Reproductive health and reproductive justice for Muslim women

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ABSTRACT
Reproductive justice is defined as “women and girls achieving economic, social, and political power, and the resources to make healthy decisions about one’s bodies, sexuality, and reproductive health for themselves and their families and their communities in all areas of [their] lives” (Zavella 2016, 1). Women of color are the targets of much prejudice in American society. (Ginsburg and Rapp 1995). Since September 11th and especially in the Trump era, Muslims continue to be “otherized” and racialized, further marginalizing Muslim women. Muslim women’s reproductive health is impacted by reductive and essentialized perspective of their religious practice, a typical view held by contemporary America. Analyzing these disparities through an intersectional lens allows the researcher to confront popular essentialisms to understand the simultaneous interaction of race, class, and gender in the lives of Muslim women. Using this approach in her study of the reproductive health of African American women in Harlem, Leith Mullings (2005) identifies certain structural constraints, including political and economic factors, that cause stressors during pregnancy and health problems for both mother and child. Her findings and similar studies on Latina women beg the question: how do gender and racial discrimination, class bias, and Islamophobia affect the reproductive health of Muslim women? In this paper, I argue that intersectionality as a method and theoretical approach should be applied to Muslim women’s reproductive health and reproductive justice issues, and I sketch out the beginning of an answer to that question.

KEYWORDS
Reproductive Justice, Intersectionality, Muslim Women, Racialized Minority.

INTRODUCTION
Thirty years ago, Edward Said (1978) introduced Orientalism to explain Western hegemonic discourse about Islam. The “otherizing” and racialization embedded in orientalist discourse has only grown since September 11th and the Trump presidency. Lila Abu-Lughod (2002), an Afghan American and Muslim anthropologist, argues that the “War against Terror” reveals an orientalist lens in which Muslim women, in particular, are inferior. Such prejudicial views toward religious beliefs and the treatment of women cover America’s constant repressive conduct around the world and seep into the administration of marginalized groups inside the United States (2002). One such domain is the health care system. Muslim feminist activists such as Linda Sarsour argue it should not be allowed to be degraded by racial discrimination and class assumptions. Sarsour (2017) clearly articulated this idea in her speech at a CUNY school of public health commencement: “We in this room together must commit to never being bystanders to poverty, lack of jobs and healthcare, sexism, violence, discrimination, racism, xenophobia, Islamophobia, anti-Semitism, and homophobia.” Likewise, other scholars like feminist writer Chandra Mohanty (2003) have called attention to the legacies of colonialism that homogenize women across “classes and cultures” while urging activists, health care providers, and researchers to overcome these legacies. However, sexism, racialization, and the essentialization of
Islam influence biomedical and public health models to the extent that Muslim women’s reproductive behavior in the United States is severely under-researched – and the findings that do exist are distorted (Walton et al. 2014). This situation and current activist movements raise the question, can Muslim women attain reproductive justice in a racialized society? In this paper, I apply the concepts of intersectionality and reproductive justice to the racialization of Muslim women’s reproductive health in America. I argue that this intersectional methodology—used previously with Latina and African American communities—is the best approach to accurately addressing the specific reproductive needs of Muslim American women.

**REPRODUCTIVE JUSTICE**

Before delving into the specifics of reproductive justice, it is important to define some key terms. Reproductive health refers to women’s social, physical, and emotional well-being during pregnancy and the well-being of their reproductive system generally throughout their lives. Reproductive rights pertain to an individual’s right to access reproductive health and to choose whether to reproduce. Reproductive justice includes securing a woman or girl’s access to their reproductive rights through equitable and beneficial social, physical, mental, economic, and educational conditions (Zavella 2016). The reproductive justice movement reveals the limitations many women of color and low-income women face when exercising their right to choose and the barriers they experience to having children because of discriminatory structures and policies. These social and economic structures are based on unequal power relations, which discipline some groups’ reproduction (in the US, women of color) and privilege others (white women) (Luna and Luker 2013).

