



Fall 2014

“In Light of Real Alternatives”: Negotiations of Fertility and Motherhood in Morocco and Oman

Victoria E. Mohr
Gettysburg College

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“In Light of Real Alternatives”: Negotiations of Fertility and Motherhood in Morocco and Oman

Abstract

Many states in the Arab world have undertaken wide-ranging family planning policies in the last two decades in an effort to curb high fertility rates. Oman and Morocco are two such countries, and their policies have had significantly different results. Morocco experienced a swift drop in fertility rates, whereas Oman's fertility has declined much more slowly over several decades. Many point to the more conservative religious and cultural context of Oman for their high fertility rates, however economics and the state of biomedical health care often present a more compelling argument for the distinct differences between Omani and Moroccan family size. While many explanations exist for inconsistencies in fertility trends, integrating these explanations into a cohesive whole allows us to see women as rational actors who make the best choices for their own context. This paper synthesizes existing literature on religion, culture, medicine and economics with field experience to comprehensively examine the multifaceted fertility decision making process of women and couples in Morocco and Oman.

Keywords

Middle East, Maternal Health, Morocco, Oman, North Africa

Disciplines

African History | African Languages and Societies | African Studies | Family, Life Course, and Society | Gender and Sexuality | International and Area Studies | Islamic World and Near East History | Maternal and Child Health | Near and Middle Eastern Studies | Obstetrics and Gynecology | Public Health | Race and Ethnicity | Sociology of Culture | Women's Health | Women's History | Women's Studies

Comments

Capstone Project for an Individual Major in Mid East Language, Culture, and Conflict

“In Light of Real Alternatives”:
Negotiations of Fertility and Motherhood in
Morocco and Oman

**Capstone Project for an Individual Major in Mid East Language, Culture,
and Conflict**

Victoria Mohr

Gettysburg College Class of 2015

Morocco and Oman, countries on the opposite ends of the Arab world, are a study in contrasts. Oman, situated in the heartland of Islam, is known for its stark deserts and bare mountains, its beautiful coasts, and its conservative culture. Ankle length dishdashas and floor length abayas are still the prevailing fashions, even though the spreading use of television and the internet means that Omanis now have access to styles from all over the world. Meanwhile in Morocco the Sahara and the snowy mountains of Ifrane are a day's drive apart, and European jeans and t-shirts occupy souk stalls next to jellaba tailors. Sitting on the very edge of the Arab-Muslim world, Moroccan Islam is often tinged with more mysticism and African influences than its Omani counterpart.

Often it is tempting to lump the Middle East and North Africa into one cultural, religious and linguistic category. This over generalization naturally trails into the realm of maternal health and fertility studies. However, the contrasts between Morocco and Oman show that this is clearly not the case. Oman is one of several Gulf states that for a long period maintained a high fertility rate in spite of developments that in comparable countries facilitated a rapid decrease in fertility¹. During this same period, Morocco was experiencing a rapid decline in fertility, despite a medical system that was scattered and sometimes difficult to access². These two states differ significantly in terms of religion, medical services, culture, and economics and in many ways both of them contradict fertility trends in other regions of the world. However, their failure to conform to fertility trends and predictions does not so much disprove the ideas behind these trends so much as show that various factors – such as biomedicine and religion – do not uniformly affect

¹ Hill, Allan G, Adaline Z Muyeed, and Jawad A al-Lawati. 2000. 'The Mortality And Health Transitions In Oman: Patterns And Processes'. *WHO Regional Office For The Eastern Mediterranean And UNICEF, Oman. Muscat* 2000.

² Data.worldbank.org,. 'Morocco | Data'. Last modified 2014. Accessed December 18, 2014. <http://data.worldbank.org/country/morocco>.

societies, but that each society shapes those factors as much as it is shaped by them. Further, within the context of rapid social change and shifting fertility determinants, it becomes clear that women, instead of being tossed about by demographic change, are aware of these factors and make fertility decisions based on what is best for themselves and their families based on their socioeconomic context.

Maternal Health in Morocco and Oman: A Survey of Two Countries

Morocco

On our way to the Institut Royal de la Culture Amazigh, on the outskirts of Rabat, my study group got off the last stop of the brand-new tram line. Walking down and around the corner from the tram stop, we passed the Hôpital Cheikh Zaid, almost mistakenly walking through its oversized gates. It blends into the chic neighborhood of large, modern office buildings. The hospital's website shows off western-style rooms and the best doctors Morocco can offer, conveniently near the rich suburbs of Rabat. Compared to the ancient medina where I had spent most of my time, I felt as though I had arrived in a different country.

A few weeks later, in the small mountain town of Oulmes, my host sister has lost patience while waiting for my other sister to see the doctor at the local hospital. We visited the hospital a week earlier for my research, and were politely escorted around the tiny and sparse maternity ward. This time, however, my host sister goes wandering off down the empty hallways behind the main office, looping her arm through mine and dragging me along behind her. The farther we get from the main entrance, the more depressing the scene becomes. A large portion of what was obviously meant to be a small but modern hospital has been abandoned, with broken glass and overgrown courtyards. We peek into what was once a kitchen, an industrial laundry

room, patient rooms and offices. Meanwhile, at the front of the building, the line to see the only doctor trails out into the lobby.³

One of the most striking things about Morocco is the sharp contrasts: rural and urban, rich and poor, gleaming western style hospitals and tiny clinics with no heat. Rapid social, economic, and demographic changes have exacerbated many of these sharp divides. Since the end of the colonial period, but particularly within the last decade, Morocco has experienced rapid urbanization, creating a new class of poor migrants in cities⁴. Though Morocco's economic growth has been slow at best, high unemployment in recent years has expanded the gaps between the wealthy and the poor. These sharp divisions naturally bear out in the realm of fertility and maternal health care. Though maternal mortality rates and fertility rates have declined for all populations, these rates remain significantly higher for rural women and poor urban women⁵. Access to medical care of varying types differs significantly along these lines of division, particularly access to biomedical care⁶.

Morocco has long had contact with Western Europe; however, biomedical health care as we know it was introduced along with colonization by the French and the Spanish, beginning in the 1920s. Initially health care facilities were available only to the French⁷, though eventually they did expand to include Moroccans. Many public health initiatives began with French fear

³ After conferring with a fellow student who had done research on the Equity and Reconciliation commission and the Years of Lead in Morocco, we suspect that the Oulmes hospital may have been built as part of reparations, but not adequately funded thereafter. Certain rural regions, including several near Oulmes, were particularly repressed during the Years of Lead. However, this connection is simply an educated guess. The United States Institute of Peace provides a good primer on the Equity and Reconciliation commission:

<http://www.usip.org/publications/truth-commission-morocco>

⁴ Hughes, Cortney. 'The "Amazing" Fertility Decline: Islam, Economics, And Reproductive Decision Making Among Working-Class Moroccan Women'. *Medical Anthropology Quarterly* 25, no. 4 (2014): 417-435.

⁵ Haut-Commissariat au Plan du Maroc, Last modified 2010. Accessed December 7, 2013.

http://www.hcp.ma/Mortalite-maternelle-nombre-de-deces-pour-100-000-naissances_a689.html.

⁶ Dieste, Josep Luis Mateo. *Health And Ritual In Morocco*, n.d.

⁷ Though Morocco was colonized by both the French and the Spanish, the healthcare system in Morocco is primarily a legacy of the French.

that Moroccans may carry diseases, one can see this even now in the design of many Moroccan cities, with the “ville nouvelle” or the part of the city built by the French, situated outside of the older Medina. Additionally, French clinics and health services that were expanded to include Moroccans were often a conduit for imperialistic goals, glorifying the wonders of “modern” (read: western) medicine and the superiority of the French way of life. Dieste notes that for the better part of the colonial years there was some opposition to the health initiatives. Examples include conflicts over burial procedures and some early reluctance to the use of French health services. Whether this was in response to the colonial aspect or due to differences in conceptualizations of health and the body is difficult to say. Resistance to the colonial medical system appears to drop off after 1945⁸.

