly through the SRHR Bootcamp. The participatory design not only created a safe and empowering space for midwives to reflect on their experiences but also contributed to knowledge exchange and mutual learning. This approach aligns with participatory action research principles, which emphasize collaboration with community stakeholders to generate contextually grounded insights and solutions (26). Embedding research within community service activities may be particularly effective in contexts where research participation is otherwise limited by logistical or cultural barriers.

While this study provides rich data, it is not without limitations. First, the sample was geographically limited to Sorong and may not capture the full diversity of experiences among midwives across Indonesia's eastern provinces. Second, as a study conducted within a community service setting, participants may have been influenced by social desirability bias, potentially limiting the depth of critique offered regarding institutional systems or policies. Additionally, the small sample size (n=15) and the use of a workshop-based setting may limit the transferability of findings, and the absence of data triangulation may affect the depth of the analysis.

CONCLUSION

This study underscores the nuanced and multifaceted attitudes of midwives toward reproductive justice within the context of Sorong, Southwest Papua. While many midwives express a willingness to respect women's choices and affirm the dignity of individuals who undergo abortion, variations were observed in how these attitudes were translated into practice. These variations were influenced by factors such as access to legal and clinical information, structural barriers in healthcare access, and the influence of personal moral beliefs on professional duties.

The findings suggest an urgent need for comprehensive training programs that equip midwives with up-to-date knowledge on abortion law, clinical guidelines, and non-directive counseling skills. Integrating legal literacy and human rights education into midwifery curricula is also critical for promoting safe, ethical, and woman-centered reproductive health care.

Furthermore, health systems may need to develop mechanisms to ensure that conscientious objection does not impede access to abortion services, especially in settings where alternatives are scarce. Policymakers should strengthen referral pathways and enforce accountability frameworks to improve

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access to reproductive health services across different settings. Addressing these gaps may support midwives in navigating their professional role in safeguarding maternal health, promoting reproductive justice, and supporting women's autonomy in a manner consistent with both international standards and local realities.

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