Barriers to accessing Sexual and Reproductive Health Rights (SRHR) among Muslim women in Uganda provides an overview of legal, religious, medical, and social factors that serve to hinder Muslim women's access to Sexual and reproductive Health and Rights in the predominantly Muslim communities of Uganda. The gathered testimonies in this research reveal a high prevalence of ignorance of sexual reproductive health rights among Muslim women in Uganda.

Many Muslim women have negative attitudes about SRHR which influence their access to and use of SRH services. The prevalence of discriminatory and misogynistic practices and ideologies prevent them from realizing their full human potential and, in some cases, from being able to meet even their most basic survival needs.

This Report is handy as a viable and reliable reference for all stakeholders with an interest in access to SRHR among Muslim women.

Produced by:

IWILAP
Pursuing Justice For All Women

Sponsored by:

LiRA Litigating
Reproductive Justice in Africa

BARRIERS

TO ACCESSING SEXUAL REPRODUCTIVE HEALTH RIGHTS AMONG MUSLIM WOMEN IN UGANDA

EDITOR: MWANGA MASTULLAH ASHAH

Barriers to accessing Sexual & Reproductive Health Rights (SRHR) among Muslim women in Uganda.

Case Study of Budaka District

October, 2024

Foreword by Mwanga Mastulah Ashah

Sexual and reproductive health is a human right, essential to human development and the achievement of Sustainable Development Goals. Applying criteria derived from a feminist perspective to the analysis of reproductive choice in Islam is a complicated task, because of the existing polarization of views on the relationship between Islam and women's status. In interpreting SRHR issues relating to Muslim women, we must rely on the actual Islamic provisions where religious authority in Islam is derived primarily from the Koran (also spelled "Quran"), which Muslims hold as divine. For cases not explicitly addressed in the Koran, Muslims look to other written sources including the collected examples and sayings of Muhammad (Hadith), and follow the direction of religious leaders. That notwithstanding, the concept of *ijtihad,* which allows the formulation of independent judgment and interpretation, is also important in Islamic teaching especially since we are now grappling with the interpretation of SRHR of women in Islam. We must hold the Quran, Hadith, and *Ijtihad* as important references as they have outrightly provided for the SRHR of women in Islam.

This report examines the barriers that hinder reproductive choice and access to SRHR among Muslim women. In examining this, the report highlights the extent to which reproductive choice is compatible with Islamic principles. It presents the argument that the impact of Islam as a barrier to accessing reproductive choice among Muslim women is largely cultural and not one provided by Islam. The report counters this stereotype by discussing the actual barriers that hinder Muslim women's access to SRHR while examining the conditions that affect various interpretations of reproductive choice within the Muslim communities taking Budaka as the study area.

I wish to thank our funder Afya na Haki for the financial and professional support in conducting this research. Your support allowed us to conduct this study on time. I thank you for helping us make a difference within the Muslim community. For the very first time, Uganda now has a report that is specific on the barriers to accessing SRHR of Muslim women. I also wish to state that we have seen considerable achievements since IWILAP started litigating SRHR and abortion cases within the Muslim community in Ugandan with commendable support from Ahaki. We face new challenges that come with resistance from the less informed about the position of Islam on issues of access to reproductive choice in Islam for the benefit of Muslim women. This report then, is timely to

highlight why we continue to face these challenges despite the clear Islamic provisions of reproductive choice while proposing possible recommendations that could enable all key stakeholders to improve access to SRHR and reproductive choice in particular.

IWILAP will continue to work with government and partners to:

- **advocate** for access to safe abortion and post-abortion care services for Muslim women through legal aid and case profiling;
- **advocate** internationally and nationally for policies and resources that address Muslim women's access to reproductive choice and SRHR rights while continuing to address controversial issues such as abortion in Islam;
- **advocate for improved access to comprehensive services**, that are responsive to the rights and needs of Muslim women;
- **address social cultural and economic barriers**, using a rights-based approach, and tackling issues outside the health sector.

Signature:

Mwanga Mastulah Ashah

CEO & General Counsel

Islamic Women's Initiative for Justice, Law and Peace (IWILAP).

April, 2024

ACKNOWLEDGEMENTS

This report was developed by the Islamic Women's Initiative for Justice, Law, and Peace (IWILAP) with funding from Afya na Haki (AHAKI) under the Litigating Reproductive Justice in Africa (LIRA) Programme. To our funder AHAKI, we take great pride in the IWILAP-AHAKI partnership. We managed to produce the first-ever report that discusses barriers to accessing SRHR of Muslim women in Uganda. Without your financial support, we would not be able to have access to the SRHR impact we do on our community– thank you for believing in our mission and helping us make a positive impact.

We also wish to appreciate the efforts of IWILAP CEO & General Counsel; Ms. Mwanga Mastulah Ashah, who guided the entire research process and editing of the report to its publication. Special thanks are greatly extended to our Director of Research & Knowledge Management Ms. Nagodyo Asmailah for her tremendous and instrumental role in the analysis and consolidation of the report.

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LIST OF ACRONYM

IWILAP	:	Islamic Women Initiative for Justice Law and Peace
AHAKI	:	Afya na Haki
SRHR	:	Sexual Reproductive Health and Rights
EC	:	Emergency contraception
WHO	:	World Health Organization
FGD	:	Focus Group Discussion
Popul	:	Population
LIRA	:	Litigation Reproductive health in Africa
UMSC	:	Uganda Muslim Supreme Council
ICPD	:	International Conference on Population and Development

ABSTRACT

This report provides an overview of legal, religious, medical, and social factors that serve to hinder Muslim women's access to Sexual and reproductive Health and Rights such as safe abortion services, contraceptives, and Family planning in the predominantly Muslim communities of Uganda. The review was mainly qualitative. The gathered testimonies in this research reveal a high prevalence of ignorance of sexual reproductive health rights among Muslim women in Uganda. This study interviewed young Muslim women, their relatives or friends, and neighbors who had accessed sexual reproductive health rights like an induced safe abortion, Family planning, and contraceptives at some point in their lives. All study participants were adults of sound mind whose consent was first sought before interviews were conducted.

Many Muslim women have poor knowledge of SRHR and negative attitudes which influence their access to and use of SRH services. Barriers to contraception use among Muslim women included lack of basic reproductive knowledge, insufficient knowledge about contraception, and negative attitudes toward family planning. Religious and cultural beliefs were barriers to contraception use and access to SRHR**.**

CHAPTER ONE

1.1 Background

Several researchers have made efforts to apply a human rights perspective to the problems that women are seen to face in the areas of reproduction and health[1]. The International Conference on Population and Development (ICPD) Programme of Action recognizes that realizing the right to reproductive health is a critical element of guaranteeing reproductive rights[2]. The notion of reproductive choice, which has long been advocated by feminists concerned with the constraints of poor health and family planning services has become the focus of systematic elaborations based on legal principles.[3]

One of the central elements that define reproductive choice is autonomy, which means that a woman can make decisions in matters of reproduction and that she has access to the information and services that make her choice possible. This autonomy, in turn, requires a set of other rights for her as an adult individual and as a citizen. Reproductive health

[1] Freedman, L. P., & Isaacs, S. L. (1993). Human Rights and Reproductive Choice. *Studies in Family Planning*, *24*(1), 18–30. https://doi.org/10.2307/2939211

[2] Center for Reproductive rights & UNFPA: ICPD & Human Rights, 20 years of advancing reproductive rights through UN treaty bodies & legal reform. June 2013 available at https://www.unfpa.org/sites/default/files/pub-pdf/icpd_and_human_rights_20_years.pdf

[3] https://www.jstor.org/stable/2137988

is thus embedded in a woman's life situation and is shaped not just by medical conditions, but also by social forces and power relationships that range from the level of the family to that of international institutions.