While the French medical system laid the foundation for the current biomedical system in Morocco, its growth has been stunted at best in the post-colonial period. Many rural communities lack any sort of facilities, and when rural hospitals and clinics do exist they often lack both material and human resources, and consistent access to those resources.⁹ In the maternity ward of the Oulmes hospital, blankets were provided by an NGO, but for the most part families were expected to bring any comforts for new mothers. Most women who give birth at this hospital stay less than 24 hours.¹⁰

A persistent problem in rural biomedical health care is the quickly rotating staff.

Medical staff- particularly midwives – are often assigned to a rural community for a year or two after completing their state-sponsored training, but as soon as this period is up they seek better

⁸ Dieste, *op. cit.*

⁹ Capelli, Irene. 'Risk And Safety In Context: Medical Pluralism And Agency In Childbirth In An Eastern Moroccan Oasis'. *Midwifery* 27, no. 6 (2011): 781-785

See also: Bourquia, Temmar et al, and Obermeyer

¹⁰ interview with the hospital midwife

employment in urban government facilities or in private medical sector.¹¹ In small close knit communities this is especially problematic because it prevents the community from building up trust with the doctors and nurses.¹² Many of these communities have consisted of the same families for many years, and outsiders are sometimes viewed with caution if not outright suspicion.

Private health care is only available to the wealthy, and the health care available to the poorer classes, though there is some government subsidization of health care, is often lacking. Even well trained staff are often overwhelmed by the number patients or their clinics and hospitals lack supplies and resources. Additionally, apart from the basic cost of medicines and care, it is noted by Obermeyer and Dieste that “the payment of such costs by the patient of his/her family will also include the payment of small bribes implicitly demanded by doctors and nurses to guarantee that procedures will be speeded up or even followed at all.”¹³

During my fieldwork in Morocco interviewing women about their pregnancy and birth experiences, many of them elaborated on their trials with the health care system. Many of the new mothers I interviewed had grown up in the time since a hospital was built in a neighboring town, where it is accessible to most of their village, and they seemed to value hospital care and births over home births. However they also complained of how uncomfortable hospitals were and of being mistreated by staff. Many of them went to the local hospital only to be transferred to a larger city hospital when complications occurred, and some of those that had the means had

¹¹ Temmar, Fatima, Bilkis Vissandjace, Marie Hatem, Alisha Apale, and Devorah Kobluk. 'Midwives In Morocco: Seeking Recognition As Skilled Partners In Women-Centred Maternity Care'. *Reproductive Health Matters* 14, no. 27 (2006): 83-90.

¹² Capelli, *op. cit.*

¹³ Dieste, *op. cit.*, p. 209,

Obermeyer, Carla Makhlouf. 'Pluralism And Pragmatism: Knowledge And Practice Of Birth In Morocco'. *Medical Anthropology Quarterly* 14, no. 2 (2000): 180-201.

even planned ahead to give birth in a nearby city with a more well-equipped hospital. Evaluating their own resources in light of gaps in Morocco's health system was a crucial part of these women's maternal health decision making process.

In addition to the biomedical system however, Morocco has a long and elaborate history of health care practices predating the colonial period. There exists a tradition of religious talismans being used to cure or ward off illness¹⁴, however central to Moroccan health systems is a variation on the Galenic humoral conception of the body. Obermeyer describes in her ethnography of birth in Morocco:

In Morocco, as in many other cultures, ideas about hot and cold provide a set of guidelines for nutrition and for the prevention and treatment of illness. The original Galenic categories for the four humors and the four qualities are limited in Morocco to the hot-cold polarity...Representations of reproductive process interact with hot-cold classifications and result in a set of practices aimed at maintaining the optimal balance in the woman's body during different phases of her reproductive life.¹⁵

Hot-cold systems are common to many cultures, and in Morocco 'hot' or 'cold' illnesses or conditions are treated with foods, drinks, or medicines that are assigned hot or cold properties that counteract the illness and restore balance to the body. Indeed, fertility and childbearing are also integrated into this system, for example infertility is conceptualized as a 'cold' condition, and both traditional and biomedical fertility treatments are conceptualized as 'warming' the body. Many of these traditional practices and their practitioners still exist today, and are often

¹⁴ Dieste, *op. cit.*

¹⁵ Obermeyer 2000, *op. cit.*, p. 185

used in conjunction with biomedical care.¹⁶ Dieste estimates that “about 60% of the population makes joint use of bio-medicine and diverse forms of traditional medicine, just under 40% rely exclusively on bio medicine and a small minority uses only traditional medicine.”¹⁷

In the course of my fieldwork in Morocco, I found that several women I interviewed turned to traditional medicine when they were dissatisfied with their experiences in the biomedical system. One woman, after having her first son at the hospital and feeling mistreated at by the nurses, had her daughter at home. This woman’s mother is a Qabla, or traditional midwife, and she attended the birth of her granddaughter.¹⁸ Obermeyer found in her ethnography of Moroccan mothers that most women switch between home and hospital births, and seek out health advice from traditional healers along with prenatal visits to hospitals and clinics. Most women, though they may prefer a certain health system, for the most part see no conflict between the different systems themselves.¹⁹ Combining methodologies is the way that Moroccan women make the most of limited or lacking resources. Dieste notes that traditional health practices are more popular amongst poor or rural people:

“However, this does not mean that there is necessarily a correspondence between social hierarchy and the hierarchy of prestige of the medical systems, i.e., the middle and upper classes also make use of other [traditional as opposed to biomedical] systems...those with less money do not necessarily use the so called traditional systems because they are more ‘superstitious’, in other words.”²⁰

¹⁶ *Ibid.*

¹⁷ Dieste, *op. cit.*, p. 17

¹⁸ Personal Interview

¹⁹ Obermeyer 2000, *op. cit.*

²⁰ Dieste, *op. cit.*, p. 169

Therefore, use of traditional systems is not a sign of “backwardness” or lack of education but rather a strategic use of limited resources.

Widespread pluralism, however, “does not imply...equality among the medical systems or a harmonious co-existence between them.”²¹ Expensive private biomedical care carries with it a significant amount of prestige in Moroccan society.²² Part and parcel to this prestige is the Moroccan government’s preference for biomedical health care. The government recently designated home births as “intrinsically risky,”²³ but apart from their disdain for traditional health systems, the Moroccan government seems to lack a clear plan of how to tackle persistent health issues, such as a dropping but still high maternal mortality rate (100 deaths per 100,000 births).²⁴ While it is obvious that biomedicine has brought some benefits, one must wonder if an opportunity is being lost to use traditional health pathways to their full potential to help their communities.

Despite the many gaps in the healthcare system, fertility in Morocco has dropped steadily, from approximately 7 at independence, to an all-time low of 2.24 in 2011.²⁵ The most recent data, from 2013, puts the current fertility rate slightly higher at 2.7.²⁶ Birth control, though available prior to 1970, came into widespread use in the mid-1970s, following the establishment of a national family planning committee.²⁷ Today birth control pills are widely available in clinics, hospitals, and pharmacies and are the most popular choice for Moroccan

²¹ Dieste, *op. cit.* p. 170

²² Obermeyer, *op. cit.*

²³ Capelli, *op. cit.*

²⁴ Haute- Commissariat au Plan du Maroc, *op. cit.*

²⁵ Ministère de la Santé, *Enquête Sur La Population Et La Santé Familiale*. Rabat: Demographic and Health Surveys Program, 2005.

²⁶ Who.int, 'WHO | Morocco'. Last modified 2014. Accessed December 13, 2014 <http://www.who.int/countries/mar/en/>.