In a world with full reproductive justice and autonomy, a woman would be informed of her rights and the health resources available to her would accommodate her background, regardless of her immigration status, education, class, and race. However, many studies have found that racial discrimination infringes upon women’s reproductive rights. Zavella (2016) discusses how Latina immigrants do not receive proper reproductive care sensitive to Latina’s cultural traditions. Her ethnographic study involved a two-day participant observation in 2015 of a California Latinas for Reproductive Justice (CLRJ) workshop where activists broke down cultural and generational barriers to teach Latinas about contraception and their reproductive rights. The CLRJ’s services help vulnerable Latina immigrants by providing information to combat their subordination. Zavella notes Latina immigrants particularly experience subordination in relation to reproductive health, as they are unaware of their rights. Zavella argues that despite being a Western nation with sufficient funding, the United States provides immigrant women with only very limited health care as racial discrimination and inequality impact its accessibility. Just as Latinas’ right to reproductive justice is affected by racialization, Muslim women are “otherized” through essentializing and reductive logic that assumes all women of color have the same reproductive behavior and should be denied reproductive justice. In the next sections, I describe the main mechanisms of this denial – especially biased representation – and explain how an intersectional approach can overcome these obstacles.

**Biased Representation**

Representations of women’s reproductive choices are often biased by racialization and classism. According to Dana-Ain Davis (2009), reproductive boundaries are policed by belittling and targeting marginalized women at every stage of their reproductive lives. Davis uses the example of *Fasano v Rogers* (1999), a case in which Black woman Deborah Perry-Rogers had to fight a custody battle over her genetic son after her eggs were “mistakenly” implanted into a White woman undergoing IVF (in vitro fertilization). Davis (2009) argues that the procedure was not actually a mistake, but rather prejudice based on racialization of women of color. The clinic clearly supported the societal belief that a white woman is more fit to be a mother than any other race. The racialization indicates “both the cultural illegibility of infertility and the general problematic of reproduction and maternalism among certain women” (2009). The direct account of racism
shows that not everyone has the right to reproduce and only certain populations are able to attain reproductive justice. Citing the portrayal of women of color as “bad” mothers, Davis argues that American society upholds a hierarchy of legitimate reproductive choices, where women of color are below white women. She explains that in the eyes of society, a “good” mother should not choose to have a child if she were poor, low-income, single, and not White. For example, if a middle-class white mother were to have multiple children, she would be encouraged, supported, and viewed as a positive member of society. However, a poor African American mother would experience very different reactions, as women of color and those of minority status are generally viewed very negatively in the eyes of society and deemed “unfit” to have children (Ginsburg and Rapp 1995). Instead of deserving government reimbursements, poor or low-income women of color are called “welfare leeches.” The racialization associated with this stigmatizing rhetoric surrounding having children is what Ginsburg and Rapp (1995) call “stratified reproduction.” Stratified reproduction theory identifies the power that gives some groups access to reproductive choices while limiting the choices of others, revealing how “some reproductive futures are valued while others are despised” (1995, 3). This means that society prefers certain groups and encourages them to reproduce, while discouraging others deemed unwanted or negative.

INTERSECTIONALITY

In order to maintain women’s reproductive health, health care professionals should consider their patients’ class, gender, and race. Working- and middle-class women of color experience exploitation, racial discrimination, and gender subordination through environmental racism, employment insecurity, and problematic housing conditions, all of which have significant impacts on their health and birth outcomes. An intersectional approach to health care examines how these conditions are produced through the simultaneous interaction of systemic and interpersonal prejudices towards race, class, and gender, rather than blaming biological race or cultural traditions.

Using the example of Sojourner Truth, an enslaved African American woman who later became involved in the women’s rights movement, Anthropologist Leith Mullings (2005) argues that the legacies of enslavement and present hardships caused by racism impact the long-term reproductive health of African American women. Focusing on “the interaction of race, class, and gender, as well as the dialectic of oppression, resilience, and resistance” in the lives of African American women (2005, 79), Mullings argues that because both middle class and working-class Black women have poor reproductive health outcomes, racism—not poverty alone—is to blame. Public health scholars David and Collins (2007) echo these claims in their discussion of how Black and White women’s exposure to different conditions (like increased stress due to minority status, not their various genetic backgrounds) result in different birth outcomes and more preterm births for Black women.

