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Abstract

Discourse on women's reproductive rights through the lens of Muslim culture. The use of contraception, assisted fertility and abortion, are analyzed in Iran and Afghanistan. The culture surrounding family planning is detailed through a woman's community, family, religion and the laws that govern the society they live in, which all influence her decision making in these matters. This piece stands as a cultural analysis of women's agency specifically in Middle Eastern Muslim culture, as it stands as a part of a global women's rights movement.

Disciplines

Female Urogenital Diseases and Pregnancy Complications | Feminist, Gender, and Sexuality Studies | Health Policy | International and Area Studies | Near and Middle Eastern Studies | Obstetrics and Gynecology | Social and Cultural Anthropology | Social Policy | Women's Studies

Comments

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Contraception, Abortion and Assisted Fertility among Muslim Women:
A Look at Islamic Culture and Policy in Iran and Afghanistan
by Hayley Jacobsen

Discourse on family planning is relevant to the lives of all women. Their rights and decisions on matters of contraception, abortion and assisted fertility are influenced by the world around them. A woman's community, family, religion and the laws that govern the society they live in all effect to what extent she can make decision on these issues and influence what she will decide for herself. For Muslim women, their religion may or may not be a larger factor in the family planning process. A Shi'a Muslim woman from Iran may experience a different situation from a Sunni Muslim in Afghanistan; and their plights may also be similar in some ways. This paper aims to look at the laws governing a woman's right and access to contraception, abortion, and assisted fertility; as well as how Islam and her community influence her access and decisions.

Iran and Afghanistan were chosen for this study as they represent the two major sects of Islam. The Islamic Republic of Afghanistan is a Central Asian country of Sunni Muslim majority. Afghanistan, which has an agriculture-dependent economy, suffers from high illiteracy rates; in 2006, 87 percent of women were illiterate (Library of Congress- Federal Research Division 2008a). The Islamic Republic of Iran is a Middle Eastern country with a Shia Muslim majority. Iran does not suffer from the same low literacy rates, with 79% of women being literate. This may be owing to the fact that Iran is a less rural nation, as its economy is dominated by the oil industry (Library of Congress- Federal Research Division 2008b). These two countries border one another. This fact suggests that there may be some shared cultural features. More

importantly, however, this paper makes a statement about the diversity of Islam by describing the differences present even between two countries in such close range to one another.

The concept of *khilafah* – human beings as moral agents – is important in the Islamic approach to family planning. The importance of one’s inner conscience and freedom of choice that *khilafah* demands aligns with a notion of self-governance on the topic of contraception as one sees fit as a God-conscious Muslim (Shaikh 2003, 105-128). These overarching concepts of individual rights, however, are not always preserved in popular interpretations of Islam.

Contraception

As in any life problem, Muslims are encouraged to consult various sources of guidance within the religious tradition. Opponents of contraception often support their rejection on the Quranic verse “kill not your children, on a plea of want, we provide sustenance for you and for them” (Q 6:151). This justification is also used as the basis of the argument against abortion, which will be discussed further. This verse is often countered with the argument that this interpretation of the verse is a misreading, for the context of this verse was in response to the pre-Islamic Arab practice of infanticide (Shaikh 2003, 105-28).

Historically Muslims addressed the issue differently from the present. Eight of nine legal schools permitted contraception, and there was a prevalent literature which provided detailed descriptions of popular understandings of contraception (105-28). Presently, both Sunni and Shia Islam agree on *azal*, or withdrawal before ejaculation, as an acceptable measure, but not necessarily in all the same circumstances. Many Shia Muslim scholars take the position that withdrawal is absolutely necessary for preventing unwanted pregnancies and for population control; therefore, they deem it acceptable without any conditions or prohibitions. Sunni

Muslims do not take such an open stance on the matter of withdrawal. Sunni scholars offer conditional allowance of withdrawal and consider it a man's prerogative. This is proven in Hadith scripture (texts that record the words and deeds of Mohammad) denoting Mohammad's allowance of a man to withdraw from a woman if he wishes. These Hadith verses can act as a double edged sword in that proponents may point to the verse as a basis for allowing withdrawal; however, it dismisses any agency for women in the decision making process (Alaeinovin 2014).