²⁷ Dieste, *op. cit.*

women, followed by the IUD.²⁸ The National Survey from 2004 states that 99% of married women have used a form of birth control at some point in their lives, with 63% of married women using some form of birth control or family planning at the time of the survey. Of that 63%, 55% were using a biomedical birth control method and 8% were using a traditional method.²⁹ By 2013 that number rose to 67%, however it is unknown if the proportion using biomedical versus traditional methods has shifted at all.³⁰ Though the push for family planning at the government level initially came in the late 60s, it boomed in the 1970s, coinciding with a major economic shift due to falling phosphate prices³¹, as well as the beginning of the long-standing conflict with Western Sahara. Courbage makes the connection between fertility and economic uncertainty:

“The sudden reversal of the economic and fiscal conditions of Moroccan households is related to the sharp drop in fertility, which diminished by 20 percent from 7,3 to 5,9 children in just four years. Moroccan families instantly faced an unprecedented situation, in which most education, social, health...expenditures had to be based on their own personal budgets rather than on the windfall profits of the state. *While socioeconomic factors (urbanization, literacy, female activity) show a gradual effect on demographic indicators, the year 1975 marks a clear turning point in Moroccan demography, precisely as a result of changing financial relations...*”³²

²⁸ Eltigani, Eltigani E. 'Changes In Family-Building Patterns In Egypt And Morocco: A Comparative Analysis'. *International Family Planning Perspectives* 26, no. 2 (2000): 73.

²⁹ Ministère de la Santé, *op. cit.*

³⁰ Who.int, *op. cit.*

³¹ Phosphates are a major natural resource and export for Morocco.

³² Courbage, Youssef. 'Fertility Transition In The Mashriq And The Maghrib: Education, Emigration, And The Diffusion Of Ideas'. In *Family, Gender, And Population In The Middle East: Policies In Context*, Carla Makhoul Obermeyer, ed. by . 1st ed. Cairo: American University in Cairo Press, 1995.p. 89, emphasis mine

Though education and certain health services are now subsidized again, economic factors still play a huge role in women's fertility decisions, particularly in light of the high unemployment of the last decade.

However, the more "gradual" factors, such as education and workforce participation cannot be ignored. As Courbage also notes, "A few years in primary school for Moroccan women translates into a decrease in fertility of over 50 percent."³³ Education is important for several of reasons: first, it often delays marriage; decreasing fertility in a society where having children out of wedlock is highly taboo. Second, it increases workplace participation and correlates with a higher use of biomedical family planning methods. Additionally, it is thought to increase autonomy and ability to access information about family planning.³⁴

Women now make up a quarter of the non-agricultural workforce in Morocco, one of the highest percentages in the Middle East and North Africa. While on the one hand this is a result of economic pressures, it is also a result of the fact that women are an increasing percentage of university students. While it is also tied to education, workforce participation in and of itself is also a powerful factor in reducing fertility.³⁵

Indeed, when making decisions about their fertility and their pregnancies, it seems that Moroccan women must contend with factors from all sides. In contrast to other countries in the region, specifically within in the scope of this paper Oman, the forces affecting women are varied and change drastically depending on demographic factors. There is no clear,

³³ Courbage, *op. cit.*, p. 86

³⁴ Inhorn, Marcia C. 'Defining Women's Health: A Dozen Messages From More Than 150 Ethnographies'. *Medical Anthropology Quarterly* 20, no. 3 (2006): 345-378.

³⁵ Courbage, *op. cit.*, p. 88

straightforward path for Moroccan women, and thus they strategically make use of the resources and knowledge that they do have.

Oman

When talking about Oman, the discussion is often divided into two eras: “pre-1970” and “post-1970.” 1970 marks the year that Sultan Qaboos bin Said took power from his father in a bloodless coup. At this time oil had just been discovered in Oman, and the industry was quickly developed under the new Sultan. Oman was one of the last Gulf states to develop an oil industry, and prior to that the economy was primarily agricultural with trading and fishing along the coast. The quality of life in Oman seemed to boom overnight, with the new Sultan investing oil money in health care and education.³⁶ Over the last four decades, Oman has undergone rapid development both in their economy and society. Prior to 1970 the Sultan was rather suspicious of outside influence (even banning items such as sunglasses) and Omanis found themselves insulated from the world around them. Only a few years into Qaboos’ reign, radios and televisions were beginning to make their way into Omani homes, and a national newspaper now brought the world to Omanis.

Prior to what is now commonly referred to by Omanis as their “renaissance,” the country was largely rural with many isolated villages, and in the interior desert region there were (and remain today) nomadic tribes. There is little data on any aspect of the sultanate prior to 1970. Most information comes from the records and recollections of the Arabian mission, a small group of missionaries from the Reformed Church in America operating in Muscat and Mutrah. They operated two hospitals, a general one and an obstetric hospital. From the turn of the century

³⁶ Hill et. al, *op. cit.*

to 1970, these were the only western medical facilities in the Sultanate. Jeannette Boersma, in her memoir of her time as a nurse midwife and missionary in the Gulf, touches on a few examples of traditional medical practices, though valuable pieces of information are often hidden in descriptions of the numerous problems that faced pre-1970 Omanis. One interesting example of this was the use of salt for antiseptic purposes after a woman had given birth, though Boersma notes that in many women this caused issues in subsequent births. Additionally, she mentions village midwives, suggesting that there did indeed exist a form of traditional obstetric care.³⁷

In her memoir Boersma recounts the numerous illnesses she encountered and the frequent health issues women faced. Malaria was common, particularly among women who had just given birth. Malaria remains dormant in the body long after the initial illness, with recurrences being triggered by stress, so often pregnant women had had malaria during childhood and childbirth triggered a recurrence. Boersma notes that eventually anti-malarial medication became a standard part of post natal care in their hospital. She also cites high rates of anemia in connection with malaria; however anemia remains prevalent in Oman today despite the near eradication of malaria. Eye issues and diseases were also common at this time. Prior to Boersma's arrival in the Oman in the late forties, nurses had gone to women in their homes for deliveries, and as she gained seniority in the hospital she began pushing for hospital births. Over the course of twenty years of work, she notes that slowly more and more women began to accept giving birth at the obstetric hospital. She describes how many women resisted the idea at first and decided on home births even when they lived nearby. Even though the obstetric hospital was eventually expanded to accommodate the increased desire for hospital deliveries and prenatal care, the number of women who had access to these services was relatively small until the

³⁷ Boersma, Jeanette, and David De Groot. *Grace In The Gulf*. Grand Rapids, Mich.: Eerdmans, 1991.

massive healthcare expansion in the 1970s. Much of the interior and the south of the country continued to rely on midwives and other traditional caregivers.³⁸ Use of midwives continued into the eighties in more remote areas, even among privileged families. Eickelman states that Omani culture is intensively private, and that this may explain the initial reluctance towards hospital births.³⁹

One of the first initiatives under the new Sultan was the establishment of a national health care system, which is free to Omani citizens. The mission hospital was quickly incorporated into the national system. Today, 99% of Omanis have access to biomedical care, meaning that the system has expanded to all but the most remote villages.⁴⁰ In the early stages of development, Oman relied heavily on foreign doctors, and sometimes Omani expatriates who had returned to the country after the coup, bringing foreign medical degrees with them. It is interesting to note that even when working with foreign doctors all obstetricians and gynecologists are, by law, female.⁴¹ This accommodation was made from the very beginning to ensure women's access to healthcare without disrupting a culture that is highly gender segregated. This stands in stark contrast to Morocco, where lack of a female doctor sometimes presents a significant barrier to more conservative women seeking health care.⁴²

In many parts of the world, expansion of medical care coincides with a significant drop in the fertility rate, not so in Oman. In the early renaissance years, there lacked any policy effort or push from society to decrease family size. Birth control was available in clinics, but was not

³⁸ *Ibid.*

³⁹ Eickelman, Christine. 'Fertility And Social Change In Oman: Women's Perspectives'. *Middle East Journal* 47, no. 4 (1993).

⁴⁰ Who.int., 'WHO | Oman'. Last modified 2014. Accessed December 13, 2014. <http://www.who.int/countries/omn/en/>.