Before assessing the extent to which reproductive choice is applicable in the context of Islam, two points must be noted: First, there is a tension in Islamic doctrine between the egalitarian view of believers who are judged solely according to merit, and the inegalitarian elements that define different roles for men and women. The other point that emerges from even a cursory examination of women's autonomy is the tremendous complexity and diversity that is found in the Muslim world.[4]

In Islam, people perceive, sexual and reproductive health (SRH) issues in a wrong way and are rarely discussed and taught in Muslim societies and are considered sensitive subjects [5] These results to poor SRH knowledge and practices.

[4] Reproductive Choice in Islam: Gender and State in Iran and Tunisia Author(s): Carla Makhlouf Obermeyer. Source: Studies in Family Planning, Jan. - Feb., 1994, Vol. 25, No. 1 (Jan. - Feb., 1994), pp. 41-51. Published by: Population Council

[5] Noura Alomair, Samah Alageel, Nathan Davies & Julia V. Bailey march 2020 :Factors influencing sexual and reproductive health of Muslim women: a systematic review

1.2 Uganda context

In recent literature, including the 2018 Lancet Commission publication, the challenges women and girls face while accessing Sexual Reproductive Health rights are identified, including the lack of infrastructures and accessible information in general services (from school to healthcare), ingrained discrimination, and misconceptions about Islam, families, communities and health providers themselves.[6] Misconceptions include the belief that Muslim women, cannot make decisions about their reproductive health, and do not need SRHR information.[7] These sustained fallacies lead to isolation, reduced self-esteem, and increased risk of physical and sexual violence (Kaggya, 019) [8]

Dependency on the family is reinforced through a lack of independent accessible communication opportunities and self-selected social networks outside of the close family system in a way that husbands do not allow their spouses to access SRHR among Muslim women.

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[6] The Lancet Commission on global mental health and sustainable development. *The Lancet*, Vol. 392, No. 10157, Published: October 10, 2018 available at: https://www.thelancet.com/commissions/global-mental-health.

[7] Alomair N, Alageel S, Davies N, Bailey JV. Factors influencing sexual and reproductive health of Muslim women: a systematic review. Reprod Health. 2020 Mar 5;17(1):33. doi: 10.1186/s12978-020-0888-1. PMID: 32138744; PMCID: PMC7059374.

[8] World Health Organization statistics Geneva

Family members play a key role as gatekeepers in promoting or obstructing the fulfillment of sexual Reproductive Health rights.

Opportunities to access SRHR information and services, and to take free decisions about sexuality and sexual health, are influenced by caretakers' and family members' perceptions and misconceptions about Islam.

The families' knowledge, beliefs, and the existence of support and information systems such as SRHR information are critical factors in the ability to resist restrictive traditional norms and social barriers.

Adolescents' curiosity in this regard leads them to take refuge in the insecure context of cyberspace and social networks. Unlimited access to virtual spaces and receiving inaccurate sexual information lays the ground for adolescents to enter the cycle of harm. Moreover, friends and peers are considered by adolescents as important sources of information that provide the ground for receiving deceptive information on sexual issues[9].

[9]Barriers to vulnerable adolescent girls' access to sexual and reproductive health Mojgan Janighorban1, Zahra Boroumandfar2*, Razieh Pourkazemi3 and Firoozeh Mostafavi4

1.3 Aim

To explore the barriers and facilitators to sexual and reproductive health rights among Muslim women in Budaka district in eastern Uganda.

1.4 Objectives of the study

The objective of the research was to explore factors/ barriers affecting access to SRHR and facilitators to seeking SRH rights among Muslim women.

1.5 Survey area: Budaka District

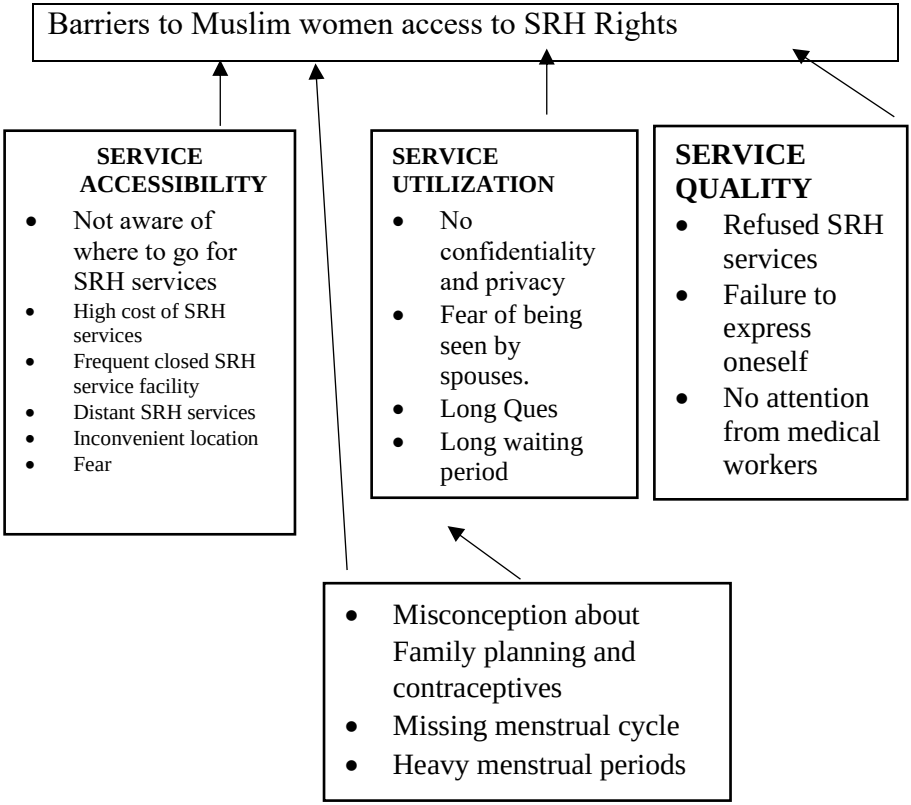
Budaka District is bordered by Mbale to the East, Kibuku District to the west, Butaleja to the South and Butebo to the North.Budaka is 29 km to Mbale city. The pollution is 207597 where 100620 are males and 106977 are females[10].

1.6 Conceptual framework guiding the analysis of the barriers and facilitators to SRHR of Muslim women

***Source*:** Khampheng Phongluxa, Factors influencing sexual and reproductive health among adolescents in Lao PDR Global Health Action 13(sup2):1791426 DOI:10.1080/16549716.2020.1791426, July

[10] According to National Population and Housing Census 2014 available at https://www.ubos.org/wp-content/uploads/publications/03_20182014_National_Census_Main_Report.pdf

2020: *Factors influencing sexual reproductive health of Muslim women and modified by the researcher*



CHAPTER TWO

METHODOLOGY

2.1 Introduction

This chapter presents the methodology that was adopted for this study. This includes the research design, study population, sample size, and selection, sampling techniques and procedure, data collection methods, data collection instruments, data quality control (validity and reliability), procedure of data collection, data analysis, and measurement of variables.

2.2 Research Design

The research design adopted was a case study that employed qualitative methods of data collection. A qualitative research design is particularly relevant to the study of Barriers to access to sexual reproductive health and rights by Muslim women because it invites participants to describe and explain their lives in their own words and to assess for themselves the extent they access these rights. Also, the choice of the qualitative approach was based on the fact that this approach provides the opportunity to document the lived experiences of Muslim women in accessing SRH services through more in-depth and detailed narratives[11].

