BATTLING BARRIERS:

RELIGION AND WOMEN'S RIGHT TO CONTRACEPTION SERVICES AND INFORMATION

Vagisha Gunasekara

championing women's sexual and reproductive rights

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LIST OF ACRONYMS

ARROW	Asian-Pacific Resource & Research Centre for Women
AWID	Association for Women in Development
CBCP	Catholic Bishops' Conference of the Philippines
ICPD	International Conference on Population Development
JCA	Justice and Charity Association, Morocco
PATH	Program for Appropriate Technology in Health
PJD	Islamic Justice and Development Party, Morocco
SG	Shirkat Gah Women's Resource Centre, Pakistan
SHE	Society for Health Education, the Maldives
SRHR	Sexual and Reproductive Health and Rights
UNFPA	United Nations Population Fund

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INTRODUCTION

Sexual and reproductive health and rights—also referred to as SRHR[1]—shapes virtually every aspect of a woman's life. It determines her chances of acquiring an education; her freedom to work and marry; her choice to have children; and her right to live a dignified and fulfilling life. Well-intentioned efforts to advance SRHR in a number of countries have been met with various obstacles, such as geographic, economic, and administrative barriers, issues relating to the quality of care, and cognitive, attitudinal, emotional, and interpersonal barriers that are strongly linked to broader socio-cultural and religious norms and practices.[2]

There is substantial evidence pointing to the role of religious beliefs and practices on people's reservations about the purpose, nature, and effects of SRHR.[3] These reservations and attitudes are often related to religious interpretations of gender, sexuality, ownership of the body, the family and its roles, and beliefs about when life begins. While some argue that restrictions on SRHR interventions are "a function of state politics rather than a reflection of religious doctrine,"[4] evidence from ten national studies[5] on the influence of religion on SRHR suggests that the boundary of "the state" and "religion" is porous, and urges us to move towards understanding the discourse and the practice of women's SRHR as produced and reproduced by rapidly changing political, economic and social contexts where patriarchy, processes of development, state ideology and practice, religious interpretations and socio-political movements of religious fundamentalist character are entangled in complex ways.

This paper elucidates evidence which underscores the growing reassertion of control over women influenced by movements advancing a distinct religious identity, and examines the implications for advocacy on advancing women's sexual and reproductive health and rights. Synthesised in this document is evidence from four countries—the Maldives, Morocco, Pakistan and the Philippines—on contraception, an area of controversy (to varying degrees) in all four countries. Evidence from each country stem from national studies on the influence of religion on contraception, and are qualitative in nature. The collated evidence is supported by secondary literature, employed to frame the complex ways in which state policies and people's perceptions link controversies around contraception to religious beliefs and interpretations, socio-political movements bearing fundamentalist ideals, and state ideology and response, all within the context of capitalist development.

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This paper is structured as follows: the first section contextualises barriers that women from developing countries face in accessing contraception within the broader economic and socio-political environment of these states; the second and third sections hone in on evidence from the Maldives, Morocco, Pakistan and the Philippines about the role of religion in shaping discourses and perceptions on contraception; the fourth section presents a conclusion, followed by a section on recommendations for future action.

SITUATING CONTRACEPTION WITHIN THE ECONOMIC AND SOCIO-POLITICAL CONTEXT OF DEVELOPING COUNTRIES

The desire to have smaller families is increasing in many parts of the world. Two inter-related forces are behind these changing preferences. First, more and more women are entering the labour force. The growth of women's rights movements, both national and transnational, has led to increased awareness about the importance of women's education, economic independence, right to work, and freedom to make choices about one's body, often shaking the rooted foundations of gender roles and patriarchal norms. Second, concerns about rapidly growing populations and the implications that it carries for the availability and adequacy of resources, have led some states to manage population growth. The third International Conference on Population Development (ICPD),[6] which was held in 1994, established a far-sighted global programme of development that placed individual rights and liberties and human well-being at the centre. This is a marked deviation from the previous approach of population control in which the individual was displaced in national population policies, and hence remained a passive recipient of policies. ICPD launched a programme that emphasised the value of investing in women and girls, both as an end and a means to development, vis-à-vis stabilised population rates. Following ICPD, many countries incorporated contraception as part of national development plans.[7]

The growing preference for small families that is rights-based is reflected in the worldwide demand for better control of timing of births, and coincides with increased access to and use of modern contraceptive methods.[8] As a result, there is a large increase in the number of women of reproductive age wanting to avoid pregnancy and in need of effective contraception. In 2015, 64% of married or in-union women of reproductive age[9] worldwide were using some form of contraception.[10] Countering this trend is the reality that the number of women in developing countries who want to avoid pregnancy and are not using modern contraception, declined only slightly.[11] In 2012, 73% of all women in 69 of the poorest countries did not use modern methods of contraception. In fact, the unmet need[12] for contraception increased between 2008 and 2012 from 153 million to 162 million women.[13] Between 2010 and 2017, nearly 222 million women, constituting 26% of women who wish to avoid pregnancy, were not using a modern method of contraception.[14] Most recent (2017) data reveals that this group of women accounts for 79% of all unintended pregnancies (ibid).

There are many reasons for the poor access to contraceptive services and information pertaining to both its demand and supply. Ravindram (2016) and research commissioned by the United Nations Population Fund (UNFPA) and the Program for Appropriate Technology in Health (PATH) (2006) identifies several interdependent barriers that women in a number of developing countries must negotiate in order to successfully utilise contraception. These barriers fall on a spectrum of tangibility. Geographic, economic, and administrative barriers are relatively more tangible in comparison to barriers relating to quality of care where attitudes of service providers are significant. Others such as cognitive, attitudinal, emotional, and interpersonal barriers strongly linked to broader socio-cultural and religious norms and practices fall on the less tangible end of the spectrum.

