الإغاثة الإسلامية
Secours Islamique

October 2008

Reproductive Health Policy

Islamic Relief is dedicated to alleviating the poverty and suffering of the world's poorest people.

Published by Islamic Relief Worldwide
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SUMMARY

Poor reproductive health is an enormous problem in the developing world. More than half a million women die every year from pregnancy-related complications. Similarly, many of the estimated 100 to 140 million women who have undergone Female Genital Cutting (FGC) have their health jeopardised. In the 2004 Strategic Conference of Islamic Relief, reproductive health was classified by the majority of Islamic Relief staff as a top priority for which a policy was needed. A 2006 survey of Islamic Relief field partners confirmed that reproductive health is a pressing issue in the communities in which they work and reconfirmed the need to have a policy in this field.

This policy aims to address a range of reproductive health problems effectively and in compliance with Islamic teachings. It is based on a review of existing literature; international and national laws, regulations and conventions on reproductive health; and extensive verbal and written consultations with Islamic Relief colleagues, religious scholars and leaders, and people working for specialist reproductive health-related organisations.

This policy paper first provides a brief overview of the main problems that the world is facing today in the field of reproductive health, and explains why reproductive health-related issues are important to Islamic Relief. It then outlines the Islamic perspectives on key issues related to reproductive health: sexual health education, family planning, abortion and FGC. Subsequently, these Islamic perspectives are linked to Islamic Relief's experience in humanitarian work. The result is a proposal on how Islamic Relief should respond to reproductive health-related problems faced by the communities it works with.

Finally, it suggests that, where appropriate:

- *Islamic Relief ensures that comprehensive information and services related to reproductive health are available to people in the communities it aims to serve.*

- *Islamic Relief respects and supports voluntary decisions about child bearing and methods of family planning, and Islamic Relief enables people to meet their reproductive health needs in the course of their life cycles in a culturally sensitive and religiously sound manner.*

- *Islamic Relief only engages in or offers referrals for abortion if this is in line with Islamic values and humanitarian imperatives. Islamic Relief does provide post-abortion care, as it is a duty of humanitarians and doctors not to make judgements but to save lives and meet a patient's needs.*

- *Islamic Relief provides education and raises awareness about the impacts and consequences of FGC among all members of the communities the organisation works with.*

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
FGC	Female Genital Cutting
FPs	Field Partners
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
MCH	Mother and Child Healthcare
NGOs	Non Governmental Organisations
PBH/PBUH	Peace Be Upon Him
STIs	Sexually Transmitted Disease
TBAs	Traditional Birth Attendants
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organisation

1 The issue

Reproductive Health (reproductive health) is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. reproductive health therefore implies that people are able to have a 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"[1]. Good reproductive health also means that men and women have the information and means to protect themselves from harmful practices and sexually transmitted infections (STIs).

Poor reproductive health is an enormous problem in the developing world, particularly in the countries that Islamic Relief works in. Today, some 200 million couples have an unmet need for contraception and an estimated 80 million women have unintended or unwanted pregnancies every year. This results in 45 million abortions annually, and an estimated 68,000 women die as a consequence of the abortive operation. More than half a million women die every year from other pregnancy-related complications. Another widespread reproductive health problem is FGC. Many of the estimated 100 to 140 million women who have undergone FGC have their health jeopardised as a consequence, and a large proportion of these women live in countries in which Islamic Relief has a presence.[2]

Improving reproductive health will improve the well-being of millions. Having the knowledge and means to make informed choices about one's reproductive health is fundamental to human well-being and is an integral part of human rights[3]. Ensuring good reproductive health is recognised as vital to achieving the Millennium Development Goals[4], and typically requires improving antenatal, delivery, postnatal, and newborn care; providing services for family planning; eliminating unsafe abortion; combating AIDS, STIs, and harmful practices; and promoting sexual health education[5].

Improving reproductive health primarily benefits women, as they face the heaviest burden of reproductive health problems, but also has beneficial trickle-down effects on other groups. Good pre-natal and obstetric care protects mothers and children. Women who can plan the timing and number of births have greater opportunities for work, education and social participation outside the home, which benefits society as a whole. Indeed, in a number of countries, smaller average family sizes have led to a larger proportion of girls being educated, and to more women moving into professional positions.[6]

2 The importance of reproductive health for Islamic Relief

For more than two decades, Islamic Relief has been dedicated to alleviating the poverty and suffering of the world's poorest people. As such, poor reproductive health and the Islamic Relief mandate are closely related. A survey of IR field partners confirmed that reproductive health is a pressing issue in the communities in which the organisation works. The survey also confirmed that Islamic Relief is in a position to address this issue. Some Islamic Relief field operations partners have, after identifying a need in their communities, implemented successful reproductive health programmes that focus on raising awareness of safe sexual practices, and on the provision of mother and child healthcare. The scope for replication and expansion of these programmes is substantial.[7]

Compared to other organisations, Islamic NGOs are relatively well-equipped to work in culturally and religiously sensitive ways in Muslim communities. They are also well-positioned to work jointly with Muslim leaders, who often play an important role in people's reproductive health-related choices. In the rural areas of Pakistan, for example, the 'religious factor' was extremely important in the decision by men not to make use of contraceptive methods.[8] The majority of married men interviewed considered that Muslim leaders were against fertility control, and 29% cited religion as a reason for their non-use of modern contraceptives. This research illustrates the ability of Muslim leaders to influence, either positively or negatively, the attitudes of Pakistan society towards reproductive health. The findings in Islamic Relief's own interviews with leading reproductive health experts in Bangladesh, Pakistan and Mali were unanimous: the most effective programmes are programmes that actively involve the local Muslim leaders.

As an Islamic faith based NGO with ample experience in the health sector, and strong links with many local Muslim leaders, Islamic Relief is in the position to change attitudes and influence behaviour in poor communities where there is a need for reproductive health interventions. It is a core part of Islamic Relief's mandate to address these issues, even if they are controversial, and to have a clear stance that can guide Islamic Relief's implementing partners when implementing their reproductive health programmes.

3 Islamic context

Islam has prescribed an approach to both health and sexuality, two important components of a healthy reproductive life.

Health is considered in Islam as a blessing given by God to human beings. The Prophet (PBUH) said, "There are two blessings which many people do not appreciate: health and leisure time." [Sahih Al-Bukhari[9], Book 81, Chapter 1, Hadith[10] No. 6412, p. 1232.]. It is a human's responsibility to preserve the blessing of health. In the context of reproductive health, this means that all should be done to prevent women's reproductive roles (i.e. pregnancy, child birth) from jeopardising their health.

Sexuality within the context of marriage is seen as one of the good things in life. Islam does not entertain the notion that sex is incompatible with devotion and does not encourage celibacy or have a tradition of monasticism. The Prophet (PBH) made this clear when he told the companions: *"I pray and I sleep; I fast and I break my fast; and I marry women. Whoever turns away from my way of life is not from me."* (Recorded by Ahmad and ibn Hibban.) [11]

This policy has been developed with the above two principles in mind.

4 Reproductive health issues

4.1 Sexual health education

4.1.1 The issue

In many places where Islamic Relief is active, the level of awareness related to reproductive health issues among young people (especially women) is extremely low. In South East Asia, only 13% of young women (15-24 years) were able to correctly identify two methods that prevent HIV transmission; in Sub-Saharan Africa, the figure was 20%.[12] The lack of knowledge reinforces misconceptions. In Mali, for example, there is a widely held belief that female genital cutting facilitates sexual intercourse and labour, and increases women's fertility. In some rural areas of Pakistan, people believe that drinking milk can prevent women from becoming pregnant, and that women should not take a bath during their menstruation. In South Africa, child rape is partly caused by the myth that having sex with a virgin will cure AIDS.