As a predominantly Sunni country, Afghanistan's contraceptive prevalence rates and policies parallel these more strict interpretations. Afghanistan has one of the highest maternal mortality rates globally, at 1,600-2,200 deaths per 100,000 live births (Haider et al. 2009, 935-53). This is paired with one of the lowest contraceptive prevalence rates, ringing in at 35.2% in urban areas and just 10.4% in rural populations, as of a 2005 National Risk and Vulnerability Assessment (Todd et al. 2008, 249-56). One factor that goes into these statistics is women's access to contraception. The health infrastructure of Afghanistan has generally been concentrated in urban centers, rather than in rural areas, despite the fact that 70% of the population live in rural areas (Haider et al. 2009, 935-53). Recently women's access to prenatal care was increased 600% in Afghanistan, yet this reform is stifled by the lack of health care access to women in rural areas.

Additionally, this theoretical improvement in women's access to contraception is challenged by the low female literacy rates and education, close adherence to traditional religious and cultural practices, and the overall lower status of women in Afghan society (Todd et al. 2008, 249-56). One of these cultural limitations is son preference, which is justified by the fact that traditionally sons stay in the family home and daughters are lost to their future in-laws (Sato 2007). Another and perhaps more influential cultural limitation is the barrier created by the

permission required from a male family member before a women can consult a health provider about contraceptive measures, and more generally the restriction of a husband's all-encompassing role as primary decision maker in the patriarchal nature of Afghan rural society (Sato 2007; Haider et al. 2009, 935-53). This may not be a true barrier to women's reproductive access in reality. Afghan women interviewed gave varied responses to what the ideal number of children is and whether contraception use is okay (Tober et al. 2006, 50-71). Women who decided not to use contraception at all, regardless of family size, supported their decision with a statement that they were afraid their husbands would take a second wife. A large number of Afghan women who said they wanted to limit the number of children they had opted for birth control methods that would be not easily detected by their husbands, showing that women often by-pass their husband's permission to seek reproductive health care. Yet these women are still concerned about what their husbands will think as well as the greater community. Afghan refugees who received contraceptive means in Iran often scheduled IUD removals and tubal ligations in advance of their return to Afghanistan along the thought process that there would be less access in Afghanistan and it would be a risk to use contraception there (50-71). There were also women who reported that both they and their husbands were compliant with contraceptive measures, cooperatively deciding on contraceptive methods. This may be an effect of acculturation, as it has been shown that male Afghan refugees in Iran changed their attitudes on family planning and contraception use over time, due to their exposure to Iranian society (Tober et al. 2006, 50-71; Todd et al. 2008, 249-56).

Iranian society is more open on the issue of contraception; religious and community leaders show support for contraception and health care access is notably greater than in Afghanistan. Iranian policy on family planning was not initially successful; however, in 1988

Iran's new family planning program was approved by Ayatollah Khamene'i, and high-ranking Shia clerics issued fatwas declaring that family planning was permissible. Reform was prompted by overpopulation that arose as a result of a lack of attention to population growth during and after military affairs with Iraq. This programming was targeted to increase women's literacy and education rates, involve men in the family planning decision making in a cooperative manner, and encourage child limitation and spacing. These reforms saw a rapid decline in fertility rate (Tober et al. 50-71; Abbasi-Shavazi et al. 2009, 1309-24; Aghajanian and Merhyar 1999, 98-102). It seems that the overall view of Iranian people with respect to contraception is that it is done to maintain family quality. Whereas Afghani Sunni Muslims have proven to predominantly associate with the ideals that Allah expects you to be fruitful and demands that you not kill children in any way, Iranian Shia Muslims draw more on Quranic ideologies of a Muslim's responsibility to foster family harmony. Part of this greater success with family planning in Iran is the overall cultural acceptance and greater access to health care. Women who visit a clinic, for any reason, are shown to a family-planning counselor to discuss their contraceptive plan. In this way family planning is almost forced upon these women; and yet, as aggressive as that seems, it means that these women are not left for want of greater access to reproductive health care and education. Women are encouraged to use any form of contraception they wish, from oral contraceptive to IUDs. Iranian women also feel less pressure from society to place family expansion before considerations of economic standing and personal well-being (Tober et al. 2006, 50-71).