Discrimination and Limitations Within the Healthcare System

Preterm births and high infant mortality rates are connected to environmental issues, employment insecurity, and poor housing conditions—all of which are influenced by racial discrimination. In a study analyzed by David and Collins in Illinois, African American women gave birth to infants with much lower birth weights than African-born women and US-born, white women (2007). David and Collins’ analysis also states that European immigrants had daughters with the same birth weight as European Americans, whereas African and Caribbean immigrants had daughters with a higher birth weight than that of established African Americans (2007). Societal inequalities manifest in structural and environmental discrepancies, such that certain facilities are only available to white populations, denying women of color the resources they need to have healthy (full weight) babies (Mullings 2005). These discrepancies mean that women of color are often exposed to violent environments and unfavorable conditions, leading to increased levels of life stress that eventually lead to poor health during pregnancy and poor birth outcomes. For instance, working-class and middle-stratum African American women
living in Harlem face stress from poor housing conditions due to neglect from discriminatory landowners and governments, which can result in eviction during pregnancy as well as higher contact with pollutants and lack of access to quality supermarkets (Mullings 2005, 81). As Zoë Carpenter points out in the case of Wisconsin, these conditions result in unhealthy pregnancies, which leads to preterm births, underweight babies, and increased mortality: “Over the past decade, more than 100 babies, at least 60 of them black, have died in Milwaukee each year, about two-thirds of them because they were born early or small” (2017, 6).

Institutional discrimination – unequal treatment in the social, economic, educational, and political systems – impacts the health of particular groups of Americans and their access to health care. As Carpenter puts it, “It’s the stress caused by racial discrimination experienced over a lifetime that leads to black American women’s troubling birth outcomes, not the individual choices those women make or how much money or education they have” (2017, 6). No matter her economic or educational status, an African American woman can feel marginalized in a health care system that does not respect her needs or circumstances. Carpenter (2017, 6) describes how fear of being treated differently due to her race leads one pregnant African American woman to have a hard time trusting her white doctors. Much like the stories of Latina women Zavella (2016) follows, when Carpenter’s interlocutor attended a labor and birth course the majority of her classmates were white and the teachers did not cover birth complications and issues relevant to women of color. Women are entitled to reproductive care tailored to their needs and taking their ancestral backgrounds into consideration, which, as Zavella (2016) and Carpenter’s (2017) cases prove, general care packages do not provide.

Mullings and Schulz (2006) emphasize that understanding intersectionality is at the core of caring for an individual’s health because health care professionals must understand biological race and genetics are not the only components affecting one’s health. Health disparities based on race/racism, class, and gender/sexism are matters of life and death. They are expressed by differences in length of life, life chances, and quality of life and death. Efforts to reduce or eliminate persistent health disparities are among the most important opportunities for improving the health of US residents and are rightfully a high priority for public health and social science scholars (Mullings and Schulz 2006).

**Racialized Minority Group**

Western epistemology labels Islam a barbaric religion that promotes “terror” and subordinates women (Said 1978). Consequently, Muslim women are often portrayed as submissive and primitive in comparison to Western women, and Western media condemns Islam as a religion that does not value women: Western images of Islam are “populated by shadowy (though extremely frightening) notions about jihad, slavery, subordination of women and irrational violence combined with extreme licentiousness” (Said 1978, 6). This Orientalist perspective relies on—and contributes to—a racialized hierarchy: “The general basis of Orientalist thought is an imaginative geography dividing the world into two unequal parts, the larger and ‘different’ one called the Orient, the other, also known as our world, called the Occident or the West” (Said 1978, 2). In this way, the Orient’s supposed barbarism legitimizes their subjugation to the Occident’s self-proclaimed righteous authority. The consequences of deeming Muslims to be a primitive group of humans are felt in the arena of reproductive health (among others), where Muslims are stereotyped as not believing in contraceptives and other forms of family planning, which limits Muslim women’s access to appropriate care (Inhorn and Sargent 2006).

