Indonesian Women, Reproductive Rights and Islam

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Abstract

This article discusses the complex relationship between Islam and women's reproductive and sexual rights in Indonesia. Specifically, the article raises important issues for Indonesian women, such as their rights within marriage, access to family planning, and adequate health services, the urgent need to reduce maternal mortality, as well as the importance of reproductive and sexual education for young women. The author focuses on the progressive interpretations of Islamic texts used in the context of health advocacy by Islamic NGOs and study groups for raising awareness about women's reproductive and sexual rights. The author also discusses the resistance to women's rights that occurs within the discourse of Islamic and syncretic Islam and offers suggestions for overcoming these challenges.

The relationship between state law, regional customs, and local interpretations of Islam plays a role in shaping women's daily lives and their ability to recognize their reproductive and sexual rights. Thus, an understanding of the relationship between Islam and reproductive rights includes an analysis of how the Qur'an is interpreted at the community, family, and personal levels, and not just at the level of theological arguments between elites. The increasing democratic space in Indonesia also represents an increasing potential for Muslim women to become actively and positively involved in both state and religious institutions to advocate for and protect their reproductive and sexual rights within the Islamic framework.

Key words: women reproductive rights; Islam and state; NTB; rights education; health advocacy.

Introduction

In popular debates about reproductive and sexual rights, formal religions are routinely represented as barriers, providing institutional as well as ideological resistance to women’s realisation of reproductive autonomy. Representations of Islam, as necessarily regressive in relation to human rights, are particularly problematic in light of the current climate of international conflict, which has created mutual suspicion and misunderstanding between Muslims and non-Muslims worldwide. Research into the plurality of Islam in different cultural and political contexts is urgently needed to challenge the popularity of reductionist representations of Islam.

1 This article is presented in the panel on “Gender and Sexual Identity” at the 3rd International Symposium of the Journal ANTROPOLOGI INDONESIA: “Rebuilding Indonesia, a Nation of ‘Unity in Diversity’: Towards a Multicultural Society”, Udayana University, Denpasar, Bali, 16–19 July 2002.
tations of Islam in the international media. The Indonesia/Australia relationship, characterised recently by conflict over refugee policy and East Timor’s independence, also has much to benefit from an improved understanding of Islam as providing an ethical framework for promoting human rights.

My interest in this topic stems from a growing awareness of the significance of spirituality and religion to the identities of Muslim women in Indonesia, and the implications of this in terms of their reproductive health. Both Indonesian and Malaysian women working to promote reproductive rights through the activities of NGOs and prayer groups have encouraged me to explore the potential of Islam in health advocacy programs. These women’s passionate conviction to finding plausible answers to issues of human justice from within their religion has deeply inspired me. The paper I am presenting today begins with a brief discussion of women’s reproductive health status in Indonesia, which provides the empirical rationale for a rights based approach to health promotion. Secondly, I outline my conceptual preparation for exploring women’s negotiations of reproductive and sexual rights at the grass roots level. Thirdly, I present my argument in favour of utilising Islam, and the Qu’ran in particular, as the basis of an ethical framework from which Muslim women’s reproductive rights can be promoted in a religiously and culturally appropriate manner. Finally, I emphasise the compatibility of Islam and a rights based approach to promoting women’s health, with the task of achieving a stable multicultural society in Indonesia.

Women’s health status and reproductive rights

Whilst acknowledging Indonesia’s population diversity, it is highly significant to note that close to 90% of Indonesians identify as Muslim. Thus, when we speak of the health status of Indonesian women we are speaking of an enormously significant proportion of the population. Despite the fact that Indonesia is not an Islamic state, its status as the world’s largest Muslim nation means that promoting the reproductive rights of Indonesian women is critical also in terms of promoting gender equality within Islam. Indonesian women of varied ethnicity have historically enjoyed a much higher status in many aspects than have Muslim women in Middle Eastern nations. For instance, ordinary women living in Sumatra, Java and Lombok have customarily exercised a high degree of spatial mobility in the public sphere (Sullivan 1994, Brenner 1998; Bennett 2002). They have also maintained considerable economic independence in terms of earning and spending their own income, and have typically managed the collective household income and acted as equal decision-makers in relation to domestic matters. Indonesian women have not generally been required to practice purdah (female seclusion), and the wearing of Muslim headdress tends to been an individual choice rather than a religious requirement for most Indonesian Muslma (Brenner 1996; Bennett 2002). However, despite these freedoms and the high social status Indonesian women enjoy as mothers, their health has remained poor by international standards and has not benefited in line with the nation’s economic development.