Knowledge about issues such as STIs' transmission mechanisms, the dangers of unsafe abortion, and family planning methods to help space births, is a necessary (though not always sufficient) condition for safe, responsible behaviour. Sexual health education during adolescence and thereafter can be an important tool in helping people improve their own reproductive health.

A frequently voiced concern is that teaching people about reproductive health will lead to promiscuous behaviour, particularly amongst young people.[13] A recent study of 85 reproductive health education programmes analysed the impact these programmes had on the sexual behaviour of young participants[14]. The results show that the majority of programmes *delayed* the initiation of sex, and *reduced* the frequency of sexual practice. (A very small number showed an increase in sexual practice, but all in developed countries). It also found that sexual education programmes lead to increased use of contraception; a reduction in the number of partners; and a decrease in 'risky' sexual behaviour. None of the programmes resulted in increased sexual risk-taking.

4.1.2 Islamic stances

Islam encourages discussion of issues related to sexuality. Aisha, the wife of the Prophet (PBUH) said, "Blessed are the women of the *Ansar* (the citizens of Madina). Shyness did not stand in their way seeking knowledge about religious matters related to sexuality." *(Sahih Muslim[15]).* A woman's menstruation cycle should be discussed as part of sexual education, and failure to do so will cause unnecessary anxiety and prevent Muslims from attaining *Tahara*[16] (purification). '*Ghusul*'[17] (also known as cleanliness) according to Islamic principals is mandatory for married couples after having intercourse.

Notwithstanding the above, there is the pervasive belief in many Muslim communities that Islam forbids discussions on sexual health, and that it would be 'un-Islamic' for women and adolescents to learn about things such as family planning, transmission of STIs, and menstruation.[18] This makes Islamic Relief's educational programmes both important and challenging.

4.1.3 Islamic Relief's position

In Islam, seeking knowledge is a duty of all Muslims. Seeking knowledge about reproductive health is no exception. Such knowledge should be presented through culturally sensitive educational or awareness raising programmes. Generally, reproductive health is to be presented as part of broader health issues, with the overall objective of enabling youth to develop into healthy, responsible, educated adults. Irrespective of the depth of the programmes, terminological caution is required (e.g., depending on the circumstances, Islamic Relief may choose to use the term 'life health education' rather than 'sexual health education').

Sexual health education also includes raising awareness about family planning methods, within the context of marriage. Islamic Relief will inform people about options that are available, in order to enable them to ensure:

- a safe space between children;
- that women are not putting their health at undue risk of potentially dangerous pregnancies.

The next section explains the Islamic Relief position on both issues.

4.2 Family planning

4.2.1 The issue

The World Health Organisation (WHO) estimates that worldwide 211 million women become pregnant each year and that about two-thirds of them deliver live infants. The remaining one-third of pregnancies ends in miscarriage, stillbirth, or induced abortion.

Some 200 million women in developing countries have an unmet need for effective contraception. Meeting their needs would prevent 23 million unplanned births a year, 22 million induced abortions, 142,000 pregnancy-related deaths, including 53,000 from unsafe abortions, and 1.4 million infant deaths.[19]

The lack of access to and/or use of family planning methods is often a consequence of social and cultural factors that influence sexual practice. The main reasons for the unmet need are lack of knowledge; health concerns; opposition from family and partners; and the lack of health facilities and trained health professionals.[20]

Within the Muslim community, a common concern is that family planning is deemed to be a western ideology which aims to limit the size of the Muslim population. In reality, family planning as such is neither a conspiracy from the West nor foreign to Islam. Islam deals with this issue in several places in the Qur'an and hadiths.

4.2.2 Islamic stances

4.2.2.1 Procreation

Family planning has been discussed at length by many religious scholars. It is very clear from the Qur'an and the hadiths that the Muslims' responsibility is to inhabit and develop the earth and in order to do so people are ordained to multiply. Thus, one of the principal purposes of marriage is procreation. This is in accordance with the following verses and hadiths:

"He brought you forth from the earth and delegated you to inhabit and develop it". (Q11:61)

"O mankind! Be careful of your duty to your Allah who created you from a single soul, and from it created its mate, and from them twain, has spread a multitude of men and women" (Q4:1)

"And kill not your children for fear of want. We shall provide sustenance for them as well as for you. Verily the killing of them is a great sin. (Q17:31)

Additionally, Sayyiduna Umar ibn Al-khattab says, "I heard the Prophet (PBH) say: if you were to trust Allah as he ought to be trusted, you would be given sustenance as birds are given it. They go out hungry in the morning and return full in the evening. (Tirmidhi[21] 2344)

"Marry women who are loving and fertile, for I will be proud of your great number before the other nations on the Day of Resurrection" (Abu Dawud[22] 1754)

However, Islam is a religion of mercy and does not decree anything that is beyond the capacity of humankind. Fertility can be controlled for birth spacing purposes; if it compromises the quality of life of the mother or the child, or the ability of the parents to raise their children.[23] The Qur'an reads:

"Allah charges no soul except to its capacity". (Q2:286)

Many religious scholar and Muslim authors have supported this argument[24]. In his book Omran (1992) argues that: "if excessive fertility leads to proven health risks to the mother and children, and/or if it leads to economic hardship or embarrassment for the father, or if it results in the inability of parents to raise their children according to religious traditions, and educate them socially, then Muslims would be allowed to regulate their fertility in such a way that these hardships are warded off or reduced." [25]

4.2.2.2 Birth spacing

There is a consensus among scholars and a verse in the Qur'an which clearly states that a distance between children should be observed. Mothers are advised to breastfeed their children for two years, during which she should not become pregnant. This is according to the following verse which reads:

"The mothers shall give such to their offspring for two whole years, if the father desires to complete the term" (2:233)

There is a consensus among religious scholars that mother requires one further year to recover[26]. Hence, 36 months is advised for birth spacing. This is the same advice as is provided by the World Health Organisation on this matter that after a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, prenatal and infant outcomes[27].

4.2.2.3 Use of contraceptive methods

There are some disagreements about the types of contraception that would be acceptable in Islam. *Azl* (coitus interruptus) as a form of contraception practiced at the time of the Prophet Mohammad (PBH) is considered by the majority of Religious Scholars as permissible. This is in accordance with the following hadiths[28]:

"We [the Companions of the Prophet (PBH)] used to practice al-azl [coitus interruptus] during the time of the Prophet (PBH) while the Qur'an was revealed" (Hadith Bukhari 4911, Muslim 1440).

"We [the Companions of the Prophet (PBH)] used to practice coitus interruptus. So we asked the Prophet (PBH) about it and he said, So you really practice it? He said this trice and then said, there is no soul that is destined to exist but will come into existence, until the Day of Judgment" (Bukhari 4912)

"We [the Companions of the Prophet (PBH)] used to practice coitus interruptus during the lifetime of the Messenger of Allah (PBH). The Messenger of Allah (PBH) came to know it and he didn't forbid us from practicing it" (Muslim 1440).

From these hadiths, the four schools of thought agreed that coitus interruptus is permissible, provided that the wife authorises the husband to do so. The wife has this authority because of her right of enjoyment and to have children (see Omran: 1992 and Obermeyer: 1992[29]). This is in accordance with the following verse:

"On the authority of Abu Huraira the Prophet (PBH) said al-azl is not allowed without the consent of the wife" (Hadith reported by Abu Dawood)

The four schools of thoughts accept that any scientific means of contraception, such as the pill, condoms, injections, and intra-uterine devices, that aim to achieve the same result as *azl* is acceptable.[30]

Finally, it is important to mention that *azl* or other methods of contraception mentioned here cannot interfere with Allah's creation. If Allah wants to create a soul, nothing can stop it.