[11]Sharon Eva Ahumuza1, Joseph KB Matovu1 Et el
Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda .

2.3 Study Population

According to Sekaran and Bougie (2013), population refers to the entire group of people; processes, things, or events that the researcher wishes to investigate and make inferences. In line with the research purpose and the unit of analysis in this study, the study population comprised Muslim women, health officers in health centers, Local council, Probation Officers, a research assistant, and a principal investigator. This research involved Muslim women of age groups 18- 45, statuses (married and locations as the primary target group, to assess how different factors influence access to sexual reproductive health and rights among Muslim women. The study involved this age bracket because women at this age are the most reproductive and at the age of 18 is the age of consent.

As a secondary target group, the research targeted factors that influence access to SRHR, i.e., family members, and individuals engaged in the provision of SRH information and services (doctors, nurses, and community health workers in public and private facilities).

2.4 Sample Size.

A total of 232 respondents were selected for the study of which 220 were female and 12 males. On this same subject, Kothari (2004) advised

that the sample size should be large enough to give a confidence interval of the desired width.

2.5 Sampling Techniques and Selection Procedure.

This study employed multiple sampling techniques. These were used for specific groups of informants. Simple random sampling was adopted in sampling the residents. For health officials and probation welfare officers, multi-stage sampling was done, which began with developing a sampling frame because they are at the forefront of handling issues of sexual reproductive health and the rights of women. They thus have more information about the study.

Research participants were selected based on pre-established demographic criteria. Muslim Women and girls were selected based on age. This is due to the mere fact that this research was targeting only Muslims. The majority of the participants had no or limited experience in accessing SRHR services to enable the research to generate accurate data. Users of services provided by the project partners through the LIRA program were not included in this research, to ensure there was no bias in the data collected.

2.6 Recruitment

Two days before data collection, selected mobilizers attained local approvals from the local council one (LC1) to allow data collection by informing them about the upcoming qualitative research and the intention to contact the various study populations. The research team and mobilizers also met with the *Amiilas* (Muslim women leaders) in all four research sites to establish networks of trust within the community before the start of recruitment. Through these connections, mobilizers identified participants using pre-established demographic criteria. The research deployed the snowball sampling technique through the help of Amiilas in the community. Mobilisers identified Ammilas as participants, to help recruit other research participants.

2.7 Ethics and Safeguarding

This research was carried out with Ethical Approvals received by, the Research Ethics Committee at the Alliance of Inclusive Muslims (AIM).

All research activities strictly followed the approved ethical protocols and referred to international ethics standards, such as the WHO guidelines on research into sexual and reproductive health rights to ensure confidentiality, confidential data management, and the protection and safeguarding of interviewed and involved persons

(WHO, 2007). The researchers and support team were mandated to carry out review and sign all safeguarding policies and code of conduct to ensure safeguarding procedures.

2.8 Other Ethical Considerations

Researchers implemented safeguarding measures, which included the protection of participants' personal information through non-identifiable IDs and disclosing information only where legally and ethically appropriate. Interviews were conducted in safe locations with audio/ visual privacy, where the participant felt comfortable speaking. Participants were referred to health services and psychosocial support if they had experienced violence or requested more information.

2.9 Informed Consent

By the ethical protocol of consent, informed consent was obtained before participants entered the research. Informed consent was collected by mobilizers from potential participants in their local language in two forms. The first stage included giving information to the participants and allowing them to reflect on the information, ensuring they felt no pressure to respond to the researcher immediately.

Secondly, the mobilizer/researcher the terms of the research, according to the points outlined in the consent forms. Following this, participants

consented to each term and fully consented before agreeing to take part in the research.

The research put in place mechanisms to protect all participants both educated and those with low literacy. These participants may not have been able to read the informed consent form, so research team was trained to guide them through it, providing all the information in the form in simple terms, in the local languages. For participants with visual disabilities, consent forms were printed in large font and when needed, verbal consent was sought

2.9.1 Research Team

The research was conducted in Budaka District and led by two researchers). The researchers worked alongside one translator/research assistants, one mobilizer. The research team was supported and guided by the program's coordinator IWILAP, with a wide volume of research experience.

2.9.2 Data Analysis and Main Themes

During the Focus Group Discussions, all interviews were recorded, translated, and transcribed. While in the field, the research team conducted daily synthesis sessions to analyze the findings and begin deriving key themes. During these sessions, the field team compared field notes, rapidly identified key patterns and themes, and developed

an overall picture of participants' feedback and experiences as reported by them. Once researchers returned from the field, together conducted a series of highly interactive workshops to further analyze and synthesize the data from multiple sources, from session notes and participant quotes discussed by the women during the interview.

CHAPTER THREE

ISLAM, ABORTION, AND FAMILY PLANNING: DIFFERENT INTERPRETATIONS: (SURAH 17:31).

3.1 Islamic views on abortion

According to the *Concise Oxford English Dictionary*, abortion means the deliberate termination of a human pregnancy. The *Black's Medical Dictionary* states that abortion is the expulsion of a foetus before it is typically viable, usually before 24 weeks of pregnancy. However, the definite period of viability is still disputable among scholars. Some books mentioned that the viability is within the 20th week of gestation.[12]

Preservation of life is one of the primary objectives of the Islamic Divine Law *(maqasid al-shariah).* Besides the preservation of life, Islamic Shariah also aims to preserve religion, intellect, honor (family lineage), and property. Conduct and behavior that is deemed to violate these aims are prohibited, while conduct that is set to achieve these aims is considered morally right. In this case, since abortion involves the termination of life, it is considered immoral; thus the general

[12] Mohamad Firdaus Mohamad Ismail, Abdurezak Abdullahi Hashib, Mohd Said bin Nurumala, Muhammad Lokman bin Md Isaa. Islamic moral judgment on abortion and its nursing applications: expository analysis. 1st International Nursing Scholars Congress. Depok (Indonesia), , 15-16 November 2016 páginas 212-216 (Febrero - Junio 2018).

perspective of Islam about abortion is not permissible unless it is done to save the mother's life, which should be carried out before the ensoulment takes place[13]. Abortion is generally forbidden after the fetus achieves ensoulment except to save the woman's life[14].

Islamic teaching and emphasis on abstinence until marriage shape the stigma for sexual and reproductive health issues of unmarried women and restrict their use of sexual and reproductive health services. As a result, the existence of weak protective laws for vulnerable adolescents, on the one hand, and the stigmatization by some NGOs whose work is on sexual reproductive health and rights such as IWILAP, on the other, have prevented this group from taking benefits of the financial and supportive assistance provided by these organizations[15]. In addition, unmarried Muslim women fear going to health facilities to seek services of SRHR as they may be referred to as sinners and punished with 100 lashes for both fornication and adultery.[16]

[13]Mohamad Firdaus Mohamad Ismaila, Abdurezak Abdullahi Hashib Mohd Said bin Nurumala Muhammad Lokman bin Md Isaa Islamic moral judgement on abortion and its nursing applications: expository analysis page 1

[14] Abdulrahman Al-Matary & Jaffar Ali : Controversies and considerations regarding the termination of pregnancy for Foetal Anomalies in Islam,BMC Medical Ethics volume 15, Article number: 10 (2014)

[15] Janighorban et al. BMC Public Health (2022) RESEARCH Barriers to vulnerable adolescent girls' access to sexual and reproductive health.