Iran's story of family planning is not at its happily-ever-after moment just yet, however; there are still some problematic aspects that need to be addressed. For example, some methods of contraception are viewed as inappropriate due to their nature of requiring intimate contact from

the health care provider. IUDs require vaginal insertion, and so a woman's genitals must be exposed and manipulated by someone other than her husband, and this strikes a chord of modesty that still permeates cultural norms. Another concern with the family planning program in Iran is its failure to acknowledge contraceptive needs of unmarried people. Traditional abstinence is still the accepted standard for unwed people. The government turns a blind eye to the reality of young people engaging in premarital sex, leaving these young people with a lack of knowledge of and access to contraceptive methods. With a lack of education about and access to effective contraception, these unmarried youths are exposed to higher risks of unwanted pregnancy and sexually transmitted diseases (Mehryar et al. 2007, 352).

Abortion

In Islam, the positions on abortion are less consensual and more varied than that of contraception. Much of the Islamic perspective on abortion is based upon the understanding of the process of fetal development. The Quran suggests that the fetus goes through transformations before becoming an actual human being; at 120 days gestation the fetus undergoes "ensoulment" (Shaikh 2003, 105-28). This leaves room for debate on whether and when abortion is permissible; however, in all Islamic legal schools, termination of a pregnancy after 120 days is considered a criminal offense. The Quran does not explicitly address abortion, so Islamic scholars must rely on other sources, including the Sunnah, Hadith, and their own virtue. This leads to multiple interpretations of the limits of abortion acceptability (Shaikh 2003, 105-28; Levine and Raghavan 2012). As of 2008-09, abortion laws in both Afghanistan and Iran dictate that abortion, before 120 days from conception, is only permitted to save the woman's life or else it is prohibited altogether. Iran makes the exception that abortion may also be permitted in cases of severe fetal impairment (Levine and Raghavan 2012).

It seems that Shia scholars have allowed abortions for limited social and medical reasons because of an expanding population and constrained health budgets. Specifically in Iran, the introduction of a theocracy thrust these religious scholars into a role of responsibility and led them to act as reformers involved in social planning and public health. Involvement in these issues is direly needed to acknowledge the social realities that more than 80,000 illegal abortions are performed in Iran every year, putting thousands of women at risk and making this a public health crisis (Hedayat et al. 2006, 652-57). With only one percent of all abortions being lawfully performed due to medical reasons, this leaves tens of thousands of abortions being performed illegally by unqualified practitioners or through self-administered termination via abortifacient drugs obtained on the black market (Hosseini-Chavoshi et al. 2012, S172-77). Leaders are also beckoned to this issue as new technologies change the starting point. Fetal imaging and monitoring advancements require reconsiderations of abortion in the context of the well-being of the fetus. Yet, Iranian law still stands that therapeutic abortion may only be performed in cases to save the mother, before four months. There is hope that Iranian law will be molded by the National Legal Medicine Organization in allowing therapeutic abortion under some 51 medical conditions that pertain to both mother and fetus (Hedayat et al. 2006, 652-57).

Although policymakers in Iran are making some headway in reevaluating the stance on the acceptance of abortion, social judgments on abortion do not follow directly. Women still suffer from the social stigmatization of abortion based on the belief that it is sinful, and thus experience societal punishment thereafter. Pressure from their peers spreads misunderstanding of the relevant reproductive health policies and discourages women from seeking reproductive care. Iranian women often experience anxiety and depression due to the societal judgments placed upon them, devaluing any improvements to Iran's reproductive health policies since women will

be cautious to seek attention. However, this may just be speculation, for there is a lack of pre- and post- abortion care available to women, no matter what personal experiences they are dealing with (Hosseini-Chavoshi et al. 2012, S172-77).