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Geographic barriers to contraceptive services is a critical issue in most developing countries, with better access in urban areas in comparison to rural locations. Though the urban-rural gap in accessing contraceptive services is closing in some countries (i.e., Bangladesh, Colombia, India, and Nicaragua), it remains acute in many parts of Sub-Saharan Africa.[15] It should come as no surprise that the cost of contraception is a key determinant of contraceptive use. Global evidence suggests that poorer women have significantly lower rates of contraceptive use than wealthier women.[16] In this regard, the provision of contraceptives by the public sector, where services are sometimes subsidised, versus the private sector, has important ramifications for access to contraceptives by poorer women. While neither the price nor the availability solely fulfils "access" to contraception, and the quality and suitability

of products, services and information carry equal weight in determining its effect on women, the public sector provision of contraceptives is crucial for the poor. As more countries move towards privatising the distribution of contraceptives, poorer women may face difficulties in acquiring contraception due to economic and class barriers. This is observed in countries like South Africa, where emergency contraceptives are only available in pharmacies, and poorer South Africans cannot afford the price of these products.[17]

Administrative barriers to contraceptive services range from inefficiencies of service delivery to legal restrictions and funding issues. Inconvenient operating hours of clinics, long waiting times,[18] and the lack of capacity and training of professionals[19] are some aspects of contraceptive delivery that discourage individuals from seeking contraception. The knowledge of service providers has a significant impact on the quality of contraceptive care. The lack of knowledge on specific contraceptive methods, such as emergency contraception, is a particular matter of concern. In South Africa for example, where emergency contraception is handled exclusively by commercial pharmacists, public sector healthcare workers remain ignorant of its existence. Lacking adequate training in the provision of emergency contraception, these healthcare workers fail to deal with post-exposure HIV prophylaxis for survivors of sexual assault.[20]

Legal barriers based on age and marital status can make it difficult for anyone who falls outside of such categories to obtain reproductive care. In Manila, Philippines, municipal clinics have been restrained from offering contraception since 2000.[21] In 2008, the Supreme Court of the Philippines refused to hear a case in which a group of women sued the city over their lack of access to contraceptives.[22] While contraction in national budgets has immediate consequences for the provision of contraceptive services, funding constraints in donor countries can also have far-reaching consequences for contraceptive service delivery in developing countries. For example, when the United States President's 2003 Emergency Plan for AIDS Relief (PEPFAR), one of the largest donors for the health sector in Sub-Saharan African countries, decided to focus only on abstinence, condom distribution programmes in many countries came to a halt.[23] U.S. President Donald Trump's reinstatement and expansion of the Global Gag Rule to include not just family planning organisations but all global health organisations via an Executive Order in January 2017 barring international NGOs that perform or promote abortions from receiving U.S. government funding would bear similar, and far more adverse results for many developing countries.[24]

There are attitudinal barriers, shaped by powerful socio-cultural values and norms. Where women and girls have internalised expectations of family and culture, their own individual attitudes are often a barrier to contraceptive uptake. In countries and cultures where motherhood is idealised, pregnancy portrays an entry to adulthood, attaches value to women, and at times can serve as an escape from abusive relationships.[25] In the context of some Latin American countries, Naslund-Hadley (2010)[26] notes that many young women are enmeshed in complex systems of disadvantage that to them, a precocious pregnancy will elevate their status in their community and add meaning to their lives, although some studies show that pregnancy does not deter violence against women.[27] Others note that pregnancy at times increases the risk of violence against women.[28]

Women face emotional and interpersonal barriers to seeking contraceptive services. Attitudes of husbands and partners play a significant role in shaping these barriers and often prevent women from consistently using contraceptives.[29] In South Asia for example, in-laws (particularly mothers-in-law) have considerable control and power over newly married women's use of contraceptives.[30] In most countries in Sub-Saharan Africa and South Asia where infertility is deeply feared and stigmatised, married women are often under pressure from their husbands, in-laws, extended family and relatives, and communities to begin childbearing soon after marriage. Women often succumb to the pressure from their families, particularly their in-laws, for the fear of abandonment and abuse which may come as a consequence of perceived infertility of married women.[31] On occasions when women muster up the courage to seek contraception, attitudes of healthcare providers may have a dampening effect on the woman's desire to acquire contraceptive services. In countries like South Africa and Rwanda, public service providers are hesitant or unwilling to provide contraceptives to young people. In South Africa for example, young girls reported getting scolded by service providers for seeking contraception.[32] Other studies[33] reveal differential treatment of queer men and women, HIV positive persons and differently-abled persons by healthcare providers, undermining the rights to health of these individuals and groups.

Religion plays a key role in producing and reproducing moral arguments against contraception which affects both the demand for and supply of contraceptive services and information. For most organised religions, matters of sexuality and family formation are paramount concerns, as they represent fundamental human behaviours that religions attempt to shape and control.

Cognitive barriers shape one's knowledge and understanding of conception and contraception. Many adolescent girls and some women, have little understanding of reproduction, how their bodies work, how to prevent pregnancy, or where to find information and/or services on contraception.[34] Misinformation about reproduction is in abundant circulation in communities, dispersed through peer and family networks.[35] In Nigeria, a study on unmet reproductive health needs found that most adolescents feared using contraceptives.[36] There were concerns about condoms not coming off or getting stuck;[37] they feared that contraceptives would cause sterility in women or even death;[38] and a study conducted in Lesotho found that young women believed that oral contraceptives caused cancer.[39]

Many of the less tangible barriers to contraceptive services (i.e. attitudinal, emotional, interpersonal and cognitive barriers) interface with broader socio-cultural and religious norms and practices on contraception. The influence of broader socio-cultural and religious norms and practices on the use of contraception cannot be overstated as they shape what women want, and determine the expectations of their families and communities. Throughout South Asia and much of Sub-Saharan Africa, girls and women are perceived as "mothers in waiting," or in other words, motherhood is what girls and women are "for;" their value to society and to the "nation" is solely dependent on their capacity for reproduction.[40] These norms have a cascading impact on the way girls and women are socialised, how they internalize their purpose in life, and ultimately shape perceptions about ownership of their bodies.