[16] Oida International journal of sustainable development (Ontario International Development agency) issn1923-6662: Penality for committing fornication and adultery pg 1

3.2 Birth Control in Islam: Limited Knowledge of Methods and Reproduction

Lack of knowledge of modern contraceptive methods and their mechanism of action has been cited as one of the major reasons for Muslim women's non-use of contraception (Khan et al., 2007; Sajid & Malik, 2010; Wu, 2010). Gender disparities in formal schooling have been identified a fundamental structural factor in limiting effective sex education in Muslim countries such as South Asian and Middle Eastern (UNESCO, 2011).

Lacking knowledge of reproductive physiology and fertile period among women especially adolescent girls may not be effectively assessing their risk of getting pregnant when they have occasional or infrequent sex (Sedgh et al., 2007).

Comparative studies elsewhere have been conducted and revealed similar results. A qualitative study among young Vietnamese women revealed they rarely received adequate sex education, which was believed too sensitive a topic to discuss, and out of twelve young women only two in the study had ever used a modern method.[17]

[17] Khanh Chi H, Thanh Thuy H, Thi Kim Oanh L, Quynh Anh T, Duc Vinh N, Thi Xuan Hanh N, Thanh Huong N. The Content and Implementation of Policies and Programs on Adolescent Sexual and Reproductive Health in Vietnam: Results and Challenges. Health Serv Insights. 2021 Aug 4;14:11786329211037500. doi: 10.1177/11786329211037500. PMID: 34393492; PMCID: PMC8358500.

A small number of Islamic jurists and other Islamic groups oppose family planning and contraceptive use generally on two grounds. First, they believe that withdrawal or any practice that prevents pregnancy is infanticide, which is repeatedly condemned and prohibited in the Quran. Second, the opponents of family planning, whether jurists or no jurists, believe that the larger the number of Muslims and the higher their population growth rate, the greater their power.[18] These advocates claim that a large population is ordained by the religion and that failure to achieve it deviates from the right path. They find support for their views not only in the Holy Book but also in the Prophet's tradition. Hence, they oppose family planning, especially if it becomes community or government policy. They also claim that family planning programs, having originated in the West, represent a conspiracy to reduce the number of Muslims and diminish their power. It is not uncommon for family planning programs to become politicized in Muslim societies. In recent history, opposition groups in several countries have rejected their governments' organized family planning programs as a political move, invoking Islam in support of their position[19].

[18] *Farzaneh Roudi-Fahimi;*Islam And Family Planning PRB Mena Policy Brief 2004
[19]Farzaneh Roudi-Fahimi: Islam and Family Planning: 2004 Population Reference Bureau.

Inadequate knowledge about contraceptive methods has been cited as one of the major reasons for the lack of its use amongst women. This can be a product of culture, insufficient counseling, and may even be a reflection of social norms. The level of awareness amongst Muslim women is associated with status, living conditions and the region[20]. Literature reveals that the significant determinants of the use of contraceptives are; younger age, women's working status and education[21]. The findings of this study indicate that older women were less knowledgeable about SRHR than younger women. This may be because the younger generation is more educated and better exposed to social media. However, an overall pattern of partial knowledge was observed.[22]

As with previous international research [23]on sexual reproductive health and rights, in the current study, healthcare providers and family

[20] Karim SI, Irfan F, Rowais NA, Zahrani BA, Qureshi R, Qadrah BH. Emergency contraception: Awareness, attitudes and barriers of Saudi Arabian Women. Pak J Med Sci. 2015 Nov-Dec;31(6):1500-5. doi: 10.12669/pjms.316.8127. PMID: 26870124; PMCID: PMC4744309.

[21] Marafie N, Ball D, Abahussain E. Awareness of hormonal emergency contraception among married women in a Kuwaiti family social network. *EJOG Reprod Biol.* 2007;130:216–222.doi: 10.1016/j.ejogrb.2006.05.023. [PubMed] [Google Scholar] [Ref list]

[22] Abdel Rahim Omran, Family Planning in the Legacy of Islam (London: Routledge, 1992); and Seyyed Hossein Nasr, Ideals and Realities of Islam (Chicago: ABC International Group, 2000).

[23] The Guttmache Institute, Guttmacher-Lancet Commission on sexual and Reproductive Health and rights (SRHR): Accelerate Progress: Sexual and Reproductive Health and Rights for All, May 9, 2018

planning services were rarely a source of information regarding SRHR. This is of concern and unfortunate, as these healthcare workers can be source of reliable information related to SRHR. A possible reason could be inhibition towards sexuality-related consultations, which are particularly difficult in some developing countries like Uganda. As mentioned by Ahlam[24] physicians in Saudi Arabia tend to avoid initiating discussions about sexual matters in their clinical practices, to respect the cultural norms. Dissemination of the information about options for contraception should become a part of routine counseling, as a knowledge-based barrier is present amongst women for the use of emergency contraception (EC).[25]

The results of this study give a mixed picture of attitudes towards EC. The majority of participating women were not prepared to use the EC method. According to the theory of Reasoned Action[26] behavior and negative attitude could be two important predictors of not using EC in the future. Most women had negative attitudes toward the increased

[24] Alzahrani, Ahlam (2011) Women's sexual health in Saudi Arabia: A focused ethnographic study. PhD thesis, University of Sheffield.
[25] Dr Syed Irfan karim et el Emergency contraception: Awareness, attitudes and barriers of Saudi Arabian Women 2015
[26] Karim SI, Irfan F, Rowais NA, Zahrani BA, Qureshi R, Qadrah BH. Emergency contraception: Awareness, attitudes and barriers of Saudi Arabian Women. Pak J Med Sci. 2015 Nov-Dec;31(6):1500-5. doi: 10.12669/pjms.316.8127. PMID: 26870124; PMCID: PMC4744309.

availability and prescription-free status of the drug.[27] The major barriers to the EC expressed by women were worries about side effects and health consequences, a result consistent with reports from other countries. Additional barriers identified were feelings of shyness and embarrassment about discussions related to contraception. While the reasons for this response could be many, one explanation could be the way women are raised in the Muslim Community. A helpful strategy to overcome this barrier can be to address the main socio-cultural concerns and offer services of female medical staff for providing education related to sexual health problems. This is an important consideration for health authorities, as it reflects a need for support and counseling.[28]

Today, positions on abortion continue to vary, though family planning is encouraged in practically all Muslim countries[29]. Generally, like many other women, violations of Muslim women's sexual and reproductive health rights are often deeply engrained in societal and religious values pertaining to women's sexuality. Patriarchal concepts of women's roles within the family mean that women are often valued

[27] DFID Sexual and reproductive health and rights A position paper. Published by the Department for International Development July 2004 available at https://www2.ohchr.org/english/issues/development/docs/rights_reproductive_health.pdf

[28] **Dr Syed Irfan karim et el** Emergency contraception: Awareness, attitudes and barriers of Saudi Arabian Women 2015

[29] Leila Hessini . :Abortion and Islam : policies and practice in the Middle East and North Africa: *https://doi.org/10,1016/S0968*

based on their ability to reproduce. Early marriage and pregnancy, or repeated pregnancies spaced too closely together, often as the result of efforts to produce male offspring because of the preference for sons, has a devastating impact on women's health with sometimes fatal consequences[30]

3.3 Abortion lessons from other Jurisdictions: International context (Fatwa)

Contemporary Fatwa has been issued in certain countries that add legal indications to otherwise restrictive laws. A fatwa in 1991 in Saudi Arabia allowed for abortion in the first 120 days after conception in the case of fetal impairment. In Iran both the Grand Mufti Ayatollah Yusuf Saanei and the Ayatollah Ali Khameni issued two Fatawa in 2005 allowing for abortion under certain circumstances. The one provided for abortion in cases of genetic disorder in the first trimester; the other allowed abortion in the first trimester if a woman's health and life were at risk.

