Islam and Contraception in Urban North India – Muslim Women's Reproductive Health Behavior and Decision-making

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Abstract: This paper is based on ethnographic research conducted in a predominantly Muslim community in South Delhi. It analyzes the reproductive health behavior and decision-making of low-income Muslim women by focusing in particular on the context, in which the lives of these women are embedded. Fieldwork methods were participant observation, life histories and the conduction of in-depth interviews with forty women as well as medical practitioners and non-governmental/governmental health workers.

It is shown that particularly socio-economic constraints as well as women's poor state of health are the main factors influencing women's reproductive decision-making. Women's perception of reproductive health behavior is also closely intertwined with the existing social context and its related social and cultural norms. Local religious beliefs and practices however play a less significant role in determining women's fertility decisions. Building on case studies of women who articulate their motivations regarding contraceptive use, I argue that Islamic norms and reasoning are fashioned pragmatically. Women manipulate, adopt or reject Islamic legal tenets in regard to contraception to achieve their own goals. All these factors result in a decline of fertility.

INTRODUCTION

Fertility rates among Muslims in India are higher than average of the population but are declining substantially and converging towards the average. Fertility among Muslims varies with socio-economic characteristics and there are significant interregional variations[1]. Muslims use contraceptive methods and the contraceptive prevalence is about 10 percentage points lower than average, which is primarily responsible for keeping Muslim fertility above the average level (Kulkarny 2010: 92-122).

[1] For example, fertility rates among Muslims in states like Kerala, Tamil Nadu, Karnataka, and Andhra Pradesh are much lower than fertility rates in Northern Indian states such as Uttar Pradesh, Rajasthan, Bihar, Haryana and Gujarat.

There have been a number of explanations exploring the causes of differences regarding the use of contraceptive methods. It is has been often argued that there is an ideological influence of religion on fertility attitudes and practices (e.g. Bhat & Zavier 2005, Moulasha & Rao 1999). In other words, Muslims have a higher fertility because there might be a theological opposition to contraception in Islam and a debate on whether Islam allows contraception. Based on fieldwork in a settlement colony in southern Delhi, I argue that Islamic law is not the main driver in determining fertility patterns of women and that women fashion religious (Islamic) norms and reproductive reasoning pragmatically in this context.

In present-day India, there are many discussions about the growth of the Indian Muslim population and about the changing religious composition of India's national population. Political interests motivate these discussions. The so called "Muslim fertility" is especially used by right-wing Hindu-parties in their battle for political power. In India Muslims are in a minority (14,23 percent of the population)[2], but from the perspective of the so-called Hindu-Right[3], Muslims are a threat to the Hindu majority. They argue that Indian Muslims are supposed to refuse contraception and Muslim fertility rates thus must be higher than that of others. In the view of "Hindu-Rights" Islamic doctrine opposes contraception and Muslims docilely respond to their religious leaders' sayings. Muslims are planning to turn Hindus into a minority, as the "Hindu-Rights" propaganda insists, thus Indian Muslims' fertility is seen as part of a plan to outnumber Hindus. With my research I want to challenge the myths of "Hindu-Rights" about Muslim fertility in India and show that Muslim women's reproductive behavior is not a straightforward product of Islamic legal prescriptions[4].

In this paper I further want to consider the fertility practices and decision-making from a woman's point of view in her local context. To give a

[2] Government Census 2011.

[3] The "Hindu Right" comprises several organizations including the Bharatiya Janata Party (BJP), the Rashtriya Swayamsevak Sangh (RSS), the Bajrang Dal, and the Vishwa Hindu Parishad (VHP) (Jeffery & Jeffery 2006: 26-27).

[4] A number of articles and studies exist in academic literature discussing the reasons for higher fertility of Muslims compared to Hindus in India. All studies argue that differences in fertility rates are more attributable to geographical location and socio-economic conditions than to religious affiliations (Jeffery & Jeffery 2000, 2006; Borooah & Iyer 2005, Bose 2005).

holistic description of women's reproductive health behavior, one has to take into account the economic, socio-cultural, religious and political settings, in which reproductive decision-making takes place. Therefore, the following questions are of primary concern: What are women's motives and explanations for the decision to use methods of contraception? What are the various factors influencing women in their daily reproductive decision-making and practices? What are individual perceptions of religious doctrine regarding contraception and how do these doctrines and individual interpretations of them influence reproductive decision-making? Specifically, how do women manipulate, adopt and construct their understanding of Islamic mandates regarding contraception to achieve their own goals?