Religion[41] plays a key role in producing and reproducing moral arguments against contraception which affects both the demand for and supply of contraceptive services and information. For most organised religions, matters of sexuality and family formation are paramount concerns, as they represent fundamental human behaviours that religions attempt to shape and control. Drawing on historical antecedents to religious doctrine and teachings, religious institutions expound moral and ethical principles regarding the appropriate age of onset of sexual activity, the regulation of non-marital sexual activity, contraception and abortion, appropriate partners, rituals for recognition of marital unions, and gender roles, assigning responsibilities and obligations for child rearing.[42] What we observe in recent times is an orchestrated entanglement of religious doctrine with political ideologies forming a potent combination that significantly affects women's SRHR.

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Evidence from the Maldives, Morocco, Pakistan and the Philippines draw attention to socio-political trends with specific injunctions for women, which in turn have profound effects on contraception. These trends include, but are not restricted to, religious fundamentalism,[43] extremism,[44] or conservative interpretations of religion. Much of the literature on women's SRHR fixates on religious fundamentalism, extremism, or conservative interpretations of religion as key determinants of regressive SRHR policy and practice. Another view that is articulated is that regressive attitudes about SRHR are linked with cultural practices, absolving the role that religion plays in preventing access. The distinctiveness implicated in these labels and categories has limited use for the exercise undertaken by this paper. Contrary to the essentialist view that presumes fixed boundaries for a culture and a religion, and also for sub-categories within a religion (i.e., "fundamentalism" or "extremism"), this paper suggests a constructivist view that assumes the interaction between religious and cultural structures with individuals who are the carriers, movers, consumers, and inventors of cultures and religions. Hence, religion as an institution is understood as fused with cultural norms, traditions, and political ideologies.

WOMEN'S MORALITY, NATION'S MODERNITY: AN ABRIDGED OVERVIEW OF RELIGION AND STATE REFORM IN THE MALDIVES, MOROCCO, PAKISTAN AND THE PHILIPPINES

In all four countries discussed in this paper, contemporary political discourse focuses on how to reconcile modernity and morality. The common post-colonial question of "How can our country develop but still follow its age-old traditions?" comes with a distinct religious-nationalist edge in light of political instability and perceived threats to the nation. All four countries have encountered varying waves of religious adaptations during times of political instability. Religious identities in the four countries do not exist as fixed primordial essences but emerge in particular socio-economic contexts. Here, women figure as agents who will hold the nation together; they are symbols of religion, nation, culture, and tradition. Women have been invested with such a responsibility because—as is the case in many societies throughout the world—they are imagined to be at the core of the nation's moral identity.[45] As economies liberalised and integrated into the global value chains, and women's labour became central to the production process in many developing countries, societal concerns about women's changing roles, fertility, and monitoring and controlling female modesty and respectability has taken centre stage. Contraception must be understood in this context.

The Republic of Maldives

The Republic of Maldives, though known in the past for its practice of moderate Islam, has been experiencing the troubling rise of religious fundamentalism in recent times. Some observe that the country's transformation owes to the growing number of adherents (particularly among youth) to a Wahhabi[46] and a Salafi-jihadi ideology, and organisations that promote this ideology, particularly in the aftermath of the Indian ocean Tsunami.[47]

In the run-up to the 2013 presidential elections, adherents of fundamentalist Islamic identity violently pushed aside moderate and inclusive forms of religious expression in the country.[48] On April 19, 2013, a public protest called for the implementation of the Sharia as the sole source of legal guidance, and on March 28, 2013, the parliament drafted a penal code bill which includes "hudud"[49] punishments.[50] Aside from pivotal political incidents, there has been an increase in extremist attitudes and actions among the general public, particularly with regard to women. In February of 2013, a 15-year-old girl, raped repeatedly by her stepfather, accused of the crimes pre-marital sex and fornication, was sentenced to 100 lashes. A leading political party at the time—Adhaalath Party—endorsed the flogging on the basis that it sets an example for others to refrain from "sinful" acts.[51] The recent turn of events is integral to Maldives' democratisation process; the creation of a multiparty system in 2005 allowed space for various voices to enter mainstream politics.[52] The emergence of the conservative Adhaalath party, amidst the global war on terror, struggle for democratic reforms, and a trend among Maldivian men to study in Madrasahs as in Saudi Arabia has contributed towards the precarious swelling of intolerance of diverse viewpoints, and advocacy of a singular worldview based on a strict interpretation of the Sharia.[53] However, glimpses of the country's progressive past are still to be found. For example, in 2013, the Maldivian government's council of religious scholars—Fiqh Academy—released a fatwa stating that abortion is acceptable under five[54] circumstances.[55]

Morocco

Morocco's recent political situation, tied intimately to geopolitics of the Middle East and North Africa (MENA) region, and the rising regional demand for democratisation vis-à-vis conservative social movements, bears implications for the realisation of women's rights. The "Moroccan Spring" of 2011, which demanded a rebalance of power between the parliament and the King, led to the victory the country's first Islamist-led government formed by the Islamist Justice and Development Party (PJD). PJD and the main opposition party in Morocco—Justice and Charity Association (JCA) that garners tremendous support from the grassroots—claim that women's rights should be sought within an Islamic paradigm, and display at best ambivalent views towards the idea of gender equality. For example, in 2014, the Moroccan Prime Minister who represents the PJD, spoke against women working outside their homes, causing outrage among many in the Moroccan women's movement.[56]

The political recalibration ushered in by the Moroccan Spring, appears to widen the democratic space, however, at the expense of women's rights; and feminist organisations struggle to adjust to the new political context in which they have to negotiate women's rights within a relatively more democratic space, albeit led by their longstanding Islamist opposition.[57] Achievements of the Moroccan women's movement notwithstanding, religious influences on social policies criminalising sex work, homosexuality, and premarital sex, and the recent polarising debate between conservative and liberal policymakers on abortion, is evidence to mounting pressures to realise women's rights. The monarch—King Mohammed VI—continues to play a significant role in Morocco's politics and remains a key ally of progressive reforms in women's rights. For example, in May 2015, under the directive of the King, Morocco initiated a process to expand legal protections for women opting for abortions, leading to a heated confrontation between religious conservatives and women's rights groups.[58]

