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Reproduction: Conception, Reproductive Choices, and Islam: Overview

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"Family, Body, Sexuality and Health"
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Women, gender, and Islam

"What gender is, what men and women are, what sorts of relations do or should obtain between them – all of these notions do not simply reflect or elaborate upon biological 'givens', but are largely products of social and cultural processes" (Ortner and Whitehead 1981, 1). The biological "givens" in this description loom particularly large in the issue of women's reproductive functioning. Rules and practices surrounding this tend to be justified by referring to women's "natural" destiny. However, women's reproductive role should be seen as a social construct, shaped by the interface between the natural, the cultural, and the social.

In societies where Islam is the dominant religion, Islamic notions, rules, and practices, including those related to gender, interface with cultural notions and traditions. In Southeast Asia, with a population of almost 300 million Muslims, processes of accommodation between local cultures and Islam have been going on for centuries, yielding country- or culture-specific configurations. Among the Minangkabau in Indonesia, for example, society is seen as governed by two complementary principles: the feminine principle of custom and tradition based on matrilineal kinship and the masculine principle as contained in Islam and court culture (Ellen 1983). In Indonesia, during the Suharto regime all encroachments on the secular base of the Indonesian state were firmly held at bay. Now voices can be heard calling for Indonesia to become an Islamic state. In an interview in a popular journal, a known militant Muslim says that shari'a law is the answer to Indonesia's problems and that women's dignity will be restored once they cover their bodies (Subkhan 2004). This shows that especially women are being made exemplary in defining Islamic identity.

To illustrate that there is no Muslim female identity that determines women's reproductive choices in Islamic cultures, Table 1 shows the widely diverging values of two fertility indicators for a selected number of Muslim countries.

Table 1

Country	Total fertility rate* (TFR)	% Prevalence modern contraceptive methods
Turkey	2.43	38
Egypt	3.29	54
Saudi Arabia	4.53	29
Islamic Republic of Iran	2.33	56

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Country	Total fertility rate* (TFR)	% Prevalence modern contraceptive methods
Afghanistan	6.80	4
Pakistan	5.08	20
Bangladesh	3.46	43
Indonesia	2.35	55

* The TFR is the total number of children a woman would have at the end of her reproductive period if at every age she has the number of children according to prevailing age-specific fertility levels.

Source: UNFPA 2004, 102–9.

This entry highlights women's reproductive role in relation to relevant Islamic norms and practices, particularly in Indonesia. The concepts of reproductive health and rights are clarified first because they delineate the scope for reproductive choice.

The Cairo reproductive health and rights paradigm

The agreement reached at the Cairo International Conference on Population and Development (ICPD) in 1994 emphasized the sexual and reproductive rights of individuals, irrespective of sex or marital status. The ICPD yielded the following definitions of reproductive health and reproductive rights:

Reproductive health implies that people are able to have satisfying and safe sex lives and that they have the capacity to have children and the freedom to decide if, when, and how often to do so.

Reproductive rights are human rights concerning access to reproductive and sexual health care, services, and information (Meijer 2002).

The ICPD and Beijing's Fourth World Conference on Women (1995) had women's reproductive and sexual rights at the top of their agenda. Esposito (1998) observes that these conferences clearly show that the issue of women and Islam has become emotionally charged.

Reproductive health

Women's reproductive health is both a determinant of and conditioned by women's reproductive choice. Surgical interventions on the genital organs of a girl can be very damaging and may constrain reproductive choice later in life. Though such practices are not confined to Muslim cultures and predate the advent of Islam (Anees 1995), in Muslim cultures they tend to be justified by reference to Islam. In their most severe form they amount to female genital mutilation (FGM), which may cause sexual and reproductive disabilities, even infertility, and is clearly in violation of women's reproductive rights.

In Indonesia, traditional birth attendants (TBAs) always assisted at most of the deliveries, and still do so in rural areas. Female circumcision is part of their services. It is usually done at 7 or 40 days after birth and amounts to a small incision in the clitoris, after which a piece of turmeric is applied. Actually, it is more accurate to refer to the practice as female genital cutting. Reproductive health watchers in Indonesia fear that, along with the decline of the role of the TBA, female genital cutting will be more often performed by medical practitioners and

will then take a more severe form. At the same time, there is evidence of modern midwives urging the TBAs to refrain from the practice altogether to prevent infection (Putranti et al. 2003).

Once women reach childbearing age and start their fertility career, the main health risks for women come from giving birth too early, too soon, or too late, and from the conditions in which they have to give birth. High levels of maternal morbidity and mortality are still widely prevalent in poor countries. Unsafe abortions are a major factor in high levels of maternal mortality. These health risks reflect women's lack of reproductive choice. Giving birth at too young an age poses a well-documented health risk. Higher age at marriage of women tends to reduce the level of maternal morbidity and mortality (UNFPA 1997). Short intervals between births are not only risky for the mother but in many cultures also deemed undesirable. A baby should be properly breastfed before the mother becomes pregnant again, as is also stated in the Qurʾān (2:233).