DESCRIPTION OF RESEARCH SITE

Chanda Nagar[5] is a low-income settlement in the Southern part of New Delhi. It has a population of around 13 000 people living on half a kilometre square, which is predominantly Muslim (more than 95%) with a Hindu- and Christian minority. The majority of Muslims is Sunni. The research area is marked by poverty and the majority of households live under severe socio-economic conditions.

A striking feature about the community is that it appears homogeneous as most of the people are from a common religious background (Islam). However there are several groups within the population that differ from each other on the bases of geographical origin, language, social norms, castes and length of stay within the area. For example, migrants from the eastern Indian states of Bengal and Bihar and the neighbouring Eastern country of Bangladesh prefer to speak Bengali and Bhojpuri and speak Hindi or Urdu only in a broken way. Their language as well as their customs differ from migrants who come from North Indian states. There is little communication between these groups.

In addition, the population of the area embodies a caste-based fragmentation (*biraderi*) with Ashraf Muslims occupying the top caste ranks and *Dalit* Muslims claiming the bottom rung of the system. The majority of Muslims of the area belongs to the lower castes, which comprise occupationally specific caste groups such as for example Ansari, *Kasab*

[5] The name of the area as that of all respondents have been changed to maintain anonymity.

(butcher), *Darzee* (tailor), *Nai* (barber), carpenter, *kabari* (junk dealer) and *rangrez* (dyer).

The population consists mainly of migrants and their families. They migrated from small towns or districts from Northern or North-Eastern Indian states like Uttar Pradesh, West Bengal, Bihar or Assam to Delhi. Reasons for migration were employment opportunities, low profit in traditional occupation, lower wages at their places of origin and distribution of land among siblings. Other inhabitants of the colony come from inner city slums of Delhi as consequence of a state resettlement. They had lived in other inner city slums of Delhi before but their houses were demolished by the state and were relocated to other areas. Poverty-induced migration from rural areas and state resettlement has led to a congestion in the area and caused increasing unemployment, the growth of an urban informal sector and further impoverishment of the population.

The men of the low-income community are involved in the informal sector as for example daily wage labourers, rag pickers and small vendors. They are not protected by labour laws, earn below the minimum wage and work often under exploitative conditions. The community has a high prevalence of unemployment, school dropouts, drug and alcohol abuse and domestic problems.

Today, the settlement colony is so overcrowded that the poorest of the inhabitants live along city sewers, under bridges, in parks and on pavements of the streets surrounding the area. Several problems associated with the rapid urbanization like lack of sanitation, poor water supply and unhealthy environmental conditions are affecting the population of the whole area. Despite its congestion and affiliated difficulties its residents declare the settlement colony as safe and peaceful. There have been no communal riots in the last decades and in addition to the area's central location in Delhi, inhabitants regard Chanda Nagar as a preferred place to live.

DESCRIPTION OF SAMPLE

I talked to 40 Muslim women altogether and collected their reproductive histories. The women selected were in the age group of around 20 to 40 years.

The majority of women I talked to were migrants and belonged to a poor socio-economic strata, but they were no homogenous group as they distinguish by region and language. Most of the women were from Uttar Pradesh, others from Bihar, West Bengal and very few from Assam, Madhya Pradesh, and Haryana. They were first, second or third generation migrants and the majority of women had been living in Delhi for more than ten years. The date of migration to Delhi began from the 1970s up until the year 2000. A small number of women moved to Chanda Nagar from other parts of the city, especially from Old Delhi.