4.2.3 Islamic Relief's position

Islamic Relief believes that women and men are regarded as complementary to each other.[31] By mutual consent, they are at liberty to try to control the number and spacing of their children. Islamic Relief will support voluntary decisions about child bearing and methods of family planning, and enable people to meet their reproductive health needs in the course of their life cycles in a culturally sensitive and religiously sound manner.

As a humanitarian organisation and in line with Islamic thought, Islamic Relief wants to protect the health of women and ensure the well-being of the family. Hence, providing advice and guidance on family planning methods and birth spacing in the context of marriage is in line with Islamic Relief's position as an Islamic faith based organisation.

In addition, the organisation may provide contraceptives in the context of marriage, when people cannot afford them or when they are inaccessible. Where women and men fear the side effects of contraception, Islamic Relief should provide medical advice regarding potential side effects that may accompany various methods of contraception.

Since Islamic Relief regards marriage between man and women as an essential building block for a cohesive society, it will not condone sexual relationships outside marriage – even though this is acknowledged to be a greatly concerning reality in the Muslim world. An implication is that Islamic Relief will not provide contraceptives to unmarried couples, unless failure to do so causes harm that exceeds the harm of sex out of wedlock. An example of such a situation is a woman who is forced into sex work, and who Islamic Relief is unable to lift out of it (through counselling, livelihood alternatives or any other method). In such a case, the organisation could consider providing her with contraceptives, whilst simultaneously bringing her in contact with organisations that may be able to support her in gaining her freedom from sex-work by way of legal protection, alternative livelihood support and/or charitable support. The motivation for this course of action is twofold. First, the contraceptives do not encourage illegitimate sex but merely make it safer. Second, the alternatives – terminating lives through likely abortions and possible transmission of the HIV virus – are more sinful than illegitimate sex. If one is forced to choose between two evils, one should choose the least harmful. Losing one's faith and religion is the worst evil, followed by losing one's life. Last comes the issue of one's irdh which concerns one's actual detestable deeds, like fornication. A Muslim who fornicates has the chance to repent, and can see his earlier sins changed to good deeds, as the Holy Qur'an states.

4.3 Abortion

4.3.1 The issue

Globally, around 45 million unintended pregnancies are terminated each year, of which an estimated 19 million are terminated in unsafe conditions. Approximately 40% of all unsafe abortions (by untrained people in unhygienic circumstances) are performed on young women aged 15 to 24. Globally, they kill an estimated 68,000 women every year. This accounts for 13% of all pregnancy-related deaths[32].

A field visit to an Islamic Relief Mother and Child health care centre confirmed the gravity of the problem, even in a conservative Muslim environment. The centre does not perform

abortions but does receive *many* girls and women who expressed a need for pregnancy termination. In most cases, these women and girls end up with a traditional village doctor who uses unhygienic instruments. As a result of these unsafe abortions, many women and girls return to the Islamic Relief centre with heavy bleeding and other serious health problems. The centre does provide post abortion care services to women and girls who have had incomplete abortions or medical complications following an unsafe abortion, but is unable to save the lives of all these women and girls.

The causes for abortion are manifold. Some have to do with the wish or need of women and girls to control their fertility.[33] Contraceptive methods may be unavailable or unaffordable, or women may not have access to them because of religious beliefs or opposition from husbands or relatives. In addition, women may fear actual and perceived side effects; and contraception sometimes fails. For many reasons, unwanted pregnancies occur and this sometimes results in abortion. Recent research carried out by the population council in Pakistan illustrates the magnitude of the problem in a Muslim country: an estimated one million abortions take place each year in Pakistan. 95 percent of them are undergone by married women.

4.3.2 Islamic stances

Abortion is a controversial issue and there is no consensus amongst Muslim scholars on its legality. Positions range from the permissibility of abortion under 120 days to absolute prohibition.

The Qur'an clearly disapproves of killing other humans:

"Take not life which Allah has made sacred" [6.151].

All Muslim scholars agree that the soul enters the foetus at 120 days from the date of conception. This consensus is based upon the following hadith and Qur'anic verse:

The Prophet (PBH) said, "Each of you is constituted in your mother's womb for forty days as a nutfah (a drop of sperm), then it becomes an 'alaqah (a clot of thick blood) for an equal period, then a mudghah (a piece of flesh) for another equal period, then the angel is sent and he breathes the soul into it". [34] (Bukhari, 3036)

"We created the human being from a certain kind of mud. Subsequently, we reproduced him from a tiny drop, that is placed into a well protected repository. Then we developed the drop into a hanging (embryo), then developed the hanging (embryo) into a bite-size (foetus), then created the bite-size (foetus) into bones, then covered the bones with flesh. We thus produce a new creature. Most blessed is Allah, the best Creator". (Q23:12-14)

Consequently, there is a consensus amongst the four principal Islamic schools of thoughts that aborting after 120 days of gestation is strictly forbidden (haram), and considered as infanticide or murder. Even then, some scholars believe that an abortion is permitted if the mother's life is in serious danger.

Prior to 120 days, abortion is still viewed by all the four school of thoughts as unlawful with the level of sin varying according to the period in which the abortion is carried out. Nonetheless, there is a consensus that prior to 120 days, abortion is permissible as a just cause when the life of the mother is in danger or when it is determined that the child will

suffer from severe disabilities[35]. Of course, this abortion has to be recommended by a trained medical practitioner. This is in accordance with the Qur'an which reads:

"Do not kill any soul which God has forbidden to be killed, except in a just cause." (Sourat Al-Isra': verse 33)

"God does not burden any human being with more than he is well able to bear." (Qur'an 2:286).

4.3.3 Islamic Relief's position

Islamic Relief medical practitioners may perform an abortion or offer a referral if it is Islamically justified and in line with national legislation. This means that the abortion can only to be performed ***prior to 120 days of gestation, and only if there is a danger to the life of the mother; or where the unborn is severely disabled; or if a pregnancy results from a rape or incest. Similarly, after 120 days of gestation, an abortion can be performed only if there is a danger to the life of the mother.***

Conversely, if an abortion is not Islamically justified, Islamic Relief medical practitioner must not carry out an abortion or offer a referral as this can be seen as assisting in the commitment of a sinful act.
Finally, Islamic Relief can provide post-abortion care. In this context, Islamic Relief's duty as a humanitarian organisation and a provider of medical services is to save lives and to meet a patient's needs.

Research shows that the majority of abortions are undertaken by married women. This should be avoided wherever possible. In that context, Islamic Relief should minimise the demand for abortions. One of the means is, as covered in the previous section, to provide information and services related to family planning methods, and to provide contraceptives in the context of marriage.[36]

4.4 Female genital cutting

4.4.1 The issue

Female genital cutting[37] (FGC) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or religious reasons. There are three different types of FGC known to be practised today. They include:

- Type I: excision of the prepuce, with or without excision of part or all of the clitoris. Type I is known as female circumcision (FC) if it is limited to the removal of the hood of the clitoris.
- Type II: excision of the clitoris with partial or total excision of the labia minora.
- Type III: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation or Pharonic practice).

Those practicing FGC claim it is done for cultural and religious reasons. It is usually performed on young girls, with the age range depending on countries and cultures.

Every year, some three million girls are subject to these practices. They are usually carried out by a traditional practitioner –also known as an excisor- with non-sterile instruments such as razor blades, scissors and kitchen knives. If the girls and their families refuse to follow this practice, they can be stigmatised, isolated and refused for marriage.