Although the issues these women face (like religious stereotypes about family planning) are different than those of other marginalized populations, there are few ethnographic accounts of Muslim women’s reproductive health. There are none on Muslim women in the United States, despite the increased racialization of Muslim women after the terror attacks on September 11, 2001. When searching for research about Muslim women’s reproductive health in Medline, a medical journal search engine, the key terms “Muslim,” “Women,” and “Reproduction” produced only
1300 Articles. Out of those 1300, only 83 were conducted on Muslim women living in the US and none of them were ethnographic accounts. Most of these articles focus on reproductive health in terms of identity, stigma, modesty, and body image, not issues of pregnancy, birth, or child rearing. This dearth led me to hypothesize that an Orientalist reduction of religious practices limits research on Muslim women's reproductive health practices.

Muslim Women's Reproductive Perspectives

Religious reductionism represents a lack of reproductive justice because it does not adequately take into consideration the intersectionality of race, class, and gender (Zavella 2016; Mullings and Schulz 2006). As Inhorn and Sargent (2006) discuss, many Westerners view Muslims as “hyperfertile” because they believe Muslims strive to produce a new crop of terrorists and to outnumber other populations. These ideas (or related essentializations of religious beliefs) bleed over into the health care industry where many professionals believe all Muslim women reject contraceptives, and into research where scholars generalize based on small sample sets, homogenizing the entire population (Walton et al. 2014). Walton et al.’s study found that fourteen lower-middle class, married Southeast Asian women believed women have the right to make choices about their own bodies without interference, but they preferred their husband to be present during medical consultations regarding their reproductive health. However, Walton et al. (2014) fail to point out that the husbands’ presence indicates these women do not operate completely autonomously in decisions about their health, nor that this reproductive behavior is not true for all Muslim women. Reducing their experiences, cultural backgrounds, and religious practices to one stereotype presents an incomplete and potentially corrosive understanding of Muslim women that reinforces them as a racialized group.

Inhorn and Sargent (2006) contradict Walton’s argument by pointing out there is "no single Muslim reproductive pattern, even in Muslims existing side by side" (2006, 4). In other words, Muslims view and practice Islamic teachings about reproduction differently, and it is wrong to generalize about religious views when providing medical treatment. Sargent (2006) further contradicts the implications of Walton’s article by arguing that Muslim men and women do not have the same perspective when it comes to reproductive health. Sargent describes how Malian immigrants in France use their diverse and gendered interpretations of Islam to make distinct reproductive decisions and engage in different discourses about reproductive issues. On the one hand, Malian men ascribe to a patriarchic view where they have power over their wives and their reproductive choices. Some of these men also do not believe in contraceptives. This being said, a local male religious leader is aware of the challenges facing immigrant parents and modifies his advice accordingly: "Islam allows four wives, but only if the husband can care for them and their children equally. This is impossible in Paris. Similarly, Malians in Paris have too many children and cannot feed them properly. In these instances, [the leader] advises spacing pregnancies or stopping" (2006, 38). On the other hand, many Malian immigrant women in France believe that "God is tolerant and understands women’s fatigue" and are comfortable using contraceptives (2006, 40). The decision of some Malian immigrant women in France to use contraceptives – regardless of their husband’s decision – not only displays autonomy but also opposes the reproductive behavior that Walton et al. (2014) implies is true for all Muslims.