The migrant women from rural areas particularly had not been to school at all in their childhood and youth, and never learned to write or read. A few women could read and write in Urdu. They didn't learn these skills in school, but had acquired them at home while being taught to read the Koran by female tutors. Half of the women either went to primary school only, or to primary and secondary school, however most of them had only a few years of education. Two women had a higher education (university). The level of education amongst the women was low because a majority of them were withdrawn from school as soon as they reached puberty since they were considered grown-up enough to be "married off". Some women were withdrawn from school in order to join paid work directly or to help out with housework and sibling care while family members worked longer hours to make ends meet.

Regarding their occupation, majority of women of the sample were working in the informal sector earning a rather low salary. Unorganized sector occupations are characterized by casual, unprotected wages and an absence of contractual relations with employers. These women were working in this sector for their livelihood and were utilizing the earned income for the purpose of their children, education and family commitments.

However, in Chanda Nagar employment of a woman outside the home - as in many parts of India - was connected to disapproval from family members and kin. A woman's honour (*izzat*) could be endangered by her daily

leaving home for work. Therefore, some women were earning their livelihood in home-based activities, for example as piece rate workers engaged in embroidery. For majority of women however, there was no question whether to work or not outside the house – they had to go for work out of sheer poverty, socioeconomic necessities and financial pressures. Women did all different kinds of work outside their homes and took whatever and whenever employment was available – for example as day labourers or as domestic servant. Women worked to contribute to the household income and to support the subsistence of the family. Three women of this group were unemployed at the time of fieldwork, but desperately searching a job. For these women living in a slum, working was more of a necessity than a privilege brought on by their condition of poverty.

However, the fact that they contributed to the household income often inadvertently did serve to strengthen their bargaining position within the family. Working outside the home marked also an immense increase in mobility for these women, in opposition to middle-class women, who often faced limitations on their mobility and employment because of their husbands or in-laws. The working women living in Chanda Nagar were highly mobile because of their financial necessities.

All of the women are “ever married women”. The term “ever married” designates a person who has been married at least once, but is not necessarily married presently (at the time of fieldwork). Thus “ever married” women include all married, widowed, divorced or separated women.

The majority of women had either completed their reproductive career or had no intention of having more children at the moment of fieldwork. On the one hand these women were currently in the situation to make decisions on how to regulate their fertility by using contraceptive methods, and on the other hand they already had experience regarding its use, availability, and problems.

DESCRIPTION OF RESEARCH METHODS

The research of this paper is based on fieldwork, which I carried out in Chanda Nagar for 12 months altogether. Fieldwork methods were participant observation, unstructured and semi-structured interviews and the collection of life histories. Due to the very sensitive research topic the explorative phase[6] of fieldwork had to take a couple of months. This was especially important because the research site is a conservative Muslim area and it is a taboo to talk about topics like contraception, as these topics are still associated with sexuality. And as these issues were regarded as culturally taboo and not supposed to be talked about, it was not an easy endeavour to ask women questions about these issues.

I participated in the women's family activities, events, discussions and their general lives at home. Due to the fact that women were spending much of their time within the house, most participant observation took place there. Occasionally I accompanied women going out, for example visiting relatives and friends or going to the market and also participated in community activities like funerals, weddings, religious holidays and school events. In addition, interactions between women and health workers in maternity centres, at homes or non-governmental organizations (NGOs) were observed. By participating in women's daily activities I was able to share their current life situation and the different kind of pressures they were exposed to in their reproductive decision-making. All these day-to-day observations were recorded in detail into a fieldwork diary.

In conjunction with the participant observation semi-structured, open-ended interviews were conducted with forty women. In particular, the women were asked about general information related to their marriage, education, occupation, their contraceptive experiences, and their knowledge of Islamic legal tenets regarding contraception. The semi-structured interviews lasted between one and one and a half hour. The majority of interviews were conducted in Urdu, a minority of interviews in English. I also invested time to get to know the women while improving my

[6] The explorative phase is marked by collecting data, getting in touch with potential informants and establishing trust relationships with them.

Urdu language skills to the point where I felt sufficiently confident in an interview session. Only after a couple of months I started to ask questions regarding contraception. The interviews were tape-recorded and translated with the help of a local female research assistant.