Female genital cutting predates Islam and is not practised by the vast Muslims. However, it has acquired a religious dimension. It is practiced by Muslims and non-Muslims alike, who reside mainly in Africa and some Middle Eastern countries. Often, parents who support the practice argue that it helps prevent promiscuous behaviour in their daughters.

FGC is dangerous and can lead to pain, shock, haemorrhaging, cysts, keloid scar formation, urinary incontinence, infections and death. Although some communities believe the opposite, women with FGC are more at risk of having difficulties during childbirth than those without it.[38] Lastly, FGC reduces or eliminates female sexual enjoyment. FGC is a violation of the bodily integrity of women and girls and is widely considered as a violation of internationally protected human rights. [39]

4.4.2 Islamic stances

The Qur'an makes no mention to FGC. However, there is a hadith (albeit a weak one) that permits - but does not encourage - the removal of the hood of the clitoris.[40]

Nevertheless, there is a range of opinions on FGC in the Islamic world. An Islamic scholarly conference on FGC[41] was held on 23rd November 2006 at the Al Azhar University in Cairo. The final statement of the conference was an appeal "to all Muslims to stop practicing this habit, according to Islam's teachings which prohibit inflicting harm on any human being" and their recommendation to the governments was "to issue laws that prohibit and criminalize this habit ... which appeared in several societies and was adopted by some Muslims although it is not sanctioned by the Qur'an or the Sunna[42]." In their recommendations the scholars said that "the conference reminds all teaching and media institutions of their role to explain to the people the harmful effects of this habit in order to eliminate it." Sheikh Al Azhar Mohammed Sayed Tantawi told the conference: "from a religious point of view, I don't find anything that says that circumcision is a must [for women]" and "in Islam, circumcision is for men only" and "we are on the side of those who ban this practice."[43] Ali Gomaa (Mufti of Egypt) told the gathering that no examples of the practice could be found in the Prophet Muhammad's life. Other Muslim scholars, including Yusuf al-Qardawi, were of the opinion that Islam did not require the practice but that some clerics felt it was allowed. He placed the responsibility on doctors to clarify the issue.

4.4.3 Islamic Relief's position

FGC causes serious harm in many of the communities in which Islamic Relief works, and is not an Islamic requirement. As Islamic Relief aims to alleviate people's suffering, Islamic Relief will, where appropriate, advocate against all forms of FGC.[44]

Islamic Relief should raise awareness of the negatives impacts and harmful consequences of FGC throughout the communities it works in, with special emphasis on parents and their families, medical practitioners, excisors, and religious and community leaders. In so doing,

Islamic Relief aims to induce a virtuous spiral in which attitudinal changes in different groups reinforce each other.

Finally, Islamic Relief's health practitioners' duty is to meet their patients' needs. Consequently, Islamic Relief's health practitioners will, whenever necessary, provide post-FGC care or offer referral to a specialised health centres.

5 How Islamic Relief should implement the reproductive health policy

Islamic Relief aims to promote sustainable economic and social development, and is particularly well-placed to play a role in the field of reproductive health. As such, there is scope for an expansion in Islamic Relief involvement in this field. Such an expansion would be in line with Islamic Relief humanitarian imperative and its Islamic perspective. It would also build upon two of Islamic Relief's traditional strengths: primary health care provision and community awareness raising.

This does not mean that Islamic Relief needs to implement reproductive health programmes everywhere and at all times. It does mean that Islamic Relief acknowledges that reproductive health is one of the pressing issues in many of the communities the organisation works in. Research has consistently demonstrated both the severity of this issue, and the enormous improvements in women's health that relatively minor investments can effect. Islamic Relief's own field research and feedback from Islamic Relief's implementing organisations confirm, for the communities that Islamic Relief works in, both the gravity of the problems and Islamic Relief's ability to address them.

In view of the sensitivities related to reproductive health, Islamic Relief will adhere to the following principles:

- Any reproductive health activities are preceded by an inclusive process of consultation and sensitisation with the local communities, imams and community leaders. This process can be lengthy, although research has shown that community leaders do nearly always agree on the importance of addressing reproductive health issues once the information is available to them.
- Islamic Relief need to recognise the sensitive nature of reproductive health, and work accordingly. This means a preparedness to change and modify interventions that might be seen as too sensitive for a community – for example being conscious of the title of a reproductive health project – and using materials that have been developed with this perspective in mind, and there are many good learning aids, manuals, tool-kits that have been carefully designed with that in mind.
- When determining what type of reproductive health project Islamic Relief wishes to implement, Islamic Relief will never use a one-size-fits-all approach. Instead, Islamic Relief will utilise country- or even community-specific research to ensure that the projects are both appropriate and meaningful.

Furthermore, in view of Islamic Relief's Islamic inspiration:

- Islamic Relief is clear and unambiguous in that the organisation does not condone sex outside of marriage.
- Islamic Relief *does not* advise people they should limit their family size. Islamic Relief *does* provide people with the information and means required to make their own choice
- Islamic Relief accepts that abortion is only permissible if a number of conditions are fulfilled. In situations where these conditions are not fulfilled, Islamic Relief will neither abort nor facilitate referrals. To prevent abortions, Islamic Relief believes that the root of the problem needs to be tackled: reducing the numbers of unwanted pregnancies.

- Islamic Relief will, where appropriate, advocate against all forms of FGC by raising awareness of its negatives and harmful impacts.

With the above in mind, this policy paper proposes that Islamic Relief ensures that comprehensive information and services related to reproductive health are available to people in the communities it serves. The organisation's aim is to enable people to meet their reproductive health needs in the course of their life cycles in a culturally sensitive and religiously sound manner, and to support responsible voluntary decisions. To ensure that Islamic Relief interventions address both behaviour and health problems, Islamic Relief will, where possible, ensure that its education and health programmes work in tandem.

5.1 Health

Islamic Relief can provide information about available family planning methods; provide family planning services where there is an unmet need for them; seek to increase the knowledge of girls and women about obstetrical issues, safe delivery, and dietary practice; strengthen health centres by employing suitably qualified HR specialists and by adding facilities of ante-natal, post-natal care and treatment; and ensure there are facilities that will enable the prevention, detection, and management of HIV/AIDS and other STIs.

5.2 Education, awareness and advocacy

Comprehensive reproductive health information needs to be available. Islamic Relief can raise awareness about reproductive health through community and Muslim leaders; work with schools to present culturally appropriate ways of raising knowledge; provide counselling and advice about practices of safe delivery; do advocacy work through local and mass media; and set up single-sex adolescent peer groups of young girls and boys, to learn about reproductive health issues. Furthermore, a holistic approach to reproductive health is essential to effectively address individuals' health, social and economic concerns. Where possible, IR will therefore incorporate reproductive health education in a wider educational context.

Islamic Relief has a particularly important role to play in the field of FGC. Alone or with like-minded organisations, Islamic Relief will advocate against all forms of FGC, and raise awareness about the health implications of the procedure in communities where it is commonly practiced.

6 Target population

6.1 Women and girls

Women and girls face the biggest burden of reproductive health problems. They face risks of complications during pregnancy and childbirths; they suffer complications from unsafe abortions; they are exposed to contracting STIs, and exposed to harmful practices such as FGC. Therefore, reproductive health projects will tend to focus its attention disproportionately on women and girls. As many of the traditional methods of conveying messages (e.g., through newspaper articles or sermons) do not reach women and girls, considerable creativity is required.

6.2 Men

Men's participation to reproductive health programmes is often limited, but can be crucial. Providing access to health information and service can help men to adopt safe sexual behaviour, and prevent them from contracting STIs. Furthermore, men can play a vital role in suggesting or approving family planning methods which can protect and improve the reproductive health life of their wives.