⁴¹ Hill et al, *op. cit.*

⁴² Obermeyer 2000, *op. cit.*

widely used.⁴³ Oman's population experienced a significant bump in the 80s and into the 90s due to dropping mortality rates. People were living longer, and more children were living to adulthood.⁴⁴ Eickelman "estimates that, prior to 1970, a fertile woman could reasonably hope to raise three or four children to adulthood," but often had far more births. Women maintained a high number of births similar to pre-1970 levels, and access to medical care meant that more women and infants lived through their births.⁴⁵

In Eickelman's ethnography of childbirth and postpartum visiting customs in the northern oasis of Al-Hamra, it seems that the increasing survival rates for women and infants may have actually spurred a higher fertility rate. Customs dictate an extended period of formal visiting following a birth, even if the child lives only a few hours. This period is referred to as Murabbiya, and is crucial for the building of social networks amongst women and maintaining a family's image and prestige. On an individual level, "the birth of a first child is a rite of passage that transforms a woman into a social adult."⁴⁶ Childless or unmarried women are far less engaged in formal visiting, and therefore regular births serve as an opportunity for women to display their hospitality and maintain their position in their community. Additionally, children are obviously valued in and of themselves, as well as sons being seen as a source of financial security.⁴⁷

However, in a country that is primarily rugged mountains and deserts, the government soon realized it would not be able to sustain population growth at the rate of the 80s and early 90s. Therefore, in 1994 the government established the birth spacing initiative. The program's

⁴³ Al Riyami, Asya, Mustafa Afifi, and Ruth M Mabry. 'Women's Autonomy, Education And Employment In Oman And Their Influence On Contraceptive Use'. *Reproductive Health Matters* 12, no. 23 (2004): 144-154.

⁴⁴ Hill et. al, op. cit.

⁴⁵ Eickelman, op. cit.

⁴⁶ *Ibid*, p. 658

⁴⁷ *Ibid*.

strategy was twofold: to discourage women under 18 or over 35 from having children, and to have couples wait three or more years between each pregnancy. Though officially the legal age of marriage is 18, there still remains an issue with girls younger than that being married.⁴⁸ However, the average age at first marriage is rising across the Middle East, and early marriage seems to be a declining practice.⁴⁹ Additionally, breastfeeding was used as a traditional form of birth spacing, with varying effectiveness, prior to the introduction of this program, which instead emphasizes birth control medications.⁵⁰

The birth spacing program was carefully tailored to accommodate the culture of Oman. It avoided explicitly telling women to reduce family size, but emphasized the health benefits of well-spaced pregnancies. Health was the overall emphasis of the program and its accompanying propaganda. Adequate space between births significantly reduces risk for pregnant women and increases the likelihood of healthy children. Even to those resistant to the program, it was difficult to object to the idea of healthier women and children. In addition to the overall emphasis on health, there were some subtle economic elements to the program, such as including the idea that smaller families had more resources to give to each child in pamphlets and the dialogues used by doctors with women. Birth control still remains relatively taboo in some parts of Oman, and therefore the program worked with religious leaders to make it clear to Omanis that family planning is not haram, or forbidden by Islam. The program also included significant outreach to men, who were likely to believe birth control to be haram than women.⁵¹

⁴⁸ Al-Rawahi, Samira, and Nancy C. Sharts-Hopko. 'Birth Spacing Initiative In Oman'. *Journal of Cultural Diversity* 9, no. 1 (2002): 23-26.

⁴⁹ Obermeyer, Carla Makhoul. 'Islam, Women, And Politics: The Demography Of Arab Countries'. *Population and Development Review* 18, no. 1 (1992): 33.

⁵⁰ Al-Rawahi et al, *op. cit.*

⁵¹ Drysdale, Alastair. 'Population Dynamics and Birth Spacing in Oman'. *International Journal of Middle East Studies* 42, no. 01 (2010): 123.

Interestingly, most Omani women who use birth control have chosen to use the birth control shot. The shot is administered every three months by a medical professional, and some countries have discontinued its use due to certain side effects. The widespread use of the birth control shot stands out in contrast to many other countries.⁵² Pills are the most widely used in Morocco, as well as other countries, because of their ease of use and distribution. Egyptians favor the IUD (Intrauterine device), the longest-lasting and lowest maintenance option.⁵³ Researchers have only been able to speculate on the popularity of the shot in Oman thus far. Some have suggested that it reflects the attitude of birth spacing as opposed to birth control or family planning, giving women three months at a time instead of a long term option like the IUD. Others have speculated that it is the easiest option to conceal from a partner not in favor of using birth control.⁵⁴

The fertility rate, which had declined very slightly in the 80s, declined more so but slowly through the nineties. Five years after the establishment of the birth spacing program, the fertility rate remained higher than expected or desired, nevertheless there had been a noticeable reduction in the fertility rate. However, there was a steeper decline throughout the early 2000s, and the fertility rate reached a low of 2.4 in 2011, though it jumped back up to 2.8 the following year. With the replacement rate being 2.1, Oman now hovers just above a rate comparable to Europe.⁵⁵

Development of health care and family planning policy by no means exist in a vacuum. As access to health care increased for women and the health system as a whole was developed,

⁵² Al-Riyami, *op. cit.*

⁵³ Eltigani, *op. cit.*

⁵⁴ Drysdale, *op. cit.*

⁵⁵ Hill et al, *op. cit.*

the Omani education system was likewise developed. Starting from 1970, equal educational opportunities were offered to both girls and boys. Girls have now overtaken boys when it comes to completing college and pursuing higher education.⁵⁶ Accompanying this increase in education, more and more women are entering the workforce. Interestingly, the early 1970s saw a large participation of women in the workforce and other aspects of nation building. Dawn Chatty describes how in a rapidly changing society, a wide variety of contexts emerged in which there was no existing definition of “appropriate” behavior for women, opening up an exploration of new roles. However, she notes that there was a significant backlash to this in the 1980s, and since that time it has been a slower process of women reentering the workforce through pursuit of education.⁵⁷

Official numbers place women at only 8.6% of “economically active” Omanis; however these statistics do not include the large number of women involved in agricultural work.⁵⁸ Those women who do work outside of agriculture, however, are often highly educated and are more likely to work in business or government jobs, or jobs with a relative amount of prestige.⁵⁹ Women not in the agricultural sector are generally discouraged from working in unskilled jobs, such as cleaners or nannies.⁶⁰ There are several possible factors that contribute to this, one being the association of cleaning and childcare jobs with foreign workers, who are widely discriminated against and mistrusted. A second suggested factor is that it is only in these upper

⁵⁶ *Ibid.*

⁵⁷ Chatty, Dawn. ‘Women Working in Oman: Individual Choice and Cultural Constraints’. *Int. J. Middle East Stud.* 32, no. 2 (2000): 241-254.

⁵⁸ Belwal, Shweta, and Rakesh Belwal. ‘Work-Life Balance, Family-Friendly Policies And Quality Of Work Life Issues: Studying Employer’s Perspectives Of Working Women In Oman’. *Journal of International Women’s Studies* 15, no. 96-117 (2014).

Chatty, *op. cit.*

⁵⁹ Belwal et al, *op. cit.*

⁶⁰ Chatty, *op. cit.*

level jobs that women make enough money to outweigh the work that they are no longer able to do in their own homes.⁶¹

One arena where Oman has aligned with fertility trends is in the correlation between education, work force participation, and family size. Women with more education are more likely to have smaller families. Working women, who as stated are often more highly educated, also are more likely to have fewer children. Most often, the correlation between education and smaller lower fertility is due to delayed marriage, but also more highly educated women are more likely to seek out or have access to family planning options. As Oman's population becomes more and more educated, there is reason to believe that this trend will continue.⁶²

Biomedicine and Discussion of Positionality

Sitting on the floor in a little concrete house in the Middle Atlas Mountains, my host sister translates my interview with her aunt. It might be her great aunt, or maybe a cousin, it is a little unclear apart from the fact that my family seems to be related to most of the other families in the village. It's a chilly December night; everyone is offered a blanket, even with the space heater in the corner. It occurs to me that this might be the only interview I ever do in my pajamas. (Thick, fuzzy pajamas are required wear this time of year.)