Pakistan

Women's rights and liberties in Pakistan are intractably intertwined with the country's democratisation process. Within this process, religion has been a defining element.[59] Since its inception, Pakistan's state formation process was marked by political instability, owing to a civil war (between East Pakistan and West Pakistan in 1971), two wars with India (1947-48 and 1965), as well as internal armed conflict in the form of insurgency.[60] Deployment of a unifying pan-Islamic identity in contemporary Pakistan though initiated at the inception, was aggressively pursued during the regime of General Zia-ul-Haq, as a way of containing internal conflict. The decade-long "Islamisation" project is known to have produced a devastating effect on women's rights in Pakistan through a series of laws and regressive social reforms.[61] Shaheed (2009)[62] contends that disempowerment of women was utilised as a repressive tool by "politico-religious elements" during this period to assert power and legitimise the state. Women's resistance to these changes culminated in the formation of the Women's Action Forum (WAF) in 1981 and a wave of feminist struggle in the 1980s had violent confrontations with General Zia's regime.

In more recent times, the global war on terror and the U.S. invasion of Afghanistan has further crystallised the country's Islamic identity as a rallying point for state-society relations. Faced with corrupt state institutions, widening inequality, and insurgencies in the tribal areas, the spillover of the global war on terror has left the Pakistani polity desperate for alternatives. Such circumstances have led to the ascendancy of a politicised religious identity among the people, and a variety of Islamist movements ranging from militant movements to social reform movements on a mission to purify the nation state.[63] The emboldening of a distinct Muslim identity politics in Pakistan has a profoundly negative effect on women's SRHR.

The Philippines

Though colonial Philippines oscillated between two powers that shared divergent views about the separation of church and state—Spain and the United States—the heavy presence of religion (Catholicism) defines post-colonial Filipino politics. When sovereignty was handed back to the Filipino people by the 1935 Constitution, the provision of the charter on religion mimicked the First Amendment to the United States Constitution.[64] However, the following sentences were appended, contributing to ambiguity of the role of the Church in state affairs:[65] "the free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall be forever allowed. No religious test shall be required for the exercise of civil or political rights." In a study of the 1987, 1973 and 1935 Constitutions, Sison (1988)[66] finds that the "separation of church and state" clause is missing. Without a Constitutional provision to play a direct role in state affairs, the Catholic Church remained in the background until 1957.[67] The courtship between the Church and political leaders became a trend during the 1950s, and culminated in the court's explicit support for Raul Manglapus against Ferdinand Marcos in the 1965 elections. In more recent times, the Church played a key role in orchestrating and mobilising public support for the resignation of the former President Joseph Estrada (Estrada vs. Desierto 2001), which paved way for Gloria Arroyo, favoured candidate of the Church for political leadership, to become President.[68]

A force to reckon with, the Catholic Church of the Philippines has been instrumental in toppling corrupt regimes, quelling military coup d'état (in 1986), impeaching two heads of state, and branding itself as the voice and face of justice for the Filipino people.[69] Among the general public, the Catholic Church, represented by the Catholic Bishops' Conference of the Philippines (CBCP) is considered a benevolent broker tackling social justice issues related to land reform, housing, mining corruption, and electoral reform.[70] Hence, its deep involvement in state policy is not just overlooked, but endorsed

by a majority of Filipinos, despite the secular Constitution of the country. This backdrop helps contextualise the results of a 2015 global survey on views on doctrines on divorce, abortion and contraceptives. While a majority of Catholics worldwide disagreed with Catholic doctrines on divorce, abortion and contraceptives, respondents from the Philippines and African countries thought that Catholic values on these aspects were valid, and found that divorce, abortion and homosexuality are "morally unacceptable."[71] The involvement of the Catholic Church in the Philippines' SRHR policies and programmes is not confined to the country alone. The Philippines' Catholic Church was an instrumental force behind the religious backlash against the ICPD in 1994 and global movements against women's SRHR such as Pope John Paul II's campaigns against sex education, contraception, emergency contraception, abortion, and HIV and AIDS in Latin American countries, African countries and the Philippines.[72]

WOMEN'S SRHR—A MATTER OF POLITICS OF NATION-STATES

Evident from this discussion is the intimate fusion of religion, whether Islam (in the case of Pakistan, the Maldives and Morocco) or Christianity (in the Philippines), and the deployment of a politicised religious identity, with democratic state formation. In the Maldives, Morocco and Pakistan, as observed in many Muslim countries in Southeast Asia (i.e., Malaysia, Indonesia), fuelling this politicised Islamic identity is the "transformation from a progressive, secular, inclusive and adaptive Islam to a more textual, ritualistic and exclusive one."[73] This transformation seeks to homogenise the multiplicity of Islamic communities under the "Wahhabi Creed."[74] The premise of this identity formation is a quest for authenticity. Acceptance of other ideas, customs, rituals and traditions is viewed as an aberration of original ideas of Islam. For many of these countries, the rise of this politico-religious identity fused with a heavy dose of Wahhabi ideology is a regressive trend that undermines progressive gains by women's organisations decades ago. In fact, the dominant Islamic discourse on women's sexual and reproductive health and rights was not always regressive.

Egypt's Al-Azhar University, an authority in global Islamic discourse in the 1970s and early 1980s, issued progressive edicts regarding women's SRHR. For example, a former Mufti of Egypt and Grand Imam of Al-Azhar University, Sheikh Jadel Haq Ali Jadel Haq, issued a fatwa in 1979 and 1980 in which he stated that Islam allows the use of contraception to space the number of children in a family, or to limit their number according to the capacities (i.e. economic, physical) of the family.[75] Based on an in-depth research conducted by the late Dr. Abdel Rahim Omran, formerly the Chief Population Adviser to Al-Azhar, he concluded that most theologians thought that contraception is permitted with the consent of the spouse.[76] Another example is that Dr. Mohammed Sayed Tantawi, formerly the Mufti of Egypt (also attached to Al-Azhar), issued a progressive fatwa which sanctioned family planning for economic, cultural, demographic or health reasons.[77] However, as influential institutions such as Al-Azhar got subsumed by Wahhabi advocates who in recent times finance the key Islamic institutions that shape the global Islamic discourse, these progressive edicts were denounced and readily replaced with new, regressive laws.