The Egyptian Grand Sheikh of al-Azhar, Muhammed Sayed Tantawi, issued a fatwa in1998, stating that unmarried women who had been

[30] *Mwanga Mastullah Ashah, 2023,A thesis submitted to the directorate of research and graduate training Makerere University in fulfillment of the requirements for the award of the Doctor of Philosophy Degree in Human Rights of Makerere University, Kampala*

raped should have access to abortion. Some people justify the abortion of a defective fetus[31].

However, the present mujtahids do not allow such abortions, even if the deformities are so serious that they are untreatable after birth, and the child may not survive after birth except for a short while and in pain. The parents should pray and hope for a normal and healthy child. Indeed, there are always chances that the fetus is developed contrary medical prediction. This chance, however is slim and negligible, thus denies us the right to terminate a life[32].

In 1998, Algeria, the Islamic Supreme Council issued a fatwa, stating that abortions were permitted in cases of rape, as rape was being used by religious extremists as a weapon of war. However, neither of these Fatwa was translated into law. In Uganda, the Uganda Muslim Supreme Council (UMSC) is silent about any fatwah on sexual reproductive health rights and yet in the previous discussion, abortion is allowed under some circumstances including rape[33].

In Egypt, the Grand Mufti argued that rape victims should have access to abortions and reconstructive hymen surgery to preserve female

[31] *https://www Berghan books.com: Situating Abortion Islam, the Arab Countries and the Tunisian Exception Pg 12*

[32] Shaheen Merali. From Marriage to Parenthood. The Heavenly Path, **Oct 2019**. Available at https://a.co/d/3Hqe7Wc

[33] *https://www Berghan books.com: Situating Abortion Islam, the Arab Countries and the Tunisian Exception*

marriageability and virginity While fatawa have generated considerable debate about carrying out an abortion, they are not legally binding unless they are translated into law. Moreover, the patriarchal tradition allows only men to serve as muftis and to interpret religious texts. The issuing of Fatwa has been criticized by women's groups in the region as an intrusion of religion into secular matters. In Algeria, for example, while the Mufti declared that rape should be a ground for abortion (a lesson that could be borrowed into the Ugandan context), some women's groups said that the secular law already included a mental health indication for abortion and Personal communication.[34] Clearly, different lenses can be used to read Islamic religious texts. However, official religious leaders and interpreters in the MENA (Middle East and North Africa) region are all men.[35] An important movement is that of women, such as the Women and Memory Forum in Egypt, claiming the right to re-interpret religious texts and history in light of contemporary realities and from a feminist perspective[36].

These efforts and others seek to highlight the basic Muslim concept of justice and equality, as well as the right of women to life, health and

[34] Caroline Brac de la Perrie`re, Algerian women's rights activist, March 2006

[35] Leila Hessini. Abortion and Islam: Policies and Practice in the Middle East and North Africa An international journal on sexual and reproductive health and rights. Volume 15, 2007 - Issue 29: Male circumcision for HIV prevention / Taking on the opposition.

[36] Research and studies. Access to Sexual and Reproductive Health and Rights Information and Services:Perspectives of women and girls with disabilities in Uganda and Bangladesh:August 2021

safety including Muslim women in Uganda who also tend to face similar inequality challenges.[37]

Laws have also been reformed to adhere more closely to Islamic principles, including regarding fetal development, the commencement of life and punishment and compensation for illegal abortion. The Ugandan context is different in such a way that there no updated laws that reflect Islamic principles including fetal development. The would-be law that is a little similar is the 1906 Marriage and Divorce of Mohamadan Act, CAP 252 which is outdated and needs amendment.[38]

[37] Manjur Hossain Patoari. The Rights of Women in Islam and Some Misconceptions: An Analysis from Bangladesh Perspective. Department of Law, International Islamic University, Chittagong, Bangladesh.
DOI: 10.4236/blr.2019.105065.
[38] https://ulii.org/akn/ug/act/ord/1906/7/eng@2000-12
1#:~:text=All%20marriages%20between%20persons%20professing,valid%20and%20registered%20as%20provided

CHAPTER FOUR
NATIONAL LEGAL BARRIERS

4.1 The 1995 Constitution of the Republic of Uganda

In Uganda abortion is illegal unless performed by a licensed medical doctor in a situation where it is intended to save the mother's life as a legal indication. It is permitted in case of risk to physical health, and mental health.

The 1995 Constitution of the Republic of Uganda is the supreme law from which all others laws in Uganda naturally flow. Article 2 (2) of the Constitution as such nullifies any law or custom that is not consistent with its provisions. Article 22 (2) of the Constitution prohibits the deprivation of the life of any person including an unborn child. It also provides that in some instances the termination of a pregnancy is lawful, by commanding that no person has the right to terminate the life of an unborn child except as may be authorized by law[39]. It is therefore without doubt that the Constitution anticipated that there would be instances in which the termination of a pregnancy should be permitted and prescribed that such instances should be laid out by the law.

[39]Social justice in health facing Uganda's law ON ABORTION Experiences from Women & Service Providers July 2016

The Parliament of Uganda has been vested with the mandate to make laws in Uganda. Article 22 (2) not only anticipated but also placed an obligation on the Parliament to make a law which would provide for instances under which the termination of a pregnancy would be permitted. Unfortunately, since the promulgation of the Constitution in October 1995, the Parliament has not fulfilled this obligation and has not created a law to prescribe instances in which a person can be permitted to terminate a pregnancy. However, the Penal Code Act of Uganda, which commenced on 15 June, 1950, provides for criminal sanctions to several aspects of abortion and, in the absence of any other law, it remains the authority on instances in which abortion is or is not permitted.

4.2 The penal code of Act laws of Uganda Cap.120 as amended section 141.Attempts to procure abortion.

Where abortion is restricted, penal and criminal codes include harsh sanctions for the person responsible for inducing the abortion and for the woman seeking abortion. Laws do not punish the man involved in the unwanted pregnancy unless he tries to perform the abortion himself. A distinctive characteristic of Islamic law is that the punishment for performing an illegal abortion consists of payment of compensation to

the couple whose fetus it was, the amount of which depends on the stage of fetal development.

It stipulates that any person who with intent to procure the miscarriage of a woman whether she is with or without a child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind or uses any other means, commits a felony and is liable to imprisonment for fourteen years[40].

Section 212 of the Penal Code Act, any person who through any act or omission prevents a child, who is about to be delivered, from being born alive can be punished upon conviction with imprisonment for life. The act or omission mentioned in the offense under Section 212 has to be of such nature that if the child had been born alive and then died, the person would have been deemed to have killed the child. This offense removes the element of intent but also adds the element of a child who is about to be delivered. The section does not specifically define who amounts to a child about to be delivered but it may be argued that a child about to be delivered could include a fetus which is capable of living on its own outside the uterus. In such instances, the accused will not be deemed to have terminated a pregnancy but will be deemed to

[40] https://reproductive rights.org .Centre for reproductive rights: Uganda's Abortion Laws

have killed an unborn child. While the Penal Code does not comprehensively provide for instances in which abortion may be permitted, it provides for a defense for a person accused of any of the offenses defined by Sections 141, 142, 143, and 212 of the Penal Code Act.

4.3 Section 142. Procuring miscarriage

Any woman who, being with child, with intent to procure her miscarriage, unlawfully administers to herself any poison or other noxious, or uses any force of any kind, or uses any other mean, or permits any such things or means to be administered to or used on her, commits a felony and is liable to imprisonment for seven years.

The constitution has or combines elements of both Islamic and English law. Therefore, the laws on abortion, permits to protect the woman's life, in cases of rape if the pregnancy is of less than 90 days' duration or if the fetus is dead in the womb[41].