Aunt Aicha is a retired Qabla, or traditional midwife. She learned from years of watching her mother, who was also a Qabla, and she proudly tells me about the healthy babies she helped deliver. I ask her about how the community is changing: do many women have births at home? Or do most choose the hospital? She tells me that most women these days go to the hospital, and

⁶¹ Al-Qudsi, Sulayman S. 'Labour Participation Of Arab Women: Estimates Of The Fertility To Labour Supply Link'. *Applied Economics* 30, no. 7 (1998): 931-941.

⁶² Al Riyami, *op. cit.*

she thinks this is a good thing. Even the small (and poorly equipped) hospital in the nearby town had more resources, if complications occur:

“Especially if they don’t have the...it comes after the baby, with the rope [umbilical cord]?” My host sister asks, not knowing the specific English term. It takes me a minute to remember how several anthropologists had noticed amongst Moroccan women a distinct fear of hemorrhage and complications from an undelivered or incomplete delivery of the placenta.⁶³

“uh, placenta.”

“pla-cen-ta?”

“Yes.”

“Yes, if they do not deliver the placenta, at the hospital they can have surgery.”

Aicha’s daughter in law interrupts after this, telling us about how she’s planning to have a hospital birth. The interview continues.

It doesn’t occur to me until I am several thousand miles from this village, and my host sister, that I gave a rather inaccurate translation. All of the Qablas I interviewed were from remote villages, and never had any kind of formal schooling. For them to use a clinical term like “placenta” seems highly unlikely. Moreover, ‘placenta’ originates from a wholly different conception of the body and childbirth, a perspective that often looks down traditional practitioners like Qablas. Perhaps “afterbirth” would have been a more accurate choice.

⁶³ Though life-threatening when it does occur, this particular complication is relatively rare. Weeks, Andrew D. "The Retained Placenta." *African Health Sciences*. (2001).

In my fieldwork I had arrived at an intersection where many cultures in the Middle East sit: a rich history of different medical practices must now make room for an increasing presence of western-style hospitals. Both international establishments and local governments push for rapid ‘modernization’. Modernization or development can be difficult topics, because they so often coincide with westernization. In the realm of health care, “In the thirds and fourth worlds, ‘modernization’ has generally been defined as a movement toward the Western supervaluation of high technology” and implementation of western styles of biomedicine.⁶⁴ In Oman, modernization of the healthcare system was rapid and wide ranging. In a few short years, the entirety of Oman seemed to acclimate to the new system.⁶⁵ Development in Morocco has been more gradual, and in some places stunted. Particularly in small villages and remote areas, the few medical options available may not hold much advantage over home care, particularly when it comes to pregnancy and childbirth.⁶⁶

For Moroccans, the best hospitals and doctors are concentrated in major cities, and though government subsidies for the most part cover the cost of health care, public hospitals are often overcrowded, require long waiting times, and the cost of travel to them is prohibitive for many rural women. Private hospitals and clinics, though available, are inaccessible to most Moroccans because of their high cost.⁶⁷ Additionally, many of the women I spoke to, even those who had chosen or even advocated for hospital births, remarked that the hospitals were understaffed, or that staff had been rude with them. A number of ethnographers have found that the majority of Moroccan women switch easily between home and hospital births - and it is only the

⁶⁴ Davis-Floyd, Robbie, and Carolyn Fishel Sargent. *Childbirth And Authoritative Knowledge*. Berkeley: University of California Press, 1997.

⁶⁵ Hill et al, *op cit.*; Eickelman, *op. cit.*

⁶⁶ Capelli, *op. cit.*

⁶⁷ Dieste, *op. cit.*

small segment of women who had hospital births for all their children that actively advocate against one of the two options, in this case home births.⁶⁸

One of the women I worked with, Nadia, had her first son at the hospital, and later had her daughter at home. Reflecting on her experiences, she describes how she felt mistreated by the staff and how the hospital was uncomfortable. Later I was able to visit the small hospital where she gave birth, in a neighboring town. It offers truly minimal resources, and several of the women I talked to came to this hospital only to be sent by the doctor or nurse to the larger hospital about two hours away. Nadia then compared her hospital birth to her second birth, that of her daughter. Nadia herself is the daughter of a Qabla, and her mother attended the birth. She also described how her second pregnancy was much easier than her first, which made her feel more comfortable about having the baby at home. Her mother helped her prepare special meals during the end of her pregnancy to ease labor, describing how going back to traditional practices - as opposed to medicine, made her birth much easier. As Obermeyer found in her fieldwork with Moroccan mothers, when women choose home births, “it is clear that women are not blindly following traditional prescriptions but, rather, are making decisions in light of real alternatives.”⁶⁹ For Nadia, her mother’s knowledge as a Qabla offered answers she couldn’t find at the hospital. Many of the women I talked to, when asked about why they chose hospital births, expressed an element of fear. On the one hand, this fear is well grounded, as high infant and maternal mortality rates from past years show. But on the other hand, the biomedical model also

⁶⁸ Obermeyer 2000, *op. cit.*

⁶⁹ *Ibid*, p. 195

relies on a certain amount of fear, particularly fear of one's interpretation of one's body as inaccurate.⁷⁰

It was, at first, easy for me to accept that traditional health practices offered better options for women who lacked access to quality biomedical care. It made sense to me that some women, those that had the means, made advance arrangements to give births at better equipped hospitals, though they may be farther away. Much of the research I encountered advocates for the expansion and improvement of the existing biomedical system in Morocco, that millennium development goals can easily be reached with nicer hospitals, equipped with the latest technology. It took much longer for me, in the process of developing this paper, to dismantle the idea that biomedicine and western styles of health care are infallible and more objective than other health systems. Biomedicine is as much a product of western culture- my own culture- as Qablas are a product of Moroccan culture – and indeed it seems that there are indeed some cases where the existing cultural health system has more answers for women.

It would be unfair to assert that biomedicine has nothing to offer Moroccan, or indeed Omani women – it is clear from rapidly decreasing maternal and neonatal mortality rates that its introduction has benefitted these women in many ways. However the introduction of biomedical care has also been accompanied by increased access to basic necessities, development of infrastructure, and a generally increasing quality of life, especially in Oman.⁷¹ These factors have also contributed to an improvement in the overall health of these two nations. Indeed, no one is arguing that women should not have to biomedical health care, much less a better quality of life.

⁷⁰ Davis Floyd et al, *op cit*.

⁷¹ Hill et al, *op. cit*.

Instead what is problematic is the power dynamic inherent in the biomedical model and also in the model of its introduction to nonwestern societies.⁷²

In my fieldwork I had to reconcile and account for myself as a part of a society responsible for that power dynamic. When asked about traditional pregnancy health practices, my informants often said they didn't know any or offered up something along the lines of "we knew nothing back then," meaning that they didn't take any medicines or eat any special diet during their pregnancies, unlike doctors encourage them to do now. For many generations of Moroccan women, pregnancy was no cause to deviate from their normal routine until the last few weeks. Though the women were self-deprecating about their medical system, this is in fact more so reflective of the intense medicalization of pregnancy in the biomedical system. In many biomedical based cultures, particularly American culture, pregnancy and childbirth are things to be intensely monitored for danger, whereas for older generations of Moroccan women it was just another nine months. Realizing this was critical for the process of removing my own health traditions and beliefs from my analysis of Moroccan women and their healthcare choices.

Further, the biomedical model places authoritative knowledge solely in the hands of doctors and other medical professionals – authoritative knowledge here meaning exclusive knowledge of a certain topic that justifies ones position to make decisions. Within the context of fertility and childbearing, authoritative knowledge in the biomedical system values the exclusive medical knowledge of the doctor or other health practitioner over a woman's awareness or knowledge of her body.⁷³ Being that the biomedical model also has its roots in western culture;

⁷² Davis-Floyd et al, *op. cit.*

⁷³ *Ibid.*

in the Moroccan and Omani contexts it presents a second layer of unequal power between doctor and patient in societies that have periods of colonialism in their history.