The political projects in the Maldives, Morocco, Pakistan and the Philippines, by their very nature, are unable to move towards recognising and endorsing women's sexuality and women's sexual rights. This is because the political ideologies espoused by these movements only value women for their procreating ability as they are considered the producers of the "nation." The familiar trope of the heterosexual nuclear family as being the foundation or primary building block of each country's nationhood defines women's SRHR.

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international agreements and consensus documents such as the ICPD.

The empirical reality of contraceptive use is that one-fourth of women who want to avoid pregnancy are not using a modern contraceptive method, and these women account for 81% of all unintended pregnancies in developing countries.[78] In Pakistan, only a little more than one-fourth of married women currently use a modern method of contraception.[79] In the Maldives, the unmet need for contraception is 28%, and 16% of conceptions among married couples was reported unwanted, and 19.8% unplanned.[80] While contraceptive use among married women of reproductive age has increased substantially in Morocco from 1980 to 2004 (owing largely to women's educational attainment and to the country's widespread family planning programme), the unmet need for contraception is 27%, and women living in poverty, unmarried women and young women are excluded from contraceptive services and information.[81] The non-uniform and lax national programme on reproductive health that has been in existence since 1998 in the Philippines has led to unfavourable outcomes in SRHR.[82] Adolescent fertility is on the rise; and the growth rate of new HIV cases among vulnerable groups, such as men having sex with men, is high at 48% per year from 2006 to 2013.[83] In all four countries, contraceptive services are not offered to unmarried individuals as non-marital sexual activity is legally prohibited on religious grounds. As evidenced by the four country reports, SRHR is also considered "women's terrain" in all four countries, with little effort to attend to SRHR of men.[84]

HOW RELIGION INFLUENCES DISCOURSE AND POLICY ON CONTRACEPTION

The analyses of the four country reports reveal that opposition to contraception hinge upon three broad moral arguments: a) any method other than a traditional method[85] of contraception is inherently wrong as it is "unnatural," "anti-life," is a form of abortion, and separates sex from procreation; b) contraception brings negative consequences, as it prevents potential humans from being conceived and hence results in controlling the population of a larger identity group (i.e. Muslims, Christians, or other identity group); and c) contraception leads to "immoral" behaviour, as it makes it easier for individuals to have sex outside marriage, contributing to widespread sexual immorality. Anxieties about encouraging sexual activity among young and unmarried individuals, including sexual experimentation, which in turn violates norms about virginity and purity, fall into this view.

CONTRACEPTION IS AGAINST DIVINE WILL

In all four countries, narratives on the "unnatural" nature of contraception are in widespread circulation, and have shaped public perceptions regarding contraception. While there is no consensus in Islam against contraception, the following quote from the Quran is selectively cited by religious authorities and the general public alike to argue that contraception is un-Islamic and that any practice that prevents pregnancy is infanticide:[86]

> *"And kill not your children for fear of poverty—we provide for them and for you. Surely the killing of them is a great wrong."*

The use of teachings such as the above show attempts to convince especially the poor not to fall victim to contraception. The conflation of contraception and population control efforts as part of modernisation programmes of the state is a common strategy employed by religious authorities to veer the public away from understanding the idea and effects of contraception. The quote carries with it assurance that religion will stand by them, guarding their security and well-being. Results of a perception survey carried out by SHE in the Maldives (2014)[87] reveals that 97% of the respondents are in favour of giving birth to "as many children as God gives." Evidence from Pakistan shows that religious clerics routinely speak against family planning in Friday sermons that mainly target men.[88] The limited autonomy of women both within and outside of home creates social hurdles for women accessing contraceptive services and information, as clerics often exhort men in Friday sermons to prevent women from using family planning as it interferes with "God's will."[89] Such evidence indicates a correlation between religious authorities' incitement of arguments against contraception using selected doctrinal teachings to fit this view, and internalisation of such views by the followers. The internalisation of ideas against contraception is further intensified by gendered power dynamics within households that limit women from seeking contraceptive services.

In the Philippines, where the Catholic Church exercises considerable power over state policy owing to its deep embeddedness in the country's struggles for political change, there is an overt involvement in policy matters regarding reproduction. The Catholic church, taking the stance that life begins from the moment the ovum is fertilised, condemns any form of contraception, except for the natural method. The natural method of contraception is encouraged using religious texts: "God has wisely ordered laws of nature and the incidence of fertility in such a way that successive births are already naturally spaced."[90] The church explicitly opposes contraception on the basis that it is anti-life: "development of chemical products, intrauterine devices and vaccines which . . . really act as abortifacients in the very early stages of the development of the life of the new human being."[91]

The role of the Catholic Church in mobilising opposition to the Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act No. 10354), guaranteeing universal access to reproductive healthcare services, methods, devices and supplies, provides strong evidence of the church's influence over shaping state policies on reproductive health and rights. The polarising debate that stemmed from the adoption of this law, commonly known as the "Reproductive Health Law," led to various challengers (as illustrated by Imbong vs. Ochoa, Jr.), knocking on the doors of the Court, beckoning it to declare the law as unconstitutional.[92] The Catholic Organisation—Opus Dei—designated as a personal prelature by Pope John Paul II in 1982, has been instrumental in pushing for and injecting the provision "protection of the fertilized ovum" as a state policy[93] and for pleading the reversal of the Reproductive Health Law before the Supreme Court of the Philippines in 2014.[94] Such views have led to initiatives such as the Executive Order banning artificial contraceptives during the term of Jose Atienza, the Mayor of Manila from 2000 to 2007, for which he was awarded the "Pro-life Achievement Award" by Human Life International, a Catholic apostolate based in Virginia, USA.[95]