Under Section 143, any person who supplies anything knowing that it will be used unlawfully to terminate a pregnancy can be punished upon conviction with imprisonment for 3 years. This offence punishes any person, including a pharmacist, who provides anything to a woman or

[41] https://justice centres go.ug> What is the law on abortion

to any person knowing that it will be used to terminate a pregnancy. The key feature cutting across these three provisions is intent. Under each of the provisions, it has to be established that there was an intention to terminate the pregnancy. Unintended termination of a pregnancy is also criminally punishable in Uganda[42].

4.4 Abortion service delivery

While abortions are common across the country, the majority of procedures in Uganda are, by World Health Organization definitions, unsafe.[43] Although unsafe abortion rates have fallen from 54 to 39 per 1000 women aged 15-45 years over a decade, absolute figures show a rise from 294 000 in 2003 to 314 000 women having unsafe abortions in 2013. Unfortunately, only 50% of the women who develop abortion complications are able to reach facilities for postabortion care. Despite the clinical evidence and the stories from undocumented cases, debate on access to safer and legal abortion is constricted, moralized, and stigmatized.[44] More recently, a 2022 study shows that unsafe abortion

[42] Ibid
[43] World Health Organisation available at https://www.who.int/health-topics/abortion#tab=tab_1
[44] Access to safe abortion in Uganda: Leveraging opportunities through the harm reduction model. Mulumba M, Kiggundu C, Nassimbwa J, Nakibuuka NM. Access to safe abortion in Uganda: Leveraging opportunities through the harm reduction model. Int J Gynaecol Obstet. 2017 Aug;138(2):231-236. doi: 10.1002/ijgo.12190. Epub 2017 May 16. PMID: 28455836

is an issue in Uganda. Women inclusive of Muslim women are dying, and suffering serious complications from trying to end their pregnancies using unsafe methods. Out of 102,509 women and girls interviewed, 61,505 (60%) of respondents told us that they had used unsafe abortion methods to get rid of unwanted pregnancies. This tells us that women and girls in these communities do not yet have all the information and resources they need to access safe abortion care. There is also an unmet need for contraception.[45]

The situation is worsened for Muslim women as they have to battle religion and cultural barriers. Women's access is affected by their socio-economic and marital status and rural–urban residence/ location as well as the law. Various medical barriers also limit and affect access, such as requiring the authorization of several doctors, cumbersome requirements for rape and health indications and spousal consent. Studies demonstrate that women can obtain legal abortions for serious health problems such as cancer, hypertension and diabetes.[46]

[45] Making Unsafe Abortion History in Uganda, August 25, 2022 available at https://saafund.org/making-unsafe-abortion-history-in-uganda/

[46] Asrat, D., Copas, A. & Olubukola, A. Exploring the association between unintended pregnancies and unmet contraceptive needs among Ugandan women of reproductive age: an analysis of the 2016 Uganda demographic and health survey. *BMC Pregnancy Childbirth* **24**, 117 (2024). https://doi.org/10.1186/s12884-023-06222-z

CHAPTER FIVE
STUDY FINDINGS

5.1 Analysis of the study findings

The study pointed out determinants at the personal, interpersonal, and environmental levels. The study findings acknowledge the influence of Islam and culture on sexual and reproductive behavior and health-care utilization. The findings also indicate that religious influences can partly explain disparities in sexual and reproductive health outcomes in Muslim communities. Husband and family opposition played a significant role in contraception and seeking SRH information and services[47]

The findings also point to the central problem women face in Muslim societies today as the prevalence of discriminatory and misogynistic practices and ideologies that prevent them from realizing their full human potential and, in some cases, from being able to meet even their most basic survival needs. There are multiple levels of factors that influence Muslim women's SRHR. Poor SRH knowledge and practices among Muslim women is a complex matter that is affected by personal, community, cultural, and religious factors and existing policies and regulations. Knowledge about devout Muslims' own experience of

[47] https://www.researchgate.net 3397: Factors influencing sexual reproductive health of Muslim women

sexual and reproductive healthcare matters is limited, thus providing weak evidence for modeling of efficient practical guidelines for sexual and reproductive healthcare directed at Muslim patients. All these factors overlap and are affected by each other.

Analyzing the results, we were confronted with four recurring factors that negatively impacted on the decision-making process: (1) women's lack of autonomy to make their own decisions regarding the termination of the pregnancy, (2) their general lack of knowledge, (3) the poor availability of local abortion services, and (4) the overpowering influence of providers on the decisions made.

The first factor involves women's lack of autonomy. In this study, most women indicate that decisions regarding the termination of a pregnancy are mostly taken by others especially their husbands, which is sometimes against their will. Parents, family members, partners, and providers decide what should happen.

As shown Int. J. Environ. Res. Public Health 2018, 15, 329 9 of 13 in the literature, this lack of autonomy in abortion decision-making is linked to power and gender inequality.

On the one hand, power reflects the degree to which individuals or groups can impose their will on others, with or without the consent of those others. In this case, the power of the parent/family is observed when they, directly or indirectly, influence their daughters to carry out an abortion, for instance by threatening to kick them out of their home. On the other hand, gender inequality is also a factor. This refers to the power imbalance between men and women and is reflected by cases in which the partner makes the decision to terminate the pregnancy.

Women's economic dependence makes them more vulnerable, dependent and subordinated indigence. For economic reasons, women, have no other choice but to obey and follow the family or partner's decisions.

Closely linked with women's lack of autonomy is their lack of knowledge. Interviewees report that they do not know where abortion services are provided. They are not acquainted with the legal procedures and do not know their sexual rights. Misconceptions about the side-effects, modes of action, or effectiveness of different contraception methods also contribute poor uptake and use among women.

This lack of knowledge among women contributes to the high prevalence of pregnancy termination outside of health facilities and not in accordance with legal procedures.

Our participants reported that abortion services are absent at a local level, as has also been pointed out by Ngwena [48]. This is a particular problem in Budaka District. Not all health facilities are authorized to perform abortions. The mere fact that only some tertiary and quaternary facilities are allowed to do so, this limits abortion centers from covering the would be demand. In fact, only people with a certain level of education and a sufficiently large social network have access to legal and proper abortion procedures and facilities.

Findings suggested that mothers' attitudes towards SRH education affected young girls' access to information and education. Many mothers wanted their daughters to learn but felt that they had inadequate information to give them, and others were embarrassed discussing such matters with their daughters. "Our information about adolescents' sexuality is low; the necessary information should be taught to them [our daughters] in school." Married woman, age 46 – Iran. [49]

[49] Factors influencing sexual and reproductive health of Muslim women: a systematic review Noura Alomair1*, Samah Alageel2 , Nathan Davies1 and Julia V. Bailey

Finally, this study shows that providers mostly decide on the location, the means used and the legal abortion procedures. Patients highly depend on the health providers' ability, professionalism and accuracy plus the selected procedures that are not mutually decided by the service provider including the patient. Providers often do not refer the client to the reference health facility and sometimes do not inform them of the legal procedures, creating a barrier between law and practice that stimulates illegal and unsafe abortion procedures. It might be due to a lack of knowledge among health providers too.

Participants who seek help at the health facility do so as they contact the provider in particular, as an indication given by someone.

As Ngwena[50] argues, the liberalization of abortion laws is not always put into practice and abortion rights merely exist on paper for example Braam' study highlights the necessity of clarifying and informing Muslim women and providers of the current legislation and ensuring that abortion services are available and accessible in all circumstances as described in the law.

[50] Ngwena, Charles G. "Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa." *Human Rights Quarterly* 32, no. 4 (2010): 783–864. http://www.jstor.org/stable/40930337.