In Morocco this represents a departure from the system of Qablas, likewise in Oman is represents a significant departure from midwives. Qablas are representative of a care system that is woman-centered and more holistic. Though they do carry a certain amount of authoritative knowledge, the power gap between them and the young women they care for is far less wide. Indeed, Qablas hold a respected position in their communities, communities that they have often been a part of since their own birth. Doctors and medically trained midwives, in Morocco referred to as *sage-femmes*,⁷⁴ hold often much more transient roles in the community and in the lives of their patients. Particularly in the case of the *sage-femmes*, they are assigned to a post for a year or two following their training. Often these posts are in rural areas, and after their assigned term *sage-femmes* are eager to move to better paying jobs in urban areas. The transient nature of many health care practitioners makes it difficult for them to build trust among patients, especially in tight-knit rural communities.⁷⁵

Additionally, in contrast to some countries that have used midwives as both a way to cover gaps in rural care but also as more holistic practitioners, the Moroccan system has designed the training program for *sage-femmes* as a smaller and very specific version of doctors training – emphasizing new technologies and techniques, then sending the midwives to communities that have none of the resources to use them.⁷⁶

Biomedicine is often painted as a magical cure for communities and countries that face a myriad of other difficulties. Though it certainly has many benefits, it is often not applied as

⁷⁴ Temmar et al, *op. cit.*

⁷⁵ Capelli, *op. cit.*

⁷⁶ Temmar et al, *op. cit.*

effectively as it could be. Efficacy is highly dependent on culturally appropriate introduction of biomedical options, and using existing cultural paradigms about health and bodies to the advantage of doctors and patients instead of emphasizing one over the other. Additionally, for poor and rural communities, there are many basic infrastructural changes that can be made to improve health and wellness in communities. In short, improving maternal and reproductive health for women is something that needs to involve synthesis and intercultural understanding.

When we study health or health care, it is just as imperative to reflect on one's own positionality as one would with any other ethnographic research. Assuming that biomedical paradigms of health and body are ultimately correct colors our ability to clearly examine existing health systems in non-western communities. Questioning the cultural position of biomedical health care can lead not only to better research, but to better health solutions for countries and communities.

Islam, Fertility, and Maternity

While in Morocco fertility rates have dropped steadily, Oman is one of several Gulf States that represent an exception to global fertility trends. The Gulf States maintained a high fertility rate throughout the eighties and nineties, and despite decreases remain high in comparison to economically similar regions.⁷⁷ Economic development is, in many regions of the world, concurrent with falling maternal and infant mortality, as well as decreasing fertility and smaller families. Oman and several other Gulf states have seen rapid economic development since the discovery of oil, and in conjunction with this a rapid improvement of the quality of life.

⁷⁷ Hill et al, *op cit*.

In the case of Oman, this economic development was put to use first and foremost to develop the national health care system. In many areas of the world, including other countries in the MENA region, even mild improvement of health care systems has correlated with a dramatic drop in fertility as contraception becomes widely available. Many have been quick to point to Islam as the cause of this slow decline, indeed “the proposition that the demography of Arab countries can be explained with reference to the strength of Islam has an obvious appeal. It offers a broad explanation for patterns that have otherwise resisted fitting prevailing models.”⁷⁸ While Islam and its role in Arab culture are certainly contributing factors, it does a disservice to the wide diversity of Islamic practice, as well as to other important cultural and economic considerations to claim that it would uniformly affect the various cultures of the Middle East.

Nevertheless, it is impossible to talk about the Arab world without acknowledging the centrality of Islam in society. Moreover, some prevailing themes present across the diversity of Arab cultures can be best explained in the language of Islam. Perhaps the most pertinent of these themes is a focus on kinship and family life.

“Family, from the prescriptive point of view of Islam, is the means of organizing the Muslim community.”⁷⁹ The importance of marriage and children is central in many Muslim societies, particularly in the Arab world. Most scholars agree that Islamic texts encourage people to marry, have children, and raise those children as Muslim. However, for most Muslims this encouragement does not constitute an unnegotiable obligation⁸⁰. Though some interpretations push families to have as many children as physically possible, more draw on an oft-cited Quranic

⁷⁸ Obermeyer 1992, *op. cit.* p. 42

⁷⁹ Bowen, Donna Lee. 'Pragmatic Morality: Islam And Family Planning In Morocco'. In *Everyday Life In The Muslim Middle East*, Donna Lee Bowen and Evelyn A. Earlyed. by . 1st ed. Bloomington: Indiana University Press, 1993.

⁸⁰ For instance, finances may keep a man from marrying, and infertile couples are not barred from marriage.

verse saying that “God does not want to burden man but wishes to improve his life” – i.e., have as many children as you can care for.⁸¹

While there is no discussion in the Quran or Hadith⁸² of birth control or family planning as we know it today, most analysis of these modern phenomena in Islamic legal texts is based on a few hadith that mention that ‘*azl*⁸³ was practiced in the time of the Prophet Mohammed. Mohammed’s life is often looked at as an ideal example for a Muslim lifestyle. While some hadith conflict on this topic, for the most part it is said that the Prophet allowed it and therefore family planning is permitted as a modern interpretation of this, as long as both partners are aware and consenting.⁸⁴ Additionally, traditionally and in many places today, breastfeeding is encouraged as a method for spacing pregnancies in a morally acceptable manner.⁸⁵ While most interpretations of Islam do not prohibit family planning or use of modern forms of birth control, when paired with the encouragement to have children it sometimes means that the circumstances are in which family planning are permitted are somewhat narrow. Further, it is not unusual people to construe cultural taboos as having Islamic origins, and therefore occasionally spreading the impression that birth control is haram, rather than just taboo.

Al-Ghazali, a renowned medieval Islamic theologian, “established five reasons for which birth control may be allowed,” the two most pertinent to this paper being “a disposition of the wife to have too closely spaced pregnancies; concern for the health of the wife from too frequent pregnancies.”⁸⁶ Unsurprisingly, these justifications play a key role in Oman’s birth spacing

⁸¹ Hughes, *op. cit.*

⁸² Hadith are the sayings of and traditions surrounding the life of the Prophet Mohammed, and are used for guidance supplemental to the Quran.

⁸³ Coitus interruptus

⁸⁴ Bowen, *op. cit.*

⁸⁵ *Ibid.*

⁸⁶ Obermeyer 1992, *op. cit.*

program. Unlike Morocco, the belief persists among some Omanis that family planning is haram. Throughout the process of designing and establishing their family planning program, the Omani government and ministry of health consulted carefully with religious leaders to make sure their program fell within Islamic morality. Today, Oman's promotion of their birth spacing program relies heavily on the justifications drawn from Al-Ghazali, emphasizing mother and infant health.⁸⁷ The language surrounding the birth spacing program is very carefully constructed to accommodate a culture and interpretation of Islam that values large families. The name of the program itself reflects this, as "in deference to cultural sensitivities [the Ministry of Health] has generally avoided using the term 'family planning' in public."⁸⁸ The term "birth spacing" reflects the idea of promoting health (as opposed to demographic objectives) in that the program encourages careful spacing of births for healthier moms and babies, rather than encouraging fewer children altogether. Drysdale describes it well:

"Whatever the demographic objectives of the program, birth spacing is consistently framed as a health issue, which serves to undermine potential resistance, in particular from men and from religious authorities. How can one oppose better health for women and children?"⁸⁹

Happy and healthy families are as much in line with both the Omani interpretation of Islam and Omani cultural values as are large families, and the birth spacing program gently pushes the idea that smaller families tend to be healthier and therefore better off.