CONTRACEPTION AS A HINDRANCE TO IDENTITY

The threat of contraception to the existence of a larger identity group (beyond the confines of a nation state) is most evident in Islamic countries. Commonly quoted in many Islamic countries is a Hadith verse from Prophet Mohammed who described a longing to see a large ummah (a worldwide Islamic community, or an Islamic nation that transcends nation states). Any attempts at confining the growth of the ummah were perceived as un-Islamic in all three Muslim countries (Maldives, Morocco, and Pakistan). When the Pakistani government stepped up its family planning awareness, spending millions in advertising with the catchy slogan *"chota khandaan zindagi asan"* (translation: small family, comfortable lives), it was countered by billboards with the message *"bara khandaan, jihad asan"* (translation: big families help jihad), the latter referring to jihad of the greater Islamic community.[96] The latter slogan has been heard during Friday sermons, signifying the effort to convince the public to defy the mission of the state.[97] The intent here is that men who attend Friday sermons will prohibit their spouses from obtaining contraceptives.

Khurram (2008)[98] notes that government initiatives on contraception in Pakistan have been caught in a vicious cycle of hostility due to religious leaders' push for a bigger ummah. When the Pakistani Taliban captured and ruled the Swat valley (a district of Khyber Pakhtunkhwa or KPK) between 2007 and 2009, they issued a religious decree against family planning on the basis that contraception was part of a Western conspiracy (led by the Americans) to eliminate Muslims and the Muslim identity.[99] In Pakistan, religious fundamentalist and extremist groups have successfully managed to demonise many health-related state interventions on the basis that they aim to reduce the greater ummah, linking family planning interventions with other programmes such as the campaigns to increase iodine intake and the polio vaccination. The religious groups argued that both these interventions caused infertility among Pakistani women, and was part of a larger international plot (in which the state of Pakistan is complicit) to reduce the number of Muslims. A report by the International Crisis Group (2015)[100] notes that people in the KPK region have been told by clerics that "polio vaccine contains elements that are not halal, which sterilise children, accelerate puberty in girls and make them more sexually active and make boys impotent as a part of the West's [anti-Islamic] plan." What is observed here is that women's fertility and their reproductive "duty" is at the heart of political movements that struggle to maintain and renew a distinct religio-political identity. Linked inextricably to the ongoing global war on terror, these discourses have profound material and ideological effects on women's SRHR.

CONTRACEPTION LEADS TO IMMORAL BEHAVIOUR

The view that contraception leads to "immoral behaviour," particularly among women, is evident in all four countries. In Morocco, where pre-marital sex is illegal according to the penal code (Articles 449 to 458 and 504 of the Moroccan Criminal Code), unmarried women are left out of most SRHR interventions, including abortion.[101] When the Moroccan government, led by the King, initiated a reform process in 2015 that called to expand legal protections for women opting for abortions, the fear of immoral behaviour was an argument put forward by the conservatives. In Pakistan, many religious clerics have publicly condemned contraception arguing that contraceptives promote vulgarity, obscenity and extramarital sexual relations. Maulana Fazlullah, a leading military leader and charismatic figure in the Swat Valley announced in public radio that providing condoms to unmarried girls "promotes prostitution and sin in our society."[102] Lady Health Workers (LHWs) working in the KPK region in Pakistan were reportedly publicly named and shamed by religious authorities as "prostitutes and servants of America" with loose morals.[103]

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In the Maldives, the provision of SRHR to unmarried individuals is often interpreted as condoning extramarital or pre-marital sexual activity. A known religious figure in the Maldives articulates this fear in the following manner:[104]

> *". . . purpose of family planning, yes, we can talk about this in front of married couples . . . but for the purpose of preventing AIDS [if we talk about contraception with unmarried individuals] . . . we are promoting the wrong idea. Meaning . . . yes, you may have sex, but safe sex. But in Islam, there is no safe sex out of wedlock."*

These statements depict a fear of a contraceptive "mentality" or a cultural shift in which contraception minimises the risk of conceiving a child, and in turn leads to an undermining of public morality and weakening of the concept of "family." These sentiments are echoed in the Philippines, using Catholic doctrine and principles related to marriage, family, and the purpose of sexual relations. The Catholic Church in the Philippines has inculcated the idea among orthodox Catholics that sexual intimacy, which is only through marriage, should necessarily lead to procreation. As such, the church gives everyone two choices—virginity or the bond of matrimony as a status in life.[105] The family is identified as both the "sanctuary of life" and the "domestic church," and marriage is laid down as the only way in which God has endorsed sexual activity.[106] In 2000 and 2011, and more recently in 2016, local government officials in the executive and legislative branches in the Philippines banned contraceptives based on "pro-life" values and teachings. In the city of Manila and the village of Ayala-Alabang, local officials executed these bans on the claims that contraceptives caused abortion, immorality, and disrespect for parents.[107] In January 2011, the Barangay Council issued a "Declaration of Policies" banning contraceptives claiming that:[108]

> *"The irresponsible and indiscriminate use of contraceptives ...undermine the solidarity of families by promoting premarital sex, giving rise to more fatherless children, more single mothers, more poverty, and more abortions...and causing a decline of legitimate marriages"..."condoms... promote and sanction immoral sexual congresses among the unmarried and especially among the young."*
>
> *"Giving rise to fatherless children" as stated in the declaration is a clear indication of the anxiety that contraception induces un-sanctioned sexual activity in women. Connecting contraceptives with the anti-life discourse, this Declaration defined "abortifacients" to cover all contraceptives. The ordinance that resulted as an outcome of this Declaration prohibited many acts including: any dispensing of contraceptives; the conduct of sex education "without prior consultation with, and written permission of, the parents or guardians of minor students in any school; the use of Barangay funds for the purchase or provision of contraceptives; and the solicitation, acceptance and dispensing of contraceptives by the Barangay or its employees."*[109]

The threat of contraception to the existence of a larger identity group (beyond the confines of a nation state) is most evident in Islamic countries.