Conception, pregnancy, and childbirth

While folk models of pregnancy and childbirth etiology vary across cultures, a recurrent theme in many such models is the idea that a woman's womb should provide an enabling environment in order to conceive. This idea can be found all over Asia. Infertility and spontaneous abortion are explained by the woman's womb being too dry or too hot, which is why marital infertility is usually blamed on the wife.

Pregnancy is to a greater or lesser degree always surrounded by prescriptions and proscriptions for the pregnant woman. Gestational stage largely determines what is allowed or desirable and what is not. In many cultures the fetus is considered to have received its soul after its movements can be felt for the first time. The question of when the fetus becomes a human being is important in determining the admissibility of induced abortion. Three tiers of time feature in the theological consideration of abortion: before 40 days, before 120 days, and after 120 days. The shape of the fetus is considered to change during each period. At 120 days, the transformations culminate in the ensoulment of the fetus. While Islamic scholarly opinion differs on the (conditional) admissibility of induced abortion before 120 days, there is consensus about its non-admissibility after 120 days (Omran 1992, 190–5).

Both mother and child are extremely vulnerable during delivery and the postpartum period. During this time they are regarded as being in a state of impurity that is considered dangerous for themselves and their environment (cf. Douglas 1984). A study of birth practices and the role of traditional midwives in three continents (Lefèber 1994) shows that the state of impurity assigned to newly delivered mothers and their babies is a cross-cultural theme, usually expressed in rules about confinement. When such rules apply, men are not allowed in the physically and culturally defined female space. Purity has to be ritually restored. In Indonesia, at 40 days after delivery, the mother takes a ritual bath and is then allowed to leave the house, prepare meals, and attend to her religious duties again. The baby is bathed and ritually cleaned from all impurity, given a name and introduced to the local community. Sometimes the local religious leader and neighbors are invited to sing about the life of the Prophet and whisper the sjahādah (confession of faith) in the baby's ears. In Bangladesh the period of postpartum impurity lasts for 7 days, after which the mother is allowed to pray and touch the Qurʾān again (Afsana and Rashid 2000).

Family planning and contraception

Fertility is thought to decline when it is within the calculus of conscious choice, lower fertility is perceived as being advantageous, and contraceptive means are available (cf. Coale 1973). However, these conditions have to be amended by adding a gender perspective and taking the normative context of fertility decisions into account.

Applying a gender perspective to the first condition implies that women are aware of having a choice about another pregnancy instead of resigning themselves to fate or the will of God, and that sexuality and reproduction are seen as two different matters instead of the one only meant to realize the other (Gupta 1996). The second condition should read: lower fertility is perceived by women as being advantageous. The condition about the availability of contraceptive means should read: contraceptive means and information and services should be available and accessible to women.

The issue of access has two interrelated dimensions: a normative and a practical one. For the first, religious leaders' views on family planning are crucial. The architects of the national family planning program in Indonesia at the beginning of the Suharto era (1967) were keenly aware of this. Prior to launching the program, they convened meetings with national religious leaders, during which intensive discussions were held and the conditional commitment of the leaders to the program was elicited. The conditional element pertained to specific methods, not to the justification for family planning. Abortion and sterilization were deemed unacceptable as official program methods. The intrauterine device (IUD) was initially placed in the same category but was later accepted (Niehof and Lubis 2003). This paved the way for implementing the Indonesian family planning program. The Islamic Republic of Iran where, based on the support and guidance provided by the country's religious leaders, a successful family planning program was developed during the past decade, represents a similar case.

For rural women the opinions of especially the local religious leaders are important for a legitimate use of contraception. During the early stages of the Indonesian family planning program, family planning fieldworkers in rural areas made sure to convince the local Muslim leaders of the desirability of spacing births by referring to the Qurʾānic verse (2:233) about the importance of breastfeeding children for two full years (Niehof 1987). Normative access to family planning for women in rural areas depends on the views of the local religious leaders and the importance their husbands attach to these. Practical access depends on the mode of service delivery and the degree of mobility granted to women, which is contingent upon prevailing norms of women's space and place, including rules about female seclusion such as purdah.

From a Muslim woman's point of view, the possible side-effects of different contraceptive methods have their specific drawbacks. Prolonged or irregular menstruation is not only uncomfortable, but also prevents Muslim women from carrying out their religious duties, since bleeding women are not allowed to pray and fast.

Concluding remarks: reproductive choice

Much attention is given to the reproductive and sexual role of women in the Qurʾān and ḥadīth. Islam acknowledges women's right to sexual gratification and, according to the letter, does not inhibit women's reproductive choice. However, practices that have a negative impact on women's reproductive health, or constrain women's reproductive choice, and that are justified by reference to Islam, are unfortunately still widely prevalent. Examples are FGM and female seclusion, the first causing trauma and reproductive disability, the latter barring access to reproductive health care and contraception. Muslim organizations for the reproductive and sexual rights of women are still facing huge challenges, even in an era of an “Islamic insurgence on gender issues” (Haddad and Esposito 1998).

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