In contrast, Morocco's family planning policy puts much less emphasis on Islam and was more transparent about the stress that a growing population would put on the country's limited

⁸⁷ Drysdale, *op. cit.*

⁸⁸ *Ibid*, p. 128

⁸⁹ *Ibid*, p. 130

resources. Indeed, many Moroccan families are acutely aware of the resources they need (or often lack) to support traditionally larger families. However, this does not mean that Islam has not played a role in the reception and wide spread use of contraception. In Hughes' ethnography of women at a clinic, many of them interpreted limiting the number of children they had as an appeal to Islamic values- citing frequently that "God does not want to burden man but wishes to improve his life." From their perspective, having fewer children allows them to be better mothers by investing more of their limited resources in each child.⁹⁰

Throughout my fieldwork in Morocco, this careful distribution of resources was apparent. Mothers who had grown up in families with five or more siblings were now insistent on having at most two children. The sudden generational shift at first surprised me, but through my interviews with mothers, it became apparent that they were responding the resources available to them. Unlike their mothers, they now had easy access to a variety of family planning methods, but at the same time unemployment is at an unprecedented high in Morocco. Visiting the home of one of the mothers I interviewed, she proudly showed off the computer she had been able to buy for her children to help with their school work. She tells me about how her husband had wanted more children, but that by only having two she was able to give them a better education and a more comfortable home.

A happier, better off family of course appeals to Islamic family values. Indeed, "the medical community and several members of the religious community in Morocco...encourage people to plan and invest their resources into a smaller number of children to give them a better life, rather than try to care for many children all at once."⁹¹ However, from Hughes' work and

⁹⁰ Hughes, *op. cit.*

⁹¹ Bowen, *op. cit.*

my own fieldwork, it is apparent that many women did not need this encouragement but have used access to family planning to economically empower their families. As Bowen found in her work with Moroccan Islamic scholars, “The importance of marriage and children to both society and individuals has not changed, but demographic changes have brought about a need for rethinking how a solid family can be maintained despite limited assets.”⁹² As much as Islamic values may shape a society, societal and economic needs are also brought to the interpretation of Islam.

The integration of Islam into societal change also shows itself through language in Morocco. Similar to Oman’s careful selection of the term “birth spacing”, in Bowen’s consultation with several Moroccan Islamic scholars, she notes that they repeatedly say that family planning is allowed, but birth control is not.⁹³ Planning and organization seem to appeal more to Islamic ideas about family in contrast to ideas about control. Though the terminology differs significantly, the connotation and careful use of language seem to carry many similarities between Morocco and Oman. Family and children are central to both of these societies, and any challenge to “traditional values” must be presented in a non-threatening manner. Moreover, the terms birth control and contraception rarely occur in studies of maternity in the Muslim/Arab world in general, except in highly technical studies. “Family planning” seems to be much more palatable in societies in which the only acceptable context for having children is marriage.

Though Islam is certainly a large factor present in the discussion on fertility, maternity, and motherhood in the Middle East, it cannot and should not stand alone. It must be understood in interaction with culture, history, economics, and medical systems. Although both Morocco

⁹² Bowen, *op. cit.*

⁹³ *Ibid.*

and Oman represent Muslim-majority societies, each society's interpretation of Islam is varied and fluid within itself, and reflective of the socioeconomic conditions of each culture. The relative amount of affluence afforded by the oil economy allows Omani families many more resources than they had even a generation or two before, and therefore options to reduce family size seem far less vital in comparison to poorer Moroccan families who have been hit hard by recent economic trends and the high unemployment.

Though these societies turn to the same Quran and Hadith, with perhaps a slight variation in the Islamic legal school present in that country, family planning policy in each country differs significantly and reflective of the different religious attitudes present in each country. Although comparisons can be made, any attempt to generalize the role that Islam plays across a region as vast and diverse as the Middle East would be futile.

Indeed, it is difficult to tease out where religion ends and culture begins. People bring their values to religion as much as religion dictates values, and cultural mores are often justified in religious terms. When it comes to new technologies, in this case new options for family planning, women are often put in the position of being "moral pioneers." Though outside pressures must be negotiated, it is ultimately their reaction to these technologies that shapes whether or not the society as a whole adopts accepts or rejects them.⁹⁴ When it comes to fertility, family, and new technologies, women as well as religious authorities must take on their own interpretation of religious texts and determine where these technologies fit in their existing cultural morality.

⁹⁴ Davis-Floyd et al, *op. cit.*

Conclusion

The past fifty years have seen tremendous shifts in the lives and experiences of women the world over. For the young women of Morocco and Oman, they now have more access to education, jobs, and health care than their grandparents would have ever dreamed of. Both of these countries, since the 1970s, have pursued different paths to a policy of decreasing fertility, but have ended up in similar places: Morocco's fertility rate now sits at 2.7,⁹⁵ Oman's at 2.8.⁹⁶ However, these two different paths, in contrast to each other, are of the utmost importance in taking a nuanced approach to fertility and maternal trends in the Middle East.

Biomedicine and Islam, though they seem to be two entirely different domains, are often presented as overwhelming forces that have the power to uniformly affect the fertility trends of different societies. However, societies and their culture, history and economics push back and shape these factors just as much as they are shaped by them. In terms of biomedicine, the way in which it is introduced into a society and the extent to which it is funded and pushed by the government is crucial. In Oman, the introduction of western medicine came in a wave of a sudden push for modernization. For a society that had been very closed off for many years, biomedicine represented entering into the world and making the most of new resources. It meant Oman was moving into a new period, having its renaissance. Resistance to new technologies was minimized first by this renaissance spirit and what biomedicine represented in that context, and second the fact that biomedicine offered solutions to stubborn health issues such as malaria.⁹⁷ For Morocco, the introduction of biomedicine was much more gradual, and at first represented

⁹⁵ Who.int [MOROCCO], *op. cit.*

⁹⁶ Who.int [OMAN], *op. cit.*

⁹⁷ Boersma, *op.cit.*

not a period of new growth but the intrusion of an imperial power.⁹⁸ Second, even when it was expanded, it was in small spurts, not in the overwhelming wave of 1970s Oman. Moroccans have not blindly accepted their flawed biomedical system warts and all, but instead drawn on the resources they have always had, their traditional medicine and practices, as well as new resources that have been slowly introduced.⁹⁹

Islam, a religious as opposed to medical system, is far more diverse in its incarnations and applications across the Middle East. While it is tempting to use religion as a universalizing factor when looking at difficult to explain fertility trends, the stark differences between Morocco and Oman should absolutely rule out this possibility. Both Moroccans and Omanis, while drawing some of their cultural values from Islamic sources, at the same time bring their cultural values and social needs to their interpretation of religion. Though many Islamic sources value or encourage large families, Moroccan women draw on the idea that God “does not wish to burden man” to show that their choice to have fewer children, and therefore provide a better life for those children, also allows them to fulfill Islamic ideals about family.¹⁰⁰ Meanwhile, in Oman where rapid economic has given new families and young mothers more and more resources for their children, having more children is not an issue. Indeed, larger families are encouraged both by certain interpretations of Islamic texts but reinforced by culture norms around visiting practices and the building of social networks. Large families are not solely an appeal to Islamic values, but also to the building of social capital.¹⁰¹

⁹⁸ Dieste, *op. cit.*

⁹⁹ Obermeyer 2000, *op. cit.*

¹⁰⁰ Hughes, *op. cit.*

¹⁰¹ Eickelman, *op. cit.*

A powerful force that pushes on not just religious and cultural factors in fertility, but also influences medical system use, is economics. In this respect, the 1970s were a crucial time for both Morocco and Oman. For Oman, the discovery of oil coincided with a change in government that led to a boom in their economy and in development. In Morocco, a government push for family planning coincided with a sudden shift in the phosphate market, and a sudden downturn for the Moroccan economy.¹⁰² The sudden reduction in economic resources forced women to now make choices based off of much more limited resources, and in turn they decided to make us of one resource that was now more available: biomedical family planning methods. In contrast, the economic boom in Oman meant development and more access to the medical system, which meant a higher survival rate for mothers and their children, and more resources to give to those surviving children.¹⁰³

In light of these sweeping forces encountered when making choices about their fertility, we might envision women as being tossed about by demographic trends. However, I assert instead that women are aware of these factors and make the best choices for themselves and their families based on the resources and socioeconomic pressures that they must navigate. This active decision making is demonstrated strongly in Morocco, in the fact that women, in spite of their government's insistence that biomedical care is best, often make alternative decisions when they've been failed by biomedical services. Likewise, Omani women demonstrate this active decision making in that though their newfound resources would go even farther with fewer children (as suggested by the birth spacing literature provided by their government and their doctors), the cultural value of children both in and of themselves and in building social networks, for several decades represented the stronger side of the scale when women weighed their options.