RELIGION AFFECTING STATE DISCOURSES

The preceding account renders that the state's discourse around contraception is significantly shaped by ideas surrounding women's fertility and reproductive expectations rooted in religious teachings. Government policies embedded with religious teachings have a profound effect on people's perceptions of and attitudes towards accessing contraceptive information and services in all four countries.

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In Pakistan, a paper reviewing the role of religious authorities in the extension of service delivery notes that, "they [religious leaders] often act as arbiters of morality, ethics and of what is prescribed or proscribed by faith. Their opinions strongly dictate the behavioural norms of their communities, in particular maternal, neonatal and child health."[110] Religious and cultural factors, demographic factors, quality of family planning programmes, attitudes towards contraceptive use and influence from the partner, family and peers determined the use of contraceptives among Maldivians.[111] In the Philippines, there is diversity among the population in subscribing to views popularised by the church. Some progressive Catholics interviewed by Likhaan researchers for example state that "the church is too obsessive about RH [reproductive health] that is very threatening and insulting to the average Filipino."[112] This has led some to be disillusioned with the Catholic church and distance themselves from the doctrine and teachings of Christianity.

Religious interpretations of gender, sexuality, ownership of the body, the family and its roles, and beliefs about when life begins appear to have infused state and society at all levels, posing formidable barriers to policies and programmes promoting contraception and the uptake of contraceptive services.

As evidenced by the four studies that are central to this paper, religion has a powerful influence on attitudes and behaviour on sexuality and reproduction. Religious interpretations of gender, sexuality, ownership of the body, the family and its roles, and beliefs about when life begins appear to have infused state and society at all levels, posing formidable barriers to policies and programmes promoting contraception and the uptake of contraceptive services. For women, outcomes associated with getting pregnant unintentionally are well documented. These include, incompletion of education, delay or abandonment of career plans, delayed prenatal care, premature delivery, low birth weight of the newborns, maternal mortality and morbidity, depression and family violence. While women are better off when they choose if and when to have children, their agency to exercise that choice is often thwarted by religio-political formations asserting control over women's bodies.

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CONCLUSIONS

This thematic paper has discussed the realities associated with operationalising the global commitment to attain universal sexual and reproductive health and rights for women and girls, as underscored by the 2030 Agenda for Sustainable Development. The barriers that women face in controlling their fertility are many and varied; they are intertwined and inexorably steeped in patriarchal gender relations. Access to contraceptive information services, an integral part of SRHR, is a challenge due to multiple political economic arrangements in which religious and cultural beliefs and practices are deeply embedded.

In the four countries discussed in this paper—Pakistan, the Maldives, Morocco and the Philippines—controversies around contraception in Islamic and Catholic contexts have revolved around the following contentions: that both religions view contraception as against the natural laws of God, that contraception is detrimental to the construction of a pan-Islamic identity and the ummah, and that contraception leads to immoral behaviour, especially in women. These perspectives have been found to influence people's perceptions and choices about contraceptive use. These contentions, however, must be read against the wider context that informs the background of this paper, that is, the preoccupation of identity politics with women's bodies. Socio-political shifts with religious overtones tend to view women and girls as mere vehicles for reproduction.

Solutions that address the barriers to contraception are complex. Malhotra (2003)[113] in an account on "empowerment" reminds us that the family itself is the central locus of women's disempowerment. While the broader cultural and social institutions work to constrain women's options, the family most often serves as the first and most significant mediator for their impacts on women's lives. There is need for multi-faceted strategies that enable and encourage women to chart their own futures, and choose motherhood only if and when they are ready. Harmful norms that condone gender-based violence and place women and girls in the untenable position of being solely responsible for the outcome of sexual activity—while lacking the decision-making power to control it—need to be ended. Women and girls need to be educated for their futures as independent citizens, with a sound grasp of their legal rights. They must be mobilised to claim the space, both within their homes and in society, to demand those rights. Men and boys need to be brought squarely into the middle of these transformations so that the ownership of SRHR moves beyond its current fixation on women.

Advancing women's rights in all four countries requires states to adopt a rights-based and gender-sensitive perspective when formulating and implementing policies and programmes by government institutions. The state has a responsibility to show zero tolerance towards rhetoric, demands and actions of religious formations or political groups that undermine women's rights to their bodies. State authorities have an obligation to consult women's rights organisations, health experts and civil society organisations when drafting policies, especially those that have direct implications on the health, wellbeing and rights of women and girls, including their SRHR, and ensure transparency of the adoption and implementation of public policies that have implications on the health and wellbeing of women and the family. The political will of the state in fulfilling its obligation to the citizens is particularly important. For example, in January 2017, President Duterte of the Philippines issued Executive Order 12 calling for full implementation of the Responsible Parenthood and Reproductive Health Act of 2012. He ordered government agencies to ensure free access to contraceptives for six million women who cannot currently obtain them.[114] While a step in the right direction, the extent to which President Duterte's action alone leads to the overturning of the temporary restraining order on implementing the RH Law remains a question. Similarly, King Mohammed VI of Morocco issued a directive in 2015 to expand legal protections of women opting for abortions. These examples indicate more about the general impact of the political will in states, and less about the particular leaders or the nature of the political system in question. The political will of the state and the support of key political leaders on achieving SRHR must be complemented with rights-based and participatory processes that determine SRHR of citizens. The fourth estate—the Media—has a responsibility to monitor and report on traces of religious or other identity-based and sexist rhetoric, demands and actions of political parties, politicians, bureaucrats and emerging social movements.

RECOMMENDATIONS

While a long-term approach to ensuring SRHR is imperative, it must be supplemented with "quick-win" strategies,[115] as broader societal changes take time—time that millions of women and girls without access to contraception do not have. This final section of the paper identifies key policy and programme measures that could help support access to contraception.