Despite the cultural differences, the result did not suggest differences between religions regarding factors influencing the decision to terminate and how the abortion is done.

These abortion stories illustrate the lack of autonomy in the decision-making process given the power and gender inequalities between adults and young Muslim women, and also between man and women.

They also show the lack of knowledge not only on the availability of abortion services at some health facilities, as well as, on the law on abortion. All these inadequacies for women are reinforced by poor availability of abortion services and the fact that the service providers were not taking their role to help those women, as it is exposed in the next sections.

Conclusively, it should be noted that in Islamic societies, issues related to sexual and reproductive health (SRH) are rarely discussed and considered sensitive subjects yet Sexual and reproductive health and rights (SRHR) are the cornerstone to the ability of many women and girls to realize their full human rights and potential. Unintended pregnancy and childbearing, disease, abuse and other violations of SRHR can profoundly alter young persons' lives, undermining their educational attainment, economic opportunities, and ability to participate in public and political life.[51] The concern is that sexual

[51] Centre for Reproductive Rights, 2017

debut occurs without adequate information on contraception, consent, and other rights and this makes such young girls especially vulnerable to abuse and violations of their rights. As a result, Muslim girls and women face significant barriers to accessing information, education, and SRHR services and access to justice that are adequate, comprehensive and free of prejudice. These barriers are made worse depending on several factors, such as age, gender, disability type, HIV status, sexuality, family and marital status, level of education, and poverty [52]

[52] Centre for Reproductive Rights, 2017

CHAPTER SIX

6.1 RECOMMENDATIONS

Based on the results of the study, we recommend the following measures to improve the abortion and Family Decision-making process among Muslim women in Uganda:

- The existing Qadhi courts should be very deliberate and intentional on hearing abortion matters and passing progressive judgements that favour abortion as rightly provided for under Islam while citing Quranic, Hadith and Fatwa provisions on abortion.
- The rightly and well stipulated Holy Quran and hadith provisions on abortion should be preached and put in practice by Muslim religious leaders as opposed to the false and stereotype preaching regarding abortion. These findings should create awareness among Muslim leaders that abortion is actually permissible within Islam to enable Muslim have access to abortion and post abortion care.
- The Uganda Muslim Supreme Council (UMSC) should pronounce itself with clear fatwas on abortion. These Fatwas will act as precedents that Muslim women could rely on to access abortion and post abortion care services.
- Strategies should be implemented to increase women's autonomy in decision-making especially the bodily autonomy as recommended by the Moputu protocol which Uganda ratified to in 2010:

- Improve communication opportunities and social networks of Muslim women and girls without any form of discrimination through a holistic approach that includes; interventions focusing on reducing dependencies of women and girls on their family members, facilitating access to education and income generating opportunities[53]
- There is a need to address gender and power inequalities. Addressing gender inequality, and promotion of more equitable power relations that lead to improved health outcomes. The interventions to promote gender-equitable and power relationships, as well as human rights, need to be central to all future programming and policies[54].
- Not with standing, patients and the whole Muslim population should be better informed about sexual reproductive health rights, national abortion laws, the recommended and legal procedures, and the locality of abortion services, since, despite the decision to terminate pregnancy resulted to the imposition, if they were well informed on that, maybe they could ably make independent decisions on safe and legal abortion, avoiding double autonomy deprivation.

[53] Sham Luma –ah Vol 2 pg 28
[54] Wasail ash-shia, Vol 14 pg 106

- Muslim health care providers indeed must be informed about the status of national abortion laws. Additionally, they should be trained in communication skills to promote shared decision-making and patient orientation in abortion counseling.
- The number of health facilities providing abortion services should be increased, particularly in remote rural areas.
- Muslim girls and women should be left to freely enjoy the constitutional right to enjoy adulthood that is constitutionally guaranteed at 18 years as the majority age. The abortion decision-making by young Muslim women is an important topic because it refers to the decisions made during the transitional period from childhood to adulthood. The decision may have life-long implications, compromising personal health, career, psychological well-being, and social acceptance. This paper, on sexual reproductive health rights especially abortion decision-making, calls attention to some attitudes that lead to the illegality of abortion despite it being done at a health facility.
- Advocacy for safe abortion by Muslim and non-Islamic organizations

Non-Islamic women groups have not addressed the issue of abortion directly; they are working to challenge the patriarchal structures that limit women's reproductive rights. We need efforts that are directly meant to challenge the Islamic stereotype of abortion as non-

permissible. In Uganda, Islamic Women Initiative for Justice Law, and Peace (IWILAP) has lobbied for changes in discriminatory family values by conducting Dialogue and sexual reproductive health series amongst Muslim women and men plus the Qadhi courts. Such activists have made strides to define marital rape as a crime and raise community awareness about violence against women and its health impact and demanding that government should respect their commitments to universal human rights most especially the Moputu protocol principles which Uganda ratified in 2010, including gender equality and non-discrimination

6.2 Positive impact on perception

Recruit women as community health workers (VHTs) and provide reasonable adjustments that allow them to do their work, appreciate and portray their participation as experts in domains that are socially relevant and outstanding.

Encourage the inclusion of women with disabilities into existing women and girl's peer groups and address issues related to SRHR that incentivize and inspire their support to other women with disabilities.

Design SRHR information materials together with women and girls to better reflect their lived experience and disseminate.

6.3 Enabling practices

Ensure the participation of Muslim women and girls and their family members in the design, implementation, monitoring, and evaluation of SRHR programs targeting both male family members (i.e. fathers, brothers, and husbands), and female caregivers of all ages.

Design inclusive outreach strategies and referral mechanisms that recognize the barriers women and girls experience in accessing SRH services.

Encourage open forums and Dialogue for the discussion and dissemination of good practices amongst healthcare workers, where Muslim women and girls can participate and contribute positively for the SRHR cause.

6.4 Limitations

The initial research design targeted non-users of SRHR services to ensure that the most marginalized and hardest-to-reach Muslim women and girls were included in the study. While the research team achieved the desired sample size, not all participants were ‘non-users’ of SRHR services, and not all Muslim women were represented.

The small budget of this research affected the researcher’s ability to engage respondents for longer periods.

During FGD, several women were sex shy and concealed certain information. This was in some cases defended by respondents who alleged that Muslim women have no right to speak in public and share their family information with outsiders before seeking informed consent from their husbands.

6.5 Conclusion

An increasing number of contemporary research publications acknowledge the influence of religion and culture on sexual and reproductive behavior and healthcare utilization. It is currently hypothesized that religious influences can partly explain disparities in sexual and reproductive health outcomes particularly abortion in Muslim communities. Moreover, there are more than 30 surah or chapters (26.3%) and 93 verses (1.5%) verses of the Qur'an and Hadith of the Prophet Muhammad that discuss SRHR.

Aware of the challenges and misconceptions surrounding abortion, organsiations such as IWILAP need to provide legal aid to Muslim women to access abortion services with Quranic and Hadith support that is well stipulated. There is already evidence where authors urge Muslim lawmakers to consider abortion post ensoulment if it is certain that the malformed fetus will die soon after birth or will be severely

malformed and physically and mentally incapacitated after birth to avoid substantial hardship that may continue for years for mothers and family members. The authors recommend that governments make decisions that support abortion.

In a context of rapid social and demographic change and transformations in women's status, the debate over sexual Reproductive Health Rights is central to discussions about how to reconcile women's rights with those of the community and the state. It is also about governments' obligations to their Muslim (women) citizens. Challenges to the status quo and the patriarchal traditions and conservative religious interpretations that keep abortion restricted and stigmatized are essential to be addressed.