6.3 Adolescents

Adolescence is a time of transition and growth from childhood to adulthood. Adolescents constitute one fifth of the world's population. Many adolescents lack information and services regarding reproductive health. As a result, adolescents may be at risk of unwanted pregnancies; incur health risks associated with early pregnancy, unsafe abortions, STIs, and HIV; and be exposed to harmful health practices such as female genital mutilation. Neglect of this population can jeopardise their health and future well being. Thus, Islamic Relief will ensure that comprehensive information and services related to reproductive health are available to adolescents.

Annex 1: Interlink between the millennium development goals and reproductive health (from UNFPA)

Ensuring good reproductive health is one of the biggest challenges we face and is fundamental in achieving the Millennium Development Goals (MDGs). The following chart outlines how reproductive health contributes to all the MDGs. The tan boxes outline these contributions, while the blue boxes show what happens in when people have limited access to reproductive health care.

MDG 1: Eradicate Extreme Poverty and Hunger

- Lower fertility, slower population growth, favourable composition, increased economic growth, reduction in poverty
- Income distribution less skewed so less extreme poverty and more scope for growth

- Higher population growth, insecure livelihoods, higher risk of food insecurity
- Teenage births and short birth intervals, some unplanned, larger than desired families
- Intergenerational poverty cycle more likely

MDG 2: Achieve Universal Primary Education

- Means fewer children, more educational resources per child, better school performance
- Reduction in child labour
- Enlarges opportunities throughout adolescence and adulthood

- Low retention rates, especially for girls
- Girls burdened with sibling care and thus less scope of success at school
- Higher pupil-teacher ratios and lower expenditures per child

MDG 3: Promote Gender Equality and Empower Women

- Later marriage and increased life opportunities
- Male participation in reproductive health results in better understanding among spouses so less domestic violence
- Increases bargaining power of women in sexual behaviour and childbearing decisions

- Harmful practices and endemic violence

- Low status and power of girls and women
- Large families more hierarchical with respect to age and gender

MDG 4: Reduce Child Mortality

- Lower risk of infant and child morbidity and mortality
- Improved knowledge about hygiene, baby-feeding and childrearing practices
- Better parenting skills
- Children in large families, more likely to be deprived in terms of nutrition and affection
- Lack of exposure to baby-friendly health initiative and baby-care practices
- Higher malnutrition, stunting and lower birthweight

MDG 5: Improve Maternal Health

- Reduction of maternal morbidity and mortality
- Availability of emergency obstetric care and antenatal care
- Fewer and well-spaced births
- Lack of contraceptive access and choice
- Births delivered by unskilled persons
- Consequences of complications of pregnancies are more serious

MDG 6: Combat HIV/AIDS, Malaria and Other Diseases

- Better information on contraction and prevention of HIV/AIDS and other STDs
- Increased negotiating skills for safe sex reduces risk
- Wider and deeper public knowledge about sexual health
- Lack of antenatal care and medicines increases risk of mother to child infection
- Lack of STI examinations and care leads to increased possibility of HIV/AIDS infection
- Early sexual debut and lack of contraceptives increase risk of HIV/AIDS

MDG 7: Ensure Environmental Stability

- Improved sustainable use of space and land
- Less pressure of existing infrastructure and basic social services
- Enhanced role of women as resource managers

- Migration to crowded urban slums deteriorates local environmental resource base
- Pressures on food and water security
- Expansion into forested areas, marginal lands and fragile eco-systems

Annex 2: Islamic Relief work on reproductive health

Amongst the twenty two countries in which IR operates, four of field partners – Bangladesh, Ethiopia, Sudan and Pakistan – are implementing some reproductive health programmes targeting particularly women and adolescents. These programmes consist of:

- Training Traditional Birth Attendants (TBAs) with the aim to increase clean and safe attended delivery.
- Mother and Child Healthcare (MCH) programme aiming to provide medical care, health education and nutritional information to women and young children, post/ante natal checks up and growth monitoring.
- Providing general family planning advice.
- Peer education programme aiming to educate adolescents on HIV/AIDS, menstruation hygiene, awareness about family planning methods, safe deliveries, referrals, and encouraging discussion amongst the adolescent are facing, or would like to learn about.

Note:
Full reports are available upon request.

Annex 3: Case study 1 on the impacts of sexual health education programmes

Impact of Sex and HIV education Programs on Sexual Behaviors of Youth in Developing and Developed countries
(2005)

Executive summary:

Sex and HIV education programs that are based on a written curriculum and that are implemented among groups of youth in school, clinic, or community settings are a promising type of intervention to reduce adolescent sexual risk behaviors. This paper summarizes a review of 83 evaluations of such programs in developing and developed countries. The programs typically focused on pregnancy or HIV/STI prevention behaviors, not on broader issues of sexuality such as developmental stages, gender roles, or romantic relationships.

The review analyzed the impact programs had on sexual risk-taking behaviors among young people. It addressed two primary research questions:
1) What are the effects, if any, of curriculum-based sex and HIV education programs on sexual risk behaviors, STI and pregnancy rates, and mediating factors such as knowledge and attitudes that affect those behaviors?
2) What are the common characteristics of the curricula-based programs that were effective in changing sexual risk behaviors? The methods used in this review included three primary activities: 1) comprehensively searching for and retrieving all studies meeting specified criteria, 2) coding all the results of those studies, and 3) conducting a content analysis of 19 curricula that were clearly effective at changing behavior.

Results and Discussion

The results are divided into four sections: characteristics of the studies reviewed, impact of programs on sexual risk behaviors and pregnancy and STI rates, impact of programs on mediating factors for sexual risk behaviors, and characteristics of the curricula-based programs that positively affected behaviors.

Characteristics of the Studies Reviewed. Of the 83 studies identified that matched the study criteria, 18 were conducted in developing countries: Belize, Brazil, Chile, Jamaica, Kenya, Mexico, Namibia, Nigeria, South Africa, Tanzania, Thailand, and Zambia. About half of the 83 focused only on preventing HIV/STIs; nearly one-third covered both HIV/STIs and pregnancy; and nearly one-fifth focused only on pregnancy. Virtually all the programs encouraged specific sexual risk reduction and protective behaviors. The vast majority encouraged abstinence but also discussed or promoted the use of condoms or contraception if young people chose to be sexually active.

More than four-fifths of the evaluations identified one or more theories that formed the basis for the program and often specified particular psychosocial mediating factors to be changed. Social learning theory and its sequel, social cognitive theory, formed the basis for more than half of the programs evaluated. About half of the studies employed an experimental design with random assignment of individual youth, classrooms of youth, or entire schools or communities, while the remaining half used

a quasi-experimental design. Only 23 studies measured impact on pregnancy or STI rates, and of these, only nine used laboratory tests to measure these health outcomes. More than half (59 percent) of the studies measured impact for a year or longer, while 22 percent measured impact for two years or longer. Many of these studies or their published articles had significant limitations such as limited explanations of the programs, problems with implementation, weak evaluation designs, measurement issues, and statistical shortcomings.

Impact of Programs on Sexual Risk Behaviors and Pregnancy and STI Rates. The 83 studies generally reported on one or more of six aspects of sexual behavior: initiation of sex, frequency of sex, number of sexual partners, condom use, contraceptive use in general, and composite measures of sexual risk-taking. A few studies reported on pregnancy and STI rates.

• *Initiation of Sex*. Of the 52 studies that measured impact on this behavior, 22 (42 percent) found that the programs significantly delayed the initiation of sex among one or more groups for at least six months, 29 (55 percent) found no significant impact, and one (in the United States) found the program hastened the initiation of sex.