Besides, life histories of individual women, which I came to know very well during my research stay, were collected. Life histories are very interesting for the analysis of reproductive health decisions, provide a background and besides a possibility to understand the cultural context in a much better way. These interviews were mostly conducted in the women's households, which in itself was a very challenging interview setting. Often, along with being interviewed, the women would simultaneously do housework. Some rooms were crowded with children so we would almost end up whispering to each other while talking about matters related to contraception. At other times men and women simply went in and out of the room interrupting the interview in process. Despite all the inconveniences, women came and spoke and were interested to help clarify issues, because as Shabana simply put it "It's a relief sometimes to empty one's heart out".

Expert interviews were conducted with a range of medical practitioners, including doctors, nurses, both governmental and non-governmental female health workers, and local midwives. These professionals provided important information on reproductive health issues and their opinion complemented the comprehension of women's notions.

The results of this research are not only based on qualitative, but also on quantitative data. Data of a Survey of the community, which had been conducted by a NGO working in the research area, has been used. The main objectives of the survey included mapping the households and developing a demographic profile of the community, assessing its' basic situation in the areas of health, education and livelihoods. One of the reasons, I decided to do my fieldwork in Chanda Nagar was the opportunity to work as a volunteer with the above mentioned NGO, who also worked on women's reproductive health issues.

Through my participation in the NGO, especially in their health centre activities I could establish good contacts to a number of women and medical doctors, but there arose of course also challenges because of my associ-

ation with this NGO[7]. There is no doubt that I was only able to enter the community through the friendship and help of NGO members. Finally, me being a woman was a great advantage when interacting with these women and asking them about their contraceptive practices. Due to my own female sex I had greater access to their world, which is rather private and more difficult to enter from outside.

REPRODUCTIVE HEALTH BEHAVIOR AND DECISION-MAKING IN THE CONTEXT OF SOCIO-CULTURAL NORMS, RELIGION, POVERTY AND WOMEN'S POOR STATE OF HEALTH

I argue that a range of factors, including socio-cultural norms, religion, socio-economic constraints and women's poor state of health, influences women's reproductive decisions and practices.

Socio-cultural norms

First and foremost, women's use of contraception is determined by the prevalent social and cultural norms in the community such as (early) marriages, the virtue of motherhood, the value of children and the woman's subordinated kinship-position at her natal and particularly conjugal home. Women's childbirth-rates are embedded in these social and cultural norms of northern India.

Marriage is nearly universal in India among Muslims as in other communities. Marriage in India, as in many other countries of the world, also points out the moment in a woman's life when sexuality and childbearing become socially acceptable. An unmarried woman cannot be legitimately a mother and this is the reason that in Chanda Nagar marriage remains near universal.

Besides being a wife, motherhood is still a much respected position for many Indian women. Because of the patrilineal system prevalent in North

[7] For example I found it difficult to balance NGO concerns with my own ideas of my duties to my assistants and study participants. When I decided to give gifts to women participating in my study or a wage to my assistants, this was viewed with great concern by NGO staff because I had set a precedent for future expectations. But after the many hours women had given, I felt it right to show my appreciation.

India, a woman leaves her natal home upon marriage to live at her husband's and in-law's home, where she has to start at the bottom of a hierarchy of women and men. The period of being married but not yet being a mother is a liminal stage in a woman' life. Uncertainty and fear prevail – and for her natal and conjugal family as well - as long as she has not given birth to a child, preferably a boy to perpetuate the patriarchal family line. Only by becoming a mother herself, will a woman be able to improve her relationship with her in-laws and in particular with her mother-in-law, so as to lead to an enhancement of her status at her conjugal home. By becoming a mother a woman's esteem will be doubled. And only by becoming a mother, a young married woman will be able to point out her identification with the household and gain a permanent position (cf. Jeffery, Jeffery & Lyon 1989; Jeffery & Jeffery 1996). The actual operation of this system was a bit diffused in an urban context such as Chanda Nagar. For example, only a part of the women lived with their joint families as many had separated from their in-laws when they migrated to Delhi. Often, women would live with their in-laws soon after marriage but would eventually shift to independent homes after some years. Still - all women were dependent on their families and if it was not their in-laws, husbands were determining their range of choices. And there were not only expectations from the family, but also from neighbours, or the community regarding the sex and number of children a woman should have. Therefore all women of the sample strived to give birth within the first or second year of marriage, and looking at the data most women had done so.