At this point, the religious provisions on abortion lead to a conclusion that a more liberal attitude regarding abortion is possible in Islamic communities, as long as traditional principles are taken into account hence the need to pursue the abortion litigation cause.

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ANNEXURE 1: FOCUS GROUP QUESTIONS QUESTIONNAIRE

Introduction

The purpose of our study is to learn about the knowledge, needs, and barriers to accessing sexual reproductive health rights among Muslim women you know, like your family, friends, and neighbors. Information shared in this meeting is confidential. Feel free to share your experience as you feel comfortable but you can also say "I know someone who…." if that is a more comfortable way to share information. Please do not mention specific people in your community by name.

This first set of questions asks about how people in your community get information related to sexual reproductive health – information about birth control, Abortion, family planning, and other related health issues.

Questions about access to information

1. When Muslim women you know have a health question related to sexual and reproductive health, how do they usually get that question answered? Where do they feel comfortable going to?

❖ Prompts:

➢ Some examples of where people might go are people, places (including the internet).

“I had a problem with my second pregnancy. I was feeling a lot of pain in the lower abdomen and decided to go to the health facility which referred me to a scan where they told me that it had become ectopic and needed termination immediately, my husband did not have enough money so we decided to go to a traditional birth attendant who gave me herbs and I got a miscarriage”.

“Internet is for the Elite “Muslim woman aged 38

➢ Are there different sources of information for men compared with women? Younger adults compared with older adults? Unmarried compared with married? Those with children compared with those with no children?

“*Of course, men get more information than us the women, they visit trading centers daily unlike we who are confined in one place doing household chores. Young people also go to trading centers to hang out with their friends, so they get information there. If you have no child then information is limited, who will tell you about anything?* Woman aged 36

2. Do you think that Muslim women you know are aware of the healthcare services and options related to sexual and reproductive health that are available to them? Why? Why not?

“A few are aware and some do not want to hear for example about Family planning because of its effects”

➢ What can we do to increase awareness?

"I think the religious leaders should also be trained on sexual reproductive rights by the government because it is as if they do not want anything about SRHR". Woman aged 25

"During Juma prayers, the Imam should sensitize the Moslem communities" Women aged between 18 and 40

Questions about access and barriers to services

3. What are some reasons that Moslem women you know may not use a public or community health clinic (such as health centers) if they have concerns about family planning, birth control or Abortion?

'As a Muslim woman, I fear to undress before a health worker. Islam allows me to undress only to my husband". Respondent aged 27

"After giving birth to my fifth born, I decided to go to a health facility for family planning services, but what I saw was horrible, when the nurse asked me about the number of children that I Have-I told her the lady seriously started abusing me as illiterate who is only interested in having sex with my partner as if literate women do not have sex". woman aged 30

"I used an injectaplan but the bleeding became so heavy for two weeks and I could not handle "a woman aged 25

➢ **Are there concerns about private information being shared?**

"For me, I fear sharing information about family planning and contraceptives because some people have Lugambo, they can report me to my husband or my mother-in-law because they do not want me to go for such, so I keep such information to myself" Muslim woman aged 24.

"When you share information with friends in the village, the whole village shall learn about you getting involved in contraceptives and they will begin back biting you" woman aged 30.

"My husband told me that he will divorce me once i started using any family planning method, as Muslims the Quran allows us to produce as many children as we can." Muslim woman aged 26.

"We are being restricted by our husbands and as such we cannot share information because it is regarded as lugambo" Muslim woman aged 22.

➢ **Do traditional cultural beliefs or religious beliefs encourage or discourage use of a local clinic for sexual or reproductive health information or services?**

"*As Muslims, our Imams do not teach us anything about family planning, Abortion, or Contraceptives, they only teach us to be submissive to our husbands"*

"Our Imams tell us that Family planning, contraceptives, and Abortion is haram because Allah created the world for procreation," said a Muslim woman aged 28.

"Our Imams only teach us to accept our co-wives in our marriages in order to go to paradise, and also not to marry non-Muslims as the Quran teaches". Muslim woman aged 30

"of course, religion discourages, because ever since I was born, I have never had of any religion that teaches about sexual reproductive rights, they only teach us not to deny our husbands sex"

With the use of local herbs, definitely some women cannot go to clinics because they are comfortable

4. Are there specific reasons why you think Moslem women may not use such a clinic if they needed one?
"Ignorance of men, they think they will spend a lot on their wives if taken to a health facility" Muslim woman aged 24.

"The health workers are very cruel especially the female ones, they are not friendly at all, even when you visit the health center very early in

the morning when they are still fresh and not yet tired". Muslim woman aged 33

"They speak English to one another and this appears as if they are back-biting us"

➢ What could clinics do to make them more welcoming and safer for Muslim women ".
"The health workers need to start their work early enough to avoid us in long queues".

"More staff need to be recruited to avoid long ques". Muslim woman aged 27

5. Do Muslim women you know experience any language barriers to getting information and services, including interpretation services? If so, please describe.

"Yes, the health workers speak English to themselves and sometimes they may not know our Lugwere language" Muslim woman aged 19.

Questions about experiences with sexual and reproductive health services.

6. Tell us about an experience when you or someone you know received sexual and reproductive health services.

"My niece aborted and was helped by a nurse who induced it but she lost her life, so I cannot abort, I shall produce as many children as I can" Muslim woman aged 30.

"I don't know why the government does not recruit more male staff because for me when I went for my IUD, it was I male musawo (Doctor) who worked on me and he was very receptive unlike the female staff who just abused us". Muslim woman aged 22.

"Oh, I went on a day for antenatal, and expectant mothers were very many yet only one nurse was attending to both departments, I stayed the entire day in the facility". Muslim woman aged 24.

Another woman stated, *"The health workers do not tell us the bad about family planning; they only talk good of the methods and yet sometimes the injection, IUD make us bleed as if we have just given birth."* Muslim woman aged 34.

➢ Some examples to comment on are service hours, costs, transportation, interactions with clinic staff, having a male or female provider, language, birth control supplies, etc.

"Sometimes you find only one nurse attending to patients, pregnant mothers and at the same time immunizing new born children, this makes wait for almost a full day in the facility"

➢ What would have made it a better experience or made the experience more comfortable?

➢ Were you (or someone you know) satisfied with the visit?

"Yes I was worked on but after visiting the health unit three times without being served" Muslim woman aged 23.

7. What would make it easier for Moslem women you know to get family planning services/safe abortion/contraceptives?

"Engage Muslim men in meetings about sexual reproductive health such that they understand the advantages of Family planning and safe abortion". Muslim woman aged 36.

General/Other Questions

8. What would Moslem women tell you were the reasons they didn't want to go to a local clinic for sexual and reproductive health services?

"Islam does not allow family planning and also it leads to over bleeding during the menstrual period" woman respondent aged 40.

"The heavy workload amongst health workers discourages us from going to a health facility because of the long ques." Woman respondent aged 28.

9. If you have one suggestion or advice about what could be done to improve the sexual and reproductive health services for Muslim women in your community, what would it be?
"Let the government recruit more medical workers to avoid long ques in health facilities"

"We feel the Amilas /Sheikhats should take the lead to organize seminars and invite the health workers to sensitize the Muslim women to discuss healthy issues". Medical worker.

"SRHR training before marriage should be conducted to raise awareness amongst Muslim girls." Medical worker.

"Government to empower health workers to adjust to change through refresher training to build capacity in SRHR" medical worker
Government to extend out reaches targeting religion" medical worker.
10. Is there anything else you would like for us to know about the sexual and reproductive health needs of the community or anything else we talked about today?