• *Frequency of Sex*. Of the 31 studies that measured impact on frequency, nine (29 percent) reduced the frequency, 19 (61 percent) found no significant change in frequency, and three (all in developed countries) found increased frequency among any major groups at any point in time.

• *Number of Sexual Partners.* Of 34 studies measuring this factor, 12 (35 percent) found a decrease in the number of sexual partners, while 21 (62 percent) found no significant impact.

• *Condom Use.* Of the 54 studies measuring program impact on condom use, almost half (48 percent) showed increased condom use; none found decreased condom use.

• *Contraceptive Use in General*. Of the 15 studies measuring impact, six showed increased contraceptive use, eight showed no impact, and one (in the United States) showed decreased contraceptive use.

• *Sexual Risk Taking*. Some studies (28) developed composite measures of sexual activity and condom use (e.g., frequency of sex without condoms). Half of them found significantly reduced sexual risk-taking. None of them found increased sexual risk-taking.

• *Pregnancy Rates.* Of the 13 studies that measured pregnancy rates, three found significant positive effects, nine found insignificant effects, and one (in the United States) found significant negative effects.

• *STI Rates.* Of the 10 studies that measured impact on STI rates, two found a positive impact, six found no significant impact, and two found a negative impact.

Overall, these results strongly indicate that these programs were far more likely to have a positive impact on behavior than a negative impact. Two-thirds (65 percent) of the studies found a significant positive impact on one or more of these sexual behaviors or outcomes, while only 7 percent found a significant negative impact. One-third (33 percent) of the programs had a positive impact on two or more behaviors or

outcomes. Furthermore, some of these programs had positive impacts for two or three years or more. In general, the patterns of findings for all the studies were similar in both developing and developed countries. They were effective with both lowand middle-income youth, in both rural and urban areas, with girls and boys, with different age groups, and in school, clinic, and community settings.

A review of replication studies of four different curricula in the United States revealed that curricula did have similar positive behavioral effects when they were replicated, provided all activities were implemented as designed in the same type of setting and with similar populations of youth. When many activities were omitted or the setting was changed, the curricula were less likely to have a positive effect.

Impact of Programs on Mediating Factors for Sexual Risk Behaviors. The studies reported on various mediating factors that contribute to the behavior changes, such as knowledge, perceived risk, values and attitudes, perception of peer norms, self-efficacy and skills, and others. Most programs increased knowledge about HIV, STIs, and pregnancy (including methods of preventing STI/HIV and pregnancy). Half of the 16 studies that measured impact on perceived HIV risk were effective at increasing this perceived risk. More than 60 percent of the many studies measuring impact on values and attitudes regarding any sexual topic were effective in improving the measured values and attitudes. More than 40 percent of the 29 studies that measured impact on perceived peer sexual behavior and norms significantly improved these perceptions. More than half of those studies that measured impact on self-efficacy to refuse unwanted sex improved that self-efficacy, and more than two-thirds increased self-efficacy to use condoms. Regarding changing motivations, 10 of 16 programs increased motivation or intention to abstain from sex or restrict the number of sex partners, and 10 of 14 programs increased intention to use a condom. Eight of 11 programs increased communication with parents or other adults about sex, condoms, or contraception.

Thus, the evidence was strong that many programs had positive effects on relevant knowledge, awareness of risk, values and attitudes, self-efficacy, and intentions – the very factors specified by many psychosocial theories as being the determinants of behavior. Furthermore, all of these factors have been demonstrated empirically to be related to their respective sexual behaviors. Thus, it appears highly likely that changes in these factors contributed to the changes in sexual risk-taking behaviors.

Characteristics of the Curriculum-Based Programs that Had Impact. The analysis of these effective curricula led to the identification of 17 common characteristics of the curricula and their implementation. The large majority of the effective programs incorporated most of the 17 characteristics of successful curriculum-based programs identified in this analysis. Also, programs that incorporated these characteristics were much more likely to change behavior positively than programs that did not incorporate many of these characteristics. Five of the 17 characterisctics involve the development of the curriculum; eight involve the curriculum itself; and four describe the implementation of the curriculum.

• *Developing the Curricula.* The development teams involved multiple people with varied backgrounds, used a logic model approach that specified health goals and other details, assessed relevant needs and assets of the target groups, designed activities consistent with community values and available resources, and pilot-tested the program.

• *Curricula Content.* Effective curricula commonly created a safe environment for youth, focused on clear goals of preventing HIV/STI and/or pregnancy, focused on specific behaviors leading to these health goals and gave a clear message about those behaviors, addressed psychosocial risk and protective factors affecting those sexual behaviors, included multiple activities to change the targeted risk and protective factors, employed instructionally sound teaching methods that actively involved the participants and helped them personalize the information, employed appropriate activities and messages (for participants' culture, age, sexual experience), and covered topics in a logical sequence.

• *Implementation of the Curricula.* When implementing curricula, effective programs commonly selected and trained educators with desired characteristics, secured at least minimal support from authorities, recruited youth if necessary, and implemented virtually all activities as designed.

Recommendations

The results and discussion led to the programmatic and research recommendations that follow.

Programmatic

• Communities should implement curriculum-based sex and HIV education programs, preferably those proven to be effective with similar populations or those incorporating as many of the effective curriculum characteristics as possible.
• Organizations developing their own curricula should follow the five characteristics for developing effective curricula and incorporate the eight content characteristics.
• Organizations should follow the five characteristics for implementing effective curricula.
• Programs may have their greatest impact in areas where issues of pregnancy and HIV/STIs are most salient. Thus, while programs should reach all youth, they should be especially certain to reach high-risk youth.
• Schools and other groups should provide adequate time and resources for these programs to be implemented.
• Organizations should encourage research to develop and evaluate programs that may be even more effective than current programs.
• Communities should not rely solely on these programs to address problems of HIV, other STIs, and pregnancy but should view them as an important component in a larger initiative that can reduce sexual risk-taking behavior to some degree.

Research

• More rigorous studies of promising programs should be conducted in developing countries.
• Evaluations can and should use randomized experimental designs.
• Sample sizes should be sufficiently large to have adequate statistical power for important statistical analyses, including those among sub-groups.
• Laboratory tests rather than self-reported data should be used for measuring pregnancy and STI rates, whenever possible.
• Statistical analyses should assess program effect on mediating factors and the impact of these factors on behaviors.

• Researchers should determine which mediating factors are most important across cultures and then measure these more consistently so that studies can be compared more easily.
• Published results of evaluations should provide more complete descriptions of their programs

Source:
Douglas K., B.A. Laris, Loor R. / YouthNet, Family Health International (FHI), Impact of Sex and HIV education Programs on Sexual Behaviors of Youth in Developing and Developed countries, Youth Research Working papers No2, 2005.

Annex 4: Case study 2 on the impacts of Islamic Relief sexual health education programmes in Bangladesh

The following case study (1) shows the successful peer education programmes implemented by Bangladesh office in Kumurpur District.

Case study 1: Bujruk Kumurpur, Visit the Peer Educators

The peer educator group is made up of a group of girls aged between 15-25, and two nurses. The nurses provide information on HIV/AIDS, menstruation hygiene, awareness about family planning methods, safe deliveries, referrals, and encourage discussion amongst the girls of the issues they are facing, or would like to learn about. The idea is both to educate young women about these health issues and that these girls then return to their friends, family, community and disseminate knowledge. We've found that young people feel more comfortable talking about these issues among their peers.