There is less literature on abortion in Afghanistan; however, it is known that their abortion law is firm in allowance only to save the mother's life. With this conservative policy and with very low contraceptive prevalence, unsafe abortions occur frequently and potentially contribute to the high maternal mortality (Todd et al. 2010, 2057-62). In a socially conservative setting, it can be assumed that women who undergo these illegal abortions are also faced with social stigma and receive little post-abortion care. These strict policies on abortion rights leave women with little agency in terms of their reproductive wishes.

Assisted Fertility

On the opposite end of the spectrum in family planning is assisted fertility or assisted reproductive technologies (ART). Where before women's agency could be found in their choice to prevent unwanted pregnancy, now we bring into discussion to what extent Muslim women have agency in combating infertility. Family is put first and foremost in Islamic culture, therefore men and women who find themselves unable to produce a family feel a great sense of failure in regards to their faith.

Medically assisted reproduction is not a new issue; Islamic scholars addressed ART relatively quickly after the first baby was born of artificial reproductive therapy. In 1978 the first fatwa was issued to the Islamic world in general, which initially ruled that ART was only to be used under lawful treatment to a husband and wife wishing to have a legitimate child and simultaneously banning the use of a third-party donor or use of a surrogate. Sunni scholars view

that use of third party genetic materials as a form of adultery, and thus it is strictly forbidden. Prominent Shia jurists were more flexible on the issue and disagreed with the Sunni judgment, and in 1999 a fatwa was issued allowing for donor technologies to be used in all forms of ART; this would include sperm, egg and embryo donation, and gestational surrogacy. This is the policy now in practice in Iran, and it is legitimized through the use of *mut'ah* or temporary marriage, for the duration of the procedure. Iran may also be more open to greater flexibility in ART as it is recently facing a decline in fertility rate. Afghanistan shows no sign of decline in its high fertility rate, and as a Sunni dominant nation it remains steadfast with the initial fatwa, permitting only certain assisted fertility methods, such as in-vitro fertilization, which do not require a third party. Third-party methods would introduce accusations of adultery and muddling of kinship (Harrison 2014).

Kinship is an important factor in the consideration of ART because a central feature of Muslim identity and family structure is authenticity of lineage. Due to this steadfastness to the sanctity of the patrilineal name, adoption into families and taking on of adoptive family names is not always acceptable. Equally, sperm donation fractures links of family genetic lineage. This remains a challenge to many artificial reproductive technologies which require a non-familial egg, sperm or embryo (Serour and Dickens 2001, 187-93). The lack of choice in ART leaves Sunni Muslim women with little agency in pursuing a family and combatting infertility.

Infertility may have serious repercussions for Muslim women. If a husband feels his wife is not doing her duty to provide children, he may take on a second wife or divorce her. An infertile woman may also experience psychological abuse from her husband; one woman recounted that her husband would humiliate her due to her infertility and insult her and her family (Behboodi-Moghadam et al. 2013, 41-46). Overall, infertility is considered a personal

tragedy affecting the entire family. An infertile couple may experience social isolation from both their community and their extended family. Across much of the Muslim Middle East, children are highly desired and parenthood is culturally mandatory. In Iran particularly, family status is especially important due to the high prevalence of infertility (Behboodi-Moghadam et al. 2013, 41-46; Harrison 2014). These factors make ART very appealing to infertile couples, especially the women who experience the greatest psychological, physical, and social hardships from the situation.