Despite the widely acclaimed success of the Indonesian Family Planning Program in drastically reducing the national fertility rate over the past twenty-five years, Indonesian women have not experienced corresponding improvements in their reproductive health status. The most alarming indicator of women’s poor reproductive health is the high incidence of maternal mortality, estimated nationally at around 450 deaths per 10,000 births. Regional
rates differ significantly, reaching as high as 650 deaths per 10,000 births in outer provinces such as NTB and Irian Jaya. These rates compare poorly to other ASEAN nations, for instance Malaysia currently has an estimated MMR rate of 20 deaths per 10,000 births. It has also been estimated recently that up to 10% of Indonesia’s maternal mortality results directly from complications arising from unsafe abortion (Widyantoro 2001).

Common problems that compound the risks associated with pregnancy and unsafe abortion include women’s poor access to contraception and contraceptive failure. While it is true that approximately 57% of married women were estimated to have adequate access to modern forms of contraception in 2000, it is also true that the unmet need for contraception for married women was estimated to be as high as 15% in some provinces. When we consider the high incidence of contraceptive failure, along with the 15% of married women who may be at direct risk of unwanted pregnancy, it indicates that women's basic right to safe contraception is still far from guaranteed in Indonesia. The situation for unmarried women is even more grave. Social stigma and legal barriers deter single women from accessing the reproductive health services and contraceptives they require. Also, single and married women alike frequently lack the necessary information to successfully negotiate reproductive health and family planning services.

2 The impact of the Indonesia’s economic crisis in the health sector has been dramatic. Budget cuts reduced the range of contraceptives available, and caused a rise in the cost of contraceptives and reproductive health services in both the private and public sectors (UNFPA and ANU 1998:55). The increased cost of private services was particularly pertinent for single women, because they are not legally entitled to public family services. Estimates on the impact of the financial crisis on reproductive health indicate that the coverage of family planning services will drop by at least 10% for married couples. As a consequence it is estimated that the number of unintended pregnancies will rise dramatically, with the consequence of 1.9 million to 3.5 million additional unwanted births for the years 1998 to 2003 (UNFPA and ANU 1998:56). Unwanted pregnancies and poor access to safe menstrual regulation is also expected to result in a serious rise in maternal mortality as the result of unsafe induced abortion. Depending on the duration of the crisis, it has been estimated that there may be between 12,680 and 17,000 extra maternal deaths between 1998 and 2003 (UNFPA and ANU 1998:56). Transmission rates of sexually transmitted diseases (including HIV) are also likely to have increased in the past few years due to the impact of the financial crisis. As the number of people living below the poverty line has risen drastically, from approximately 11% in 1996 to 40% in 1998, sexual networking for economic survival has no doubt increased across the nation. Reports of the growth of commercial sex in Jakarta (Allman, 2001:108) and in Lombok (UNFPA and ANU 1998:63) confirm that poverty has a direct impact upon the political economy of sex in Indonesia. The dynamic nature of contemporary sexual networks, and the fluidity of the population of women and men who move in and out of sex work and other professions that are targeted as high risk, reinforces the urgency of HIV/AIDS prevention from within a human rights framework.

Women’s poor access to information is perpetuated by the reluctance of the Indonesian Government to support comprehensive reproductive education for youth, and by the lack of skills and time required for service providers to offer information and counseling in primary health care settings.

Why is it that a society, which has traditionally accorded women a high social status and has embraced the ideology and practice of family planning, has not also experienced commensurate improvements in terms of women’s reproductive health?