Importantly, to become a member of the peer educator group, IR staff asks for the consent of the parents first, and are very careful not to set up any group without the full consent of the community. They have a question box where any member of the community can ask a private question and the nurse will visit the person concerned.

The peer educators informed us how ignorant they were before the group discussion, and how much they have learned since being a member, as well as how friends and family have benefited from their knowledge and frequently seek advice from them.

It was amazing to see the knowledge that the peer educators acquired within two sessions, particularly on the topic of HIV/AIDS prevention and Family Planning. We asked one of the peer educators how they would advise their friends if they were HIV/AIDS infected. She responded that he/she is a human being and should be not discriminated because he/she is infected. However if her friend is married she will advise him/her to use condoms during sexual intercourse.

We asked the group how important these programmes are. They responded that they always wanted to learn about HIV/AIDS, family planning etc. Now they can disseminate the knowledge they have acquired. They told us that some girls outside the peer educators come to ask them questions like what they have learnt during these sessions, how they can advise them on health problems.

This programme seems to encourage thinking about broader issues affecting the girls' lives. The peer educators were concerned about the economic and health problems that a high number of children may cause within a family, and even resource problems facing the country as a whole. A particular peer educator told us her own experience of being five children in her family. She argued that being too many in her family, deprive them from proper nutrition, and healthy life.

Annex 5: Abortion laws in the countries where Islamic Relief works

Country	Life	Health	Mental	Rape	Defect	Social	Demand
Afghanistan	Y	N	N	N	N	N	N
Albania	Y	Y	Y	Y	Y	Y	Y
Bangladesh	Y	1	1	1	1	1	1
Bosnia	Y	Y	Y	Y	Y	Y	Y
Chad	Y	N	N	N	N	N	N
China	Y	Y	Y	Y	Y	Y	Y
Egypt	R	N	N	N	N	N	N
India	Y	Y	2	2	2	2	N
Indonesia	Y	N	N	N	N	N	N
Iran	Y	N	N	N	N	N	N
Iraq	R	N	N	N	R	N	N
Jordan	Y	Y	Y	N	N	N	N
Kenya	R	R	R	N	N	N	N
Lebanon	Y	N	N	N	N	N	N
Malawi	R	N	N	N	N	N	N
Malaysia	1	1	1	N	N	N	N
Mali	Y	N	N	N	N	N	N
Mauritius	Y	N	N	N	N	N	N
Niger	Y	N	N	N	N	N	N
Pakistan	Y	Y	Y	N	N	N	N
Russia	2	2	2	2	2	2	1
Rwanda	Y	Y	Y	N	N	N	N
Somalia	Y	N	N	N	N	N	N
South Africa	2	2	2	2	2	2	1
Sri Lanka	Y	N	N	N	N	N	N
Sudan	Y	N	N	N	Y	N	N
Yemen	Y	N	N	N	N	N	N

Key:

The meanings of the columns are:

Life	to save the life of the mother
Health	to preserve the physical health of the mother
Mental	to preserve the mental health of the mother
Rape	in cases of rape and incest
Defect	when the unborn child has medical problems or birth defects
Social	for social and/or economic reasons, e.g. if the mother cannot afford to support a child
Demand	available on demand, no reason need be given

Values given for each column:

Yes	legal for this reason
No	not legal for this reason
1	legal, but only in the first trimester (three months) of pregnancy (exact time frames vary)
2	legal, but only in the first two trimesters (six months) of pregnancy (exact time frames vary)
R	generally legal but with significant restrictions
?	information not available, or law is ambiguous

[1] 165 nations endorsed this definition proposed by the WHO at the International Conference on Population and Development (Cairo, 1994).
[2] Mahmoud F Fathalla, Steven W Sinding, Allan Rosenfield and Mohammed MF Fathalla, Sexual and reproductive health for all: a call for action.*The Lancet, Volume 368, Issue 9552, 9 December 2006-15 December 2006, Pages 2095-2100*
[3] There are a number of other international agreements related to reproductive health, notably the 1995 World Conference on Women, the 4th International Conference on Population and Development, the International Covenant on Economic, Social and Cultural Rights, and the Covenant for the End of All Forms of Discrimination against Women".
[4] See Annex 1.
[5] These core issues are the first issues that this policy is going to highlight, because they were identified by Islamic Relief field partners. However this policy doesn't elaborate on HIV/AIDS as this is discussed in a separate policy paper.
[6] www.unfpa.org/intercenter/cycle/labour.htm, presenting the examples of Indonesia, Singapore, South Korea and Thailand.
[7] Four of IR FP – Bangladesh, Ethiopia, Sudan and Pakistan – are implementing some reproductive health programmes.
[8] Moazzam Ali and Hiroshi Ushijima, *Perceptions of men on role of Muslim leaders in reproductive health issues in rural Pakistan*, Cambridge University Press, (2005), pp 115-122.
[9] Sahih Al-Bukhari is the title of the books of hadiths compiled by Muhammad ibn Isma'il al-Bukhari, a religious scholar. The collection is described as sahih (authentic).
[10] Sayings and traditions of the Prophet Mohammed (PBUH) that help to formulate Islamic law.
[11] The Prophet (PBH) came to this conclusion as follows: *'Three men came to the Prophet (PBH)'s wives questioning them about his devotion ('ibada). When they were told they were for despising slightly his devotion, saying, "Where do we come short of the Prophet (PBH)? And God has pardoned his sins past and future." One of them said: "As for me I will ever pray by night." The second said: "I will ever fast by day and not break by fast." The third: "I will turn aside from women and never marry." Then the Prophet (PBH) came to them, and said: "Are ye they who speak thus? Verily I am the most God-fearing and pious among you, yet I fast and break my fast. I pray and sleep; I marry women. And he who turns away from my sunna is none of mine." [ahmed, ibn habban]*
[12] Additional figures are available at http://www.unfpa.org/hiv/women/report/chapter2.html.
[13] This concern was raised particularly strongly in a round table meeting held with members of IR Pakistan headquarters in Islamabad for example.
[14] Douglas K., B.A. Laris, Loor R. / YouthNet, Family Health International (FHI), Impact of Sex and HIV education Programs on Sexual Behaviors of Youth in Developing and Developed countries, Youth Research Working papers No2, 2005, also available at
http://www.fhi.org/NR/rdonlyres/ea77gewes4v3axgiyrnkrpmixaph6cmaesuz3nccrodokejfmerwzi5lsgvvmwl3yfegftswh5m5gc/sexedworkingpaperfinal.pdf
See also UNICEF. 2002. Young People and HIV/AIDS: Opportunity in Crisis. New York. p. 26., also available at http://www.unicef.org/publications/files/pub_youngpeople_hivaids_en.pdf
[15] The title of the books of hadith compiled by Abul Husayn Muslim ibn al-Hajjaj, a religious scholar. The collection is described as Sahih (authentic).
[16] In Islam, tahara is a state of ritual purity. Tahara is required for participating in daily prayers or ther ritual acts. Two types of purification are possible: major and minor. Major purification is required after things like menstruation and sexual intercourse, whereas minor purification is required before prayers. The use of water is recommended, but the use of sand is permitted if no water is available.
[17] Gusul, means washing the entire body with water.
[18] The author of this policy noted just how intense the taboo was when interviewing local men in Neelum valley, Kashmir, where a question about women and adolescents being taught about reproductive health-related issues demonstrated considerable hostility.
[19] UNFPA, "Global Population Policy Update", Issue 67. 13 December 2006
[20] http://www.fhi.org/en/reproductive health/Pubs/Network/v19_4/unmet.htm
[21] Abu ibn Isa al-Tirmidhi, was a medieval collector of hadiths.
[22] Abu Da'ud Sulayman ibn Ash'ath al-Azad Sijistani, was a noted collector of hadith.
[23] This is the view of many Religious scholars who issued the following fatwas in support to family planning (FP):

- "Sheikh Mahmoud Shaltout (the former Grand Imam of Al-Azhar, Egypt) in 1959 endorsed the use of contraception for health, social and economic reasons: Planning in this sense is not incompatible with nature, and is not disagreeable to national conscience, and is not forbidden by

Sharia'a, if not prescribed by it (Omran, Abdel Rahim, "Family Planning in the Legacy of Islam", Routledge, London and New York, 1992 (p.75).