Tober et al. (2006) agrees with Sargent in their discussion of Shi’a Muslims’ family-planning habits and use of contraceptives in Iran. Tober at al. describe Iran’s thorough family planning system, the Women’s Health Volunteer Program, which includes the participation of Mosques and health clinics to educate women and men about contraceptives (including vasectomy and tubal ligation), encourage child spacing, and discourage child rearing before the age of 18 and after the age of 35. To support this effort, Iran’s religious leaders draw on verses from the Quran to argue in favor of the importance of maintaining family harmony through the promotion of healthy families over plentiful families. Tober et al.’s data on Iranian Muslim women using contraceptives...
and practicing autonomous reproductive behaviors contradicts the American orientalist perspective that presents Muslim women as primitive. In fact, the findings from the one medical study on the reproductive health of Muslim Women in the United State suggests that “American Muslim women’s contraception utilization patterns . . . . are possibly countervailing and likely multifaceted” because they “share certain similarities with both American women in general and disadvantaged racial and ethnic minority groups in the United States” (Bhudwani et al 2018, 1). From this data, Bhudwani et al extrapolate that, despite the size of the population, Muslim women’s reproductive health practices are not represented in biomedical and public health models. When a Muslim woman walks into a reproductive health clinic, she is automatically reduced to a depiction of what the West thinks women of her faith believe. Her personal choices and her diverse background, including education and socioeconomic status, are often misrepresented. More research is needed to accurately understand the use of contraceptives and reproductive health choices among Muslim women living in the Unites States.

Understanding the Reproductive Health of a Minority Group

In this paper, I have suggested that intersectionality as a method and theoretical approach is the best strategy for understanding the reproductive health and justice issues of Muslim women. Without such intersectional data detailing the diverse background of Muslim women and how their background affects their reproductive health, it is easy for health systems and providers to forget that Islam is a religion practiced by people from many different cultures. Each individual has their own interpretation of “being Muslim” and there are different outcomes and experiences for women across the United States. There are African American Muslims, there are South Asian Muslims, there are White Muslims, etc., and all of those racial or ethnic backgrounds connect to other factors which affect reproductive health including housing and economic issues. Unlike the public health/biomedical model that Walton et al. (2014) presented, I claim that it is impossible to treat adherence to Islam (or a cultural identity of being a Muslim) as a universal determinant of women’s autonomy and reproductive behavior. I trace some of the origins of the misguided public-health/biomedical model back to the Western Orientalist perspective (Said 1978), which reduces all Muslim women to a stereotype. The post-9/11 Western discourse about the “evil” and “wrongdoing” of Muslims and their abuse of women produces Islamophobia and dismisses the US’s own terrorizing tactics, including the mistreatment of Muslim women at home and abroad (Abu-Lughod 2002). These discourses misrepresent religious views while racializing and homogenizing Muslims. Like essentializations about religious belief, treating race as the biological reason for people’s lifestyles and life choices leads to misunderstandings about the reproductive behaviors of minority groups. Mullings and Schulz (2006, 44) expand on this idea:

Alleged cultural traits, behaviors, or beliefs, frequently implicitly or explicitly considered to be associated with racial groups, are often seen as constant, unchanging, and independent of social and historical processes. Analyses that construct culture or lifestyle in this manner simply substitute an essentialized notion of culture for race, with little attention to the structure of constraints within which people make lifestyle choices.

Looking at individuals like a token of a group instead of tracing the social relations that affect those individual lives leads to an ineffective analysis and provides an insufficient basis for health interventions (2006, 44). For instance, if a woman in a hijab walks into an abortion clinic, she may very likely be profiled based on the obvious marker of her Islamic faith instead of taking her educational or socio-economic background into consideration. This kind of generalization erases intersectionality in favor of stereotypical expectations based on “looking” Muslim and gets repeated over and over again. Without pushback from the public health and medical community, it becomes religious prejudice that hinders women’s access to reproductive health and justice.
One of the main barriers to overcoming these problems is the lack of researchers, especially anthropologists, covering the reproductive health behavior of Muslim women in the United States. Fortunately, Budhwani and colleague’s (2018) recent article shows things are beginning to progress and there is growing interest in Muslim women’s reproductive health. I exhort researchers to take up these activists’ mantle and apply intersectionality as both method and theoretical approach to understand and ameliorate reproductive health and justice issues for Muslim women.

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WORKS CITED