The answer is complex, and can only be partially addressed in this paper. However, one significant factor is the ideology of population control that has guided the Indonesian Family Planning Program since the 1970’s. This ideology has not been centrally concerned with women’s reproductive rights, but rather with encouraging married women to conform to the program’s rec-
ommendations in terms of contraceptive acceptance (Smyth 1993). The notions of women’s reproductive autonomy, or equal responsibility for women and men with regard to contraception and reproduction, have been absent from BKKBN’s health promotion and social marketing campaigns. Women have been encouraged to accept primary responsibility for family planning as a duty, rather than as a basic right. This attitude has been perpetuated by the gender stereotypes of state development ideology, in which women are encouraged to pursue a life of self-sacrifice, considering their welfare as secondary to that of their families (Suryakusuma 1987). The alternative notion that the common good can only be served by promoting the welfare of all members of the family or group has been ignored. This alternative argument is based on the principles of human equality and justice espoused in the Qu’ran. In fact, the Qu’ran explicitly states that a nation or community cannot prosper if the welfare of its women is neglected. It is most unfortunate, that the true meaning of the Qu’ran has been widely misinterpreted in state development ideology to support gender inequality, rather than to promote the equality of all Muslims (Istidah 1995).

In Muslim communities throughout the world, women and men are improving their access to the central text of Islam, the Qu’ran, and are becoming increasingly involved in interpreting the word of God for the common good of their communities. Opportunities to participate in religious education are typically embraced by the majority of Indonesian Muslims and provide enormous potential for the inclusion of ordinary people as active participants in social debate, rather than as passive acceptors of state policy. Introducing a rights based approach to promoting women’s reproductive health will require a significant shift in the way in which women’s status and health are understood at the levels of policy and health services. Notions of women’s equality and reproductive rights, which are enshrined in the Qu’ran, will need to be communicated to women and their families in terms that are applicable to their everyday lives and are compatible with their values and beliefs as Muslims. I believe that this process has great potential for success in the current political climate. It engages directly with Muslims at the grass roots level—it is inclusive of ordinary people—and it offers an alternative space for religious and social dialogue that is not associated with the corruption and struggle for centralised power that has dominated national politics in recent times.

**Conceptualising reproductive rights**

When conceptualising reproductive rights it is important to make the distinction between normative rights and substantive rights. Normative rights refers to theoretical norms on human rights that are widely accepted either at international, national or local levels. Substantive rights refer alternatively to how rights are actually recognised on the ground level, or in this case how Muslim women’s reproductive rights are actually respected or violated in their every day lives.

To demonstrate this distinction I will use the example of women’s right to family planning. This normative right is enshrined in international agreements such as the Cairo Platform for Action (1994), the Beijing Declaration (1995) and in national legislation. Family planning for married couples is also widely supported as compatible with Islamic beliefs and practices in Indonesia. Traditional methods of contraception, and menstrual regulation using *jamiu*, have also been customary among different ethnic groups throughout Indonesia. We can thus state that multiple normative rights frameworks in Indonesia support women’s right to family planning.

However, when we view family planning as a substantive right, we must acknowledge that not all women have access to family planning.
services in Indonesia. Moreover, the substantive rights of unmarried women are seriously compromised because they are not protected under the normative frameworks that apply to married women.

The relationship between substantive and normative rights is complex—on the one hand we usually expect that normative rights are developed to protect people’s substantive rights. On the other hand—difficulties in gaining acceptance of women’s substantive rights can also influence the development of normative rights. For example, social or religious pressure not to allow single people to access to contraception and family planning services has resulted in the Indonesian Government placing reservations on normative human rights documents such as Cairo and Beijing so that they apply only to married couples.

Notions of reproductive rights that are formed at international and national levels are not necessarily compatible with women’s understandings of how they negotiate their reproductive health and sexual lives (Patchesky 1998). Normative concepts of reproductive rights also have different meanings to different Muslim women depending on their identity. That is, differences in age, marital status, sexual orientation, ethnicity or class may all impact upon how women conceptualise and negotiate their rights. In responding to these dilemmas, it is useful to situate the abstract principles of human rights within the varied contexts of women’s everyday lives, before we attempt to develop strategies for promoting their rights. Two concepts I have found useful in exploring women’s reproductive and sexual lives are: “self determination” (or control) over one’s body, and women’s sense of “entitlement” to their rights.3

At a glance these concepts may seem analogous, however an awareness of or desire for, self-determination does not always translate into a sense of entitlement. For instance, single Muslim women who desire sexual relationships before marriage do not necessarily believe they are entitled to such freedom. They may engage in premarital sex, but understand their actions as inappropriate and inexcusable. Alternatively, married Muslim women who would like to exercise self-determination by refusing their husband’s requests for sex may not have a sense of their entitlement to do so. Even when women have both the desire to exercise self-determination and a sense of entitlement, it does not mean that they can or will exercise their rights. A typical example of this is when women choose not to assert their rights because they believe that the risk involved is too great. For instance, a woman who wishes to limit her family size may not access family planning services against her husband’s will for fear of his reaction.