¹⁰² Dieste, *op cit.*

¹⁰³ Hill et al, *op. cit.*

Women constantly encounter different options when engaging in decision making about their fertility, and this is a unifying factor of fertility trends, regardless of economic, social, and medical factors. Understanding all of these factors, within the context of each society, and how women negotiate them is crucial for anyone who wishes to understand fertility trends in any given country. Indeed, governments must gain greater understanding of how their policies interact with existing fertility determinants if they wish to manipulate fertility within their country, but at the same time greater understanding of fertility determinants can be understood in the context of empowering women through their fertility choices.

Bibliography

- Al Riyami, Asya, Mustafa Afifi, and Ruth M Mabry. 'Women's Autonomy, Education And Employment In Oman And Their Influence On Contraceptive Use'. *Reproductive Health Matters* 12, no. 23 (2004): 144-154.
- Al-Qudsi, Sulayman S. 'Labour Participation Of Arab Women: Estimates Of The Fertility To Labour Supply Link'. *Applied Economics* 30, no. 7 (1998): 931-941.
- Al-Rawahi, Samira, and Nancy C. Sharts-Hopko. 'Birth Spacing Initiative In Oman'. *Journal of Cultural Diversity* 9, no. 1 (2002): 23-26.
- Belwal, Shweta, and Rakesh Belwal. 'Work-Life Balance, Family-Friendly Policies And Quality Of Work Life Issues: Studying Employer's Perspectives Of Working Women In Oman'. *Journal of International Women's Studies* 15, no. 96-117 (2014).
- Boersma, Jeanette, and David De Groot. *Grace In The Gulf*. Grand Rapids, Mich.: Eerdmans, 1991.
- Bowen, Donna Lee. 'Pragmatic Morality: Islam And Family Planning In Morocco'. In *Everyday Life In The Muslim Middle East*, Donna Lee Bowen and Evelyn A. Earlyed. by . 1st ed. Bloomington: Indiana University Press, 1993.
- Capelli, Irene. 'Risk And Safety In Context: Medical Pluralism And Agency In Childbirth In An Eastern Moroccan Oasis'. *Midwifery* 27, no. 6 (2011): 781-785.
- Chatty, Dawn. 'Women Working in Oman: Individual Choice and Cultural Constraints'. *Int. J. Middle East Stud.* 32, no. 2 (2000): 241-254.
- Courbage, Youssef. 'Fertility Transition In The Mashriq And The Maghrib: Education, Emigration, And The Diffusion Of Ideas'. In *Family, Gender, And Population In The*

- Middle East: Policies In Context*, Carla Makhlouf Obermeyer ed. by . 1st ed. Cairo: American University in Cairo Press, 1995.
- Data.worldbank.org,. 'Morocco | Data'. Last modified 2014. Accessed December 18, 2014.
<http://data.worldbank.org/country/morocco>.
- Davis-Floyd, Robbie, and Carolyn Fishel Sargent. *Childbirth And Authoritative Knowledge*. Berkeley: University of California Press, 1997.
- Dieste, Josep Luis Mateo. *Health And Ritual In Morocco*, n.d.
- Drysdale, Alasdair. 'Population Dynamics and Birth Spacing in Oman'. *International Journal of Middle East Studies* 42, no. 01 (2010): 123.
- Eickelman, Christine. 'Fertility And Social Change In Oman: Women's Perspectives'. *Middle East Journal* 47, no. 4 (1993).
- Eltigani, Eltigani E. 'Changes In Family-Building Patterns In Egypt And Morocco: A Comparative Analysis'. *International Family Planning Perspectives* 26, no. 2 (2000): 73.
- Haut-Commissariat au Plan du Maroc, Last modified 2010. Accessed December 7, 2013.
http://www.hcp.ma/Mortalite-maternelle-nombre-de-deces-pour-100-000-naissances_a689.html.
- Hill, Allan G, Adaline Z Muyeed, and Jawad A al-Lawati. 2000. 'The Mortality And Health Transitions In Oman: Patterns And Processes'. *WHO Regional Office For The Eastern Mediterranean And UNICEF, Oman. Muscat 2000*.
- Hughes, Cortney. 'The "Amazing" Fertility Decline: Islam, Economics, And Reproductive Decision Making Among Working-Class Moroccan Women'. *Medical Anthropology Quarterly* 25, no. 4 (2014): 417-435.
- Inhorn, Marcia C. 'Defining Women's Health: A Dozen Messages From More Than 150

- Ethnographies'. *Medical Anthropology Quarterly* 20, no. 3 (2006): 345-378.
- Ministere de la Sante,. *Enquête Sur La Population Et La Santé Familiale*. Rabat: Demographic and Health Surveys Program, 2005.
- Obermeyer, Carla Makhoul. 'Islam, Women, And Politics: The Demography Of Arab Countries'. *Population and Development Review* 18, no. 1 (1992): 33.
- Obermeyer, Carla Makhoul. 'Pluralism And Pragmatism: Knowledge And Practice Of Birth In Morocco'. *Medical Anthropology Quarterly* 14, no. 2 (2000): 180-201.
- Temmar, Fatima, Bilkis Vissandjace, Marie Hatem, Alisha Apale, and Devorah Kobluk. 'Midwives In Morocco: Seeking Recognition As Skilled Partners In Women-Centred Maternity Care'. *Reproductive Health Matters* 14, no. 27 (2006): 83-90.
- Weeks, Andrew D. "The Retained Placenta." *African Health Sciences*. (2001).
- Who.int,. 'WHO | Morocco'. Last modified 2014. Accessed December 13, 2014.
<http://www.who.int/countries/mar/en/>.
- Who.int,. 'WHO | Oman'. Last modified 2014. Accessed December 13, 2014.
<http://www.who.int/countries/omn/en/>.

Works Consulted

- Alshishtawy, Mo'ness. 'Strategic Approach To Improving Maternal Survival In Oman'. *Oman Medical Journal* 23, no. 3 (2014): 179-186.
- Bourquia, Rahma. 'Women, Uncertainty, And Reproduction In Morocco'. In *Family, Gender, And Population In The Middle East: Policies In Context*, Carla Makhoulf Obermeyer. by . 1st ed. Cairo: American University in Cairo Press, 1995.
- Brown, Lisanne, Mostafa Tyane, Jane Bertrand, Don Lauro, Mohamed Abou-ouakil, and Lisa deMaria. 'Quality Of Care In Family Planning Services In Morocco'. *Studies in Family Planning* 26, no. 3 (1995): 154.
- Obermeyer, Carla Makhoulf. 'Reproductive Rights In The West And In The Middle East: A Cross Cultural Perspective'. In *Family, Gender, And Population In The Middle East: Policies In Context*, Carla Makhoulf Obermeyer. by . 1st ed. Cairo: American University in Cairo Press, 1995.
- Rhodes, Lorna A. 'Studying Biomedicine As A Cultural System'. In *Handbook Of Medical Anthropology: Contemporary Theory And Method*, Carolyn F. Sargent and Thomas M. Johnson. by , 165-180. 2nd ed. Westport: Greenwood Press, 1996.
- Who.int,. 'WHO | Morocco Takes A Stride Forward For Mothers And Children'. Last modified 2014. Accessed December 13, 2014. <http://www.who.int/features/2014/morocco-maternal-health/en/>.