Conclusions

Issues of contraception, abortion and fertility have engaged women in debate with their religion, communities and governments. Reproductive concerns are very intimate, yet so many outside sources try to tell women how they should act or decide on these matters. Women may look to their faith or their community for support and advice on these decisions, but it seems unjust to force a particular decision upon them. The governments of Iran and Afghanistan act from very limited perspectives. They must work to address the realities of their nations and broaden their mindset on these important issues. Contraception should be made accessible to everyone, as it is naive to think that partners are waiting until marriage to be sexually active. As for abortion, there are many reasons a women may want an abortion; but these governments stand firm in the ruling that the only reason a women should have an abortion is if it threatens hers or her baby's life. Yet the statistics show that women are seeking out illegal abortions in high numbers, and these governments ignore this public health crisis. That is not to say that the governments of Afghanistan and Iran are completely inflexible and blind to the issues facing their peoples. Iran especially has made strides in family-planning programming. However, these

governments must be more responsive to the real issues their citizens face, rather than what they deem as respectable to acknowledge.

As for Islam's specific role in reproductive issues, there is a great deal of ambiguity. The Qur'an is lacking in direct references to issue of abortion, contraception and assisted fertility as we know them today. This leaves room for interpretation, which can be both helpful and hurtful. The flexibility that Islamic texts offer by not absolutely defining rules on these reproductive issues offers women room for negotiation. Women may turn to their sacred texts and find an understanding of the word that supports them in their decisions. Additionally, Islamic scholars tend to be responsive to current issues. Fatwas given on contraception, abortion and assisted fertility differ between Sunni and Shia Islam; however, they both offer a lucid basis that Muslim-majority governments will add to. It is not Islam itself that limits women on these issues; it is the governments that tack on stipulations to fatwas which effectively make a women's window of agency narrower and narrower. The governments then justify these additions through Islam, and in this way Islam comes to be seen as an antagonist to women's reproductive rights. As with any religion, different interpretations lead to conflict in opinions based on the same texts, making it difficult to discern whose understanding more accurately reflects the core of Islamic values.

Afghanistan, from this analysis, seems to be stricter in its rulings and limits on women's agency. Yet Iran does not provide a perfect solution with its family planning programs either. The main issue is women's accessibility to reproductive health care, which is dictated by both physical accessibility and social implications. In Iran, contraceptive counseling is readily available, but only to married women. Social preconceptions on who should and should not be having sex must not stand in the way of every woman receiving the care she wants and needs. In Afghanistan, it is not just young and unwed women influenced by the society around them.

Afghani women feel social pressures from their communities, families, and husbands on issues of contraception and abortion. Women may forego seeking care due to the social stigmatization that would come with these efforts, or suffer psychological and physical abuse after opting to take contraceptive or abortive measures. Therefore, even if Afghanistan were to decide to make reforms parallel to Iran, more must be done than simply changing laws and creating new reproductive health care facilities. These facilities must first be placed in coordination with national demographics, i.e. providing sufficient programming in rural areas. Most importantly, these new family planning programs need to have an educational portion that is palatable and accessible to a wide audience of women. Many women in these countries do not know of their options pertaining to reproductive health, including what services are available to them and general knowledge of reproductive health. Education on these issues is key in changing popular attitudes toward contraception, abortion and assisted fertility. Even if there is programming, if no one knows it is there or dares take advantage of it, in fear of the social wrath that they will face, what good are these programs really doing? Education can combat the stigmatization of these issues and make programming realistically accessible.

This is not just a Muslim women's issue. Reproductive health is relevant for women globally. This topic is especially relevant to American women, with the recent controversy around Planned Parenthood. Issues of women's agency and right to contraception and abortion are hotly debated with the 2016 elections approaching. While American women are facing these challenges domestically, it is important to keep in mind women's rights and agency on a global scale. The decisions made in America may not be suitable for Iran or Afghanistan due to cultural difference, but these decisions do affect one another. American feminism should maintain global considerations of the impact of their stances and efforts within women's reproductive rights. It is

apparent that, for Muslim majority countries like Iran and Afghanistan, Islam plays a major role not only in policy decision making but also in personal decision making by individuals. As American feminism tackles issues of contraception, abortion and assisted fertility from a more secular perspective, it is imperative to not isolate those who justify their agency as a women through religion. In the US, Iran, and Afghanistan, the battle is not won for women's reproductive rights; there is work to be done for women's advocacy to enhance women's access and agency in reproductive matters.

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