My understanding of how women negotiate their substantive rights has been influenced primarily by the experience of conducting ethnographic research with single Indonesian women in Mataram, Lombok from 1996 to 1998. This field research involved the exploration of many reproductive health issues, including premarital sex and abortion.4 In interviews with young women the significance of their spiritual identities and beliefs became increasingly apparent. Key concepts that women evoked when sharing their stories included: divine love (love for Allah and the love of Allah), dosa (sin), harram (acts that are religiously forbidden), janin (the human soul and the process of ensoulment), nasib and jodoh (destiny and soulmates), karma and mercy or divine forgive-

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3 These concepts have been used by the International Reproductive Rights Action Group (RRRAG) to conduct research in various cross-cultural contexts. See Patchesky and Judd eds. (1998) for examples.

4 See Bennett (2001) for an in-depth discussion of premarital abortion in Lombok, Indonesia.
ness. The following excerpt from an interview conducted with a young Muslim woman in 1997, demonstrates the centrality of religion and spirituality in understanding her reproductive choices, their consequences and of her sense of self-worth.\(^5\)

Indrah: The first time I did it [had sex] I got pregnant. I tried drinking *jamu* and jumping from the stairs, but it didn’t work. It turned out that my *janin* (baby’s soul) was very strong. I told my friend and she gave me some medicine from the chemist. I drank it because I was too young to have baby and the boy did not keep his promise to marry me. The medicine worked, and I had a lot of bleeding. Afterwards, I became very thin and weak.

Linda: So, since you experienced the bleeding have you visited a midwife or doctor for a check up?

Indrah: No, I’m too embarrassed. If people know what I have done no one will marry me. I pray that no one will find out my secret. I have lost my chance to find *jodoh* (soulmate). How can I ever tell any man the truth about myself?

Linda: Have you been able to speak to anyone about your experience, besides the friend who gave you the medicine?

Indrah: No, not until now, this is the first opportunity for me to share my story. I have never mentioned the pregnancy to that boy who got close to me. We are not friends any more. I regret being friends with him. But whether I like it or not I have to accept it—it’s my *nasib* (destiny). If I pray to Allah every day he will *maafkan* (forgive) my dosa (sin), but if my family know what I have done they will never be able to accept me. Allah has been my only friend until now.

It was only through my interviews and relationships with young Muslim women that I truly began to comprehend, that programs developed to promote reproductive and sexual rights needed to directly engage with women’s spiritual identities and beliefs in order for them to have meaning and practical application in women’s lives. Women’s religious and cultural values are fundamental in shaping both their desires for self-determination and their sense of entitlement to reproductive rights. They are also central in shaping the beliefs and values of women’s partners, and the gender dynamics of their relationships, and thus how successful women are at establishing a sense of entitlement and at negotiating their rights.

Central to my exploration of reproductive rights is also the belief that reproductive and sexual rights cannot be divorced from social, economic and political rights. That is, individual women cannot exercise their reproductive and sexual rights without an enabling environment. Thus, understanding the contexts in which women do, or do not, exercise self-determination also requires examining how women’s social, economic and political positioning creates an enabling or limiting environment (Makhiouf Obermeyer 1994). For instance, if women are vulnerable due to economic dependence on men they may endure violations of their rights rather than risk desertion or loss of income. Women in situations where they fear losing custody of their children may also sacrifice their rights rather than risking divorce and loss of access to their children. Until women are guaranteed their rights to economic equality, to initiate divorce without social discrimination, and to receive child custody and maintenance, many women in abusive relationships will not assert their entitlement to basic reproductive and sexual rights.