BOX 1: QUICK WIN

A key finding reiterated across all four studies is the link between the level of education of religious leaders and their support for contraception, including abortion (in the case of Morocco). This highlights an opportunity for state institutions and civil society groups to engage with selected group of religious authority figures for advocating contraception.

1. **Health-policy making must be led by evidence and the needs of the population, and not by religious edicts or norms.** However, given that religion pervades all aspects of life for most citizens, it is important to change religious and socio-cultural norms about gender and sexuality through awareness raising and other communication activities (i.e., school programmes, programmes in religious schools or churches in collaboration with progressive religious figures, media):
   - Religious and cultural norms that place the social "duty" or responsibility of reproduction on women and girls alone must be challenged. Men's and boys' roles in reproduction needs to be acknowledged, and they must be included in SRHR initiatives.
   - Heteronormativity, gender roles and gender stereotypes (including views of men and masculinities) must be challenged. Society must be challenged to see women as more than sexual objects or reproductive machines. Women must be made aware that they can refuse sexual relations. Dominant ideas about "masculinity" must be challenged and men and boys must be involved in these programmes.
   - Space to create alternative discourses on gender and sexuality within the realm of religion must be encouraged in public and private schools, religious schools and in media channels as well as more generally. Building alternative discourses must entail revisiting "authenticity" of religious interpretations. Approaches such as critical pedagogy is particularly useful in building alternative discourses.
   - Progressive religious interpretations addressing SRHR must be brought into the discourse and publicly discussed (i.e. Al-Azhar fatwas from the 1970s and 1980s).
   - Collection of timely and disaggregated data that assesses people's reproductive needs and rights must be funded and carried out as routine practice.

BOX 2: A TALE OF CAUTION – PAKISTAN

As a result of the 2010 devolution reforms in Pakistan, health service delivery became a devolved subject and was assigned to the provinces. However, Pakistani provincial institutions did not have the capacity to provide health services immediately, especially during disasters (i.e. 2010 floods and 2015 earthquake). At the time, the Pakistani state was widely criticized for its slow and poor response. This was readily exploited by Falah-e-Insaniat, a "charity wing" of the banned Jamaat-ud-Dawa that started an ambulance service free of charge. This opportunity allowed such groups to be the face of justice and service for the people. Subsequently, the fundamentalist groups' ideas about women and sexuality were aggressively proliferated by groups of similar nature.

Source: Brohi and Zaman 2016

2. **Building capacity to deliver high quality SRH services and information:**
   - The availability of contraceptives must be increased and the cost of receiving contraceptive services and information should be reduced. Voucher programmes that provide free SRH care and door-to-door programmes as implemented in Pakistan must be improved and continued. Religious and cultural norms that place the social "duty" or responsibility of reproduction on women and girls alone must be challenged. Men's and boys' roles in reproduction needs to be acknowledged, and they must be included in SRHR initiatives.
   - States must make emergency contraception available. Training of healthcare professionals and pharmacists on emergency contraception must be undertaken. Awareness programmes on this method must be built around media campaigns to effectively communicate the purpose and effects of this method of contraception. In countries where abortion is illegal, civil society advocacy to recognise post-abortion care as part of post-natal care and framing it as a medical issue may be a step towards drawing attention to a critical women's health issue.
   - National SRH policies and programmes must be formulated accounting for inter-linkages among otherwise separate policy areas such as gender-based violence and policies addressing HIV/AIDS.
   - National budgets and donor funding priorities must reflect the need for better SRH care and services.
   - Donor agencies must plan for and fund contingencies arising from the recent reinstatement of the global gag rule.
   - In countries where SRH is a devolved subject, the central government must ensure that the provincial or local authorities are able to provide services meeting quality benchmarks.

3. **Advocacy on sexual and reproductive health and rights:**
   - Efforts must be made to ensure full access to contraceptives for all women (regardless of marital status) and adolescents.
   - The capacity of healthcare professionals and other community leaders to understand legal provisions on SRHR must be increased through capacity strengthening opportunities.
   - Efforts must be made to lobby and influence state institutions at various levels of governance in appropriating sufficient funds for SRHR programming.
   - States must be held to account to make public consensus documents on SRHR policies and programmes.

4. **States have to ensure sexual and reproductive rights:**
   - States must adhere to and prioritise values, principles and the directives of international commitments that they have signed and ratified.
   - States must adopt policies that ensure full access to contraceptives for all women (regardless of marital status and age).
   - States must ensure effective implementation of policies that mandate full access to contraceptives for all women (regardless of marital status and age).
   - States must adopt a rights-based approach to conceptualising policies on sexual and reproductive health and ensure that the influence of religion on access to services and information on contraception is addressed as part of this.
   - States must adopt the practice of consultation and collaboration with women's rights groups and movements in drafting all stages of SRHR policies and programmes, and monitoring and implementation of the same.
   - States must make public consensus documents on SRHR.

BOX 3: GOOD PRACTICE EXAMPLE

As shown in the case of Pakistan, targeting selected local-level clerics and medical practitioners for sensitization on contraception has yielded positive changes in their perceptions of SRHR interventions. Similarly, in the Maldives, leading religious scholars who agree that family planning is permitted in Islam can be engaged to dispel myths and confusions about certain contraceptive methods among the public.

Source: Brohi and Zaman 2016; SHE 2016

ENDNOTES

1 Defined as follows: Reproductive health: reproductive health implies that people are able to have a responsible, satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Reproductive rights: reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. Sexual health: implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases. Sexual rights: include the right of all persons to be free of coercion, discrimination and violence, to obtain the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decided whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life (ARROW 2012: 17).

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Battling Barriers: Religion and Women's Right to Contraception Services and Information

This thematic paper is an initiative of a regional partnership working on building the interlinkages of religion (fundamentalisms and extremisms) on women's sexual and reproductive health and rights (SRHR). The initiative involved generating evidence from ten countries with national partners from Bangladesh, Egypt, India, Indonesia, Malaysia, the Maldives, Morocco, Pakistan, the Philippines, and Sri Lanka.

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ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

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