- Sheikh Sha'arawi (Omran 1992) also sanctioned FP. His only reservation and warning was to be careful not to confuse planning with predestination or guarantee of rizq (sustenance) by Allah. Nevertheless he listed among the acceptable indications the preservation of the wife's health and beauty and limited space in the family house.
- Also, the proceedings of the Rabat Conference held in Morocco in 1971 to review the Islamic position on FP and to exchange information on population problems in the Muslim world clearly indicate a favourable position towards FP: …the Islamic law allows the Muslim family to be able to look after itself as regards the procreation of children, whether this is in the sense of having many or few of them. It also gives the right …to plan suitably spaced pregnancies" (in Omran 1992)

[24] Mulana Abul Kalam Azad , the most famous and well known Islamic scholar in Bangladesh, chairman of the Masjid Council for Community Advancement (MACCA). Furthermore, the biggest discussion of family planning and birth control was undertaken in 1988 by 23 scholars of various schools of thought at the Majma al-Fiqh al-Islaami. They concluded that "it is permissible to control the timing of births with the intent of distancing the occurrences of pregnancy or to delay it for a specific amount of time, based on mutual consultation and agreement between them". Their proceedings, papers and discussions may be found in Part One of the Fifth Volume of Majallah Majma al-Fiqh al-Islaami (1988/1409 A.H.). These proceedings are 748 pages all about the question of birth control and related issues.

[25] Omran, Abdel Rahim, "Family Planning in the Legacy of Islam", Routledge, London and New York, 1992 (p.75)

[26] Many Religious scholars came together in Pakistan in 2005 to discuss this. They came with the consensus that mothers require 34 months for birth spacing.

[27] DaVanzo J, Razzaque A, Rahman M, Hale L, Ahmed K, Khan MA, Mustafa AG, Gausia K (draft, no date). The effects of birth spacing on infant and child mortality, pregnancy outcomes and maternal morbidity and mortality in Matlab, Bangladesh.

[28] This is the view of many Religious scholars who issued the following fatwas to show their support contraceptive methods:

- "In 1964 Sheikh Abdullah Al-Qalqili, Mufti of Jordan issued a fatwa in which he stated: "There is agreement among the exponents of jurisprudence that coitus interruptus, as one of the methods for the prevention of childbearing, is allowed. Doctors of religion inferred from this that it is permissible to take a drug to prevent childbearing, or even to induce abortion. We confidently rule in this fatwa that it is permitted to take measures to limit childbearing". (Omran, 1992)
- In 1980 Sheikh Yusuf al-Qaradawi, Professor of Islamic Studies at Qatar University confirmed that modern contraceptive methods are similar in purpose to *azl* and are allowed by analogy. (Omran, 1992)
- In 1971 at the Rabat Conference, Sheikh Mahammad Mahdi Shamsuddin argued that Islam wants his followers to be healthy, safe and happy and anything that may endanger this goal should be avoided: this includes frequent pregnancies, unwanted children and large families. This shows his support to family planning as well as to methods of contraception" (*ibid*.)

[29] Obermeyer, Makhlouf Carla, "Islam, Women, and Politics: The Demography of Arab Countries" Population and Development Review, Vol. 18, No.1 (Mar., 1992), pp 33-60

[30] Sheikh Faysal Mawlawi, deputy chairman of the European Council for Fatwa and Research, states: In addition, the majority of Muslim scholars agree that any scientific means that help achieve the same result gained through *Al-`Azl* is permissible, especially when resorting to this scientific means is driven by a religiously acceptable reason. However, if the wife agrees not to beget children, then all forms of *Al-`Azl* becomes permissible according to all scholars."

[31] This in accordance with the following verses:

"the believer, men and women, are protector one of another" At-Tawbah:71

" your wives are your garments, and you are their garments" Al-Baqarah: 137

"And among His signs is this, that He created for you mates from among yourselves, that you may dwell in tranquillity with them, and He has put love and mercy between your hearts. Undoubtedly in these are signs for those who reflect." (Qur'an 30:21)

[32] UNFPA, http://www.unfpa.org/swp/2004/english/ch7/page11.htm and WHO http://www.wpro.who.int/sites/rph/data/abortion.htm

[33] WHO, "*Population growth, MDGS and reproductive health"*, Department of reproductive health and research, (March 2006), page 9.

[34] Musallam, B.F., *Sex and Society in Islam* (Cambridge University Press, 1983) p. 176.

[35] This includes: A danger to the physical and/or mental health, a pregnancy resulting from a rape, the mother already suffers from a mental illness restricting her ability to take care of herself and her future child.
[36] Recent research carried out by the population council in Pakistan showed that 1 million abortions (which are illegal in Pakistan) take place each year in Pakistan – 95% are married women.
[37] We agreed to use the term FGC for those who agued that FGC is not a mutilation. There were many debates as what terminology to use, and we opted for the word cutting.
[38] *Female Genital Mutilation and Obstetric Outcome: WHO collaborative prospective study in six African countries* (WHO, 2006) http://www.who.int/reproductive-health/fgm/index.html
[39] This is highlighted in the following international conventions and declarations:
1948 - The Universal Declaration of Human rights (article 25)
1966 - The International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights (article 12)
1979 – The Convention on the Elimination of All Forms of Discrimination against Women (article 2f, 5a, general recommendation 14, general recommendation 24)
1989 – The Convention on the Rights of the Child (article 19.1, 37a, 24.3)
1993 – Vienna Declaration and the Programme of Action of the World Conference on Human Rights.
1994 – The Programme of Action of the Internation conference on Population and Development
1995 – The Platform for Action of the Fourth World Conference on Women
1997 – The African Charter on Human and Peoples' Rights (article 4, 5, 16, 18.3) and the Addis Ababa Declaration
1998 - The Banjul Declaration
1999 - The United Nations Social, Humanitarian and Cultural Committee.
2000 - The Beijing Declaration and Platform for Action.
[40] Anas reported that the Prophet (PBUH) said to a woman in al-Madinah who circumcised women: *"When you trim (the skin surrounding the clitoris), do it slightly and not excessively. This would bring beauty to the woman's face and please her husband" (as-Sahihah No 722)*
From this, many religious scholars are of the view that moderate forms of FGC, such as FC (slight trimming of the clitoral hood), can be regarded as optional, with the exception of the Imam Shafii which declares FC as mandatory.
[41] "International Conference of Scholars to Proscribe Abuse of the Female Body";
http://www.iht.com/articles/ap/2006/11/23/africa/ME_GEN_Egypt_Female_Circumcision.php
[42] Sunnah is the title given to the collector of recorded words and actions of the Prophet Mohammad (PBUH). Literally, Sunnah means "a path or way, a manner of life".
[43] http://www.crin.org/resources/infodetail.asp?id=11794
[44] FGM also impairs the women's right to sexual enjoyment. Allah considers sexual pleasure for man and for women as normal and legitimate: "it is lawful for you to go into your wives during the night preceding the (day's) fast: they are as a garment for you and you are as a garment for them' (2:187).