**Islam as an ethical framework for rights education and health advocacy**

Based on a review of published and unpublished literature, and health advocacy materials from Indonesia and Malaysia, I have identified a number of core principles that tend to guide Islamic NGOs and prayer groups in

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\(^5\) A pseudonym has been used to protect the identity of my informant
their education and advocacy activities. These include:

- Islam is explicitly concerned with social justice and human rights. Subsequently, to promote human rights is a form of *jihad* (striving on behalf of the faith) that is both a duty and meritorious (Ibrahim 1997: 61; Osman 2002:1).
- According to Islam women and men are created equal and are entitled to the same rights. The sexual difference of women and men is acknowledged and appreciated in the Qu’ran, but is not seen as a basis for sexual or gender inequality (Anwar 1998:8; Wadud 1996:2).
- Reproduction and sexuality are explicitly mentioned in the Qu’ran and Hadith. Therefore, they are not taboo or shameful subjects and may be discussed in both public.
- The Qu’ran states that the welfare of women as individuals, not only as mothers, is fundamental to the welfare of society (Ahmad 1995:48).
- The Qu’ran states that men have explicit obligations to promote the welfare of women and that this is one of the fundamental responsibilities required of men in marriage (Ibrahim 1997:63; Mas’udi 1997:101).
- Islam clearly accepts that sexual relations are not just for the purposes of reproduction. Sexual unions play an important role in nurturing the relationship between partners and are a symbolic re-enactment of the union between the self and God (Mas’udi 1997:105; Mahatir 2001:15).
- Contraception and the spacing of children are explicitly mentioned in the Hadith and are both acceptable within Islam (ISICPFW 1990:17).
- According to the Qu’ran women and men should share dual responsibility for child rearing (Abdullah 1996:5).

These simple statements provide a powerful ethical framework that aims to strengthen women’s sense of entitlement to reproductive and sexual rights. The framework draws upon acceptable religious and cultural values and does not require women to reject their commitment to Islam or adopt foreign notions of human rights as the starting point for health education and advocacy.

Two ideological pillars of Islam that further support the applicability of this ethical framework in contemporary Indonesia are the moral universality of the Qu’ran, and the importance of divine mercy. If one is a Muslim, then it is usual to trust that Allah is both just and merciful. It is also generally accepted that it is not a mortal right to judge the moral or spiritual worth of others, and that such judgement is reserved for Allah alone. Following this logic, it seems inappropriate for mortals to decided that some individuals are more entitled to the basic human rights enshrined in the Qu’ran than others. Stated conversely, it would seem most appropriate to argue that due to the universal applicability of the Qu’ran, all people are equally entitled to their human rights, regardless of their identity or behaviour.

A powerful example of this argument is practice is the work of Marina Mahatir (from Malaysia), who is an advocate on behalf of Muslims who are HIV positive. Mahatir emphasises the mercy, grace and beneficence of Allah. She reminds us, that the true intent and actions of individuals’ who transgress religious and social ideals, can be known only by Allah. She also notes that illness and misfortune whether it be AIDS, cancer or unwanted pregnancy, are not

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6 Some of the organisations who have provided materials for this review include P3M in Jakarta, the State Institute of Islamic Studies in Yogyakarta, and Korporasi Annisa in Lombok. In Malaysia, I have accessed materials through ARROW, Sisters in Islam, IKMAS at Universiti Kebangsaan Malaysia and the Malaysian AIDS council.
necessarily the fault of the person most effected, more than one person may be responsible. This is certainly the case for premarital pregnancy or sexually transmitted infections. When we deconstruct the complicated nature and causes of transgressive behaviour among Muslims it becomes clear that harsh social sanctions, which punish individuals who have strayed, are not in accordance with Islam’s emphasis on mercy. If individual Muslims are not shown mercy in times of need, it is likely that they will experience repeated violations of their rights and that their suffering will be greater.

Conclusion

Working towards a stable multicultural society requires acknowledging, tolerating and even celebrating difference. It also requires widespread agreement on common principles or values that enshrine the rights of all members of society despite their differences. Indonesian Muslims and non-Muslims alike have much to gain from adopting a rights based approach to promoting reproductive health. Such an approach should be grounded within an ethical framework that is culturally appropriate, and is spiritually significant for the people it aims to engage. Participation in religious education, grass roots health promotion and human rights advocacy are mutually compatible activities that can have a direct impact on elevating women’s health status, by promoting women’s sense of entitlement to self-determination in their reproductive and sexual lives. The widening democratic space in Indonesia has also expanded the roles that women and ordinary people can play in calling for positive political and social change. The pursuit of gender equality for Muslims and Indonesian women in general, must also continue across the broader social, economic and political planes of Indonesian society in order to create an enabling environment in which women can successfully negotiate their reproductive rights.

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