If a woman doesn't conceive within the first year of marriage or shortly after, she may become a subject of defamation by household members and neighbours. Infertile women still face severe social problems in present-day Indian society (Mishra & Dubey 2014: 160-161). For example, childlessness is considered inauspicious and childless women are not allowed to participate in any auspicious occasion particularly rituals related to childbirth. In India, women with children have a higher status within the family and in general (cf. Seal 2000; Jeffery & Jeffery 1996; Hussain 2008). And this applies also to the research area - women of reproductive age are highly respected as mothers and wives, but if they fail to meet these ideals for some reason, they become rather marginalised in the society of Chanda Nagar.

Thus, pregnancy and childbirth were seen to provide the primary identity of women. However, women generally attain a certain degree of autonomy as they get older, and eventually gain authority within the family if and when they become mothers-in-law themselves. The cyclical nature of this gender system ensures that women have an interest in maintaining gender roles to a certain extent (Kirmani 2013: 172).

Despite sons being preferred, all women declared that a family is not complete without daughters because both have special social characteristics and functions. It is important to have a son because he continues the father's lineage and it is only him, who is able to carry out the funeral rites for his father. However, a daughter is essential as she supports her mother with the household chores, by taking care of younger siblings, and is a huge social and emotional support. It was obvious that daughters were as welcome as sons for the women of Chanda Nagar. In addition, children are a valuable means of insurance in old age - there is no widespread or national system of social security in India, and women who have never been married or do not have children are often in a precarious position in old age.

Marriage, the virtue of being a mother and the value of children – all place a premium on the fertility of a woman and the importance of childbearing. Therefore, women barely try to prevent the birth of a child if they are freshly wedded. Women like to keep giving birth until both a daughter and a son were born; only at this point may they decide to stop childbearing and start to use contraception. The majority of young women considered two or three children to be enough, as long as one of them was a boy, and then decide for contraception. However, if couples have daughters only, most of them continue to have children until a son is born. Some women explained that they had more children, as they desired.

Within the family however, contrasting opinions were found regarding the ideal number of children. In general, the senior generation, in particular the mothers-in-law, were much more eager to get more children into the family than the younger generation. Women's reproductive interest was also in many cases separate and distinct from that of their husbands. Therefore negotiations pertaining to number of children may not necessarily reflect decisions of a "couple". However, there were women who did not share the idea of going on giving birth to children just because their moth-

ers-in-law or husbands insisted on it, especially if women felt they had enough children. These women regarded themselves as having the right to decide over their body, to conceive or give birth to a child, even if their mother-in-law or husband opposed their choice. Women – having reached their social optimum number of children or more – therefore went for example to a gynaecologist for the insertion of an IUD (intrauterine device), underwent a sterilisation or even resorted to an abortion. In these cases women sometimes went to arrange for contraception behind the backs of their in-laws or husband and secretly defied them. These women did submit to local hierarchies, but they also employed their own reason and listened to their body. They were not passive, although the constraints, under which they must resist or make their choices, were severe. The decision for and the use of contraceptive methods, despite prevalent social or familial objections, was a way for women in Chanda Nagar to achieve their own reproductive goals and challenge what presently prevailed as socially legitimate norms.

> Nafisa, married, 24 years old, two sons: "I have two small sons, therefore when pregnant again I decided for an abortion. Nowadays two children are enough and we couldn't afford another one, because my husband does not find work. If we can make both of them eligible it's enough. We are eight-nine people living in one room; there is no more space left. When my period was two weeks late, I went to a doctor to make a test. He transferred me to a public hospital where the abortion was carried out. Additionally, I underwent a sterilisation. After the operation I was very weak, however I didn't have any pain. My mother and my sister accompanied me to the hospital. They agreed with me on my decision. However, my mother-in-law didn't. I didn't tell her anything in the beginning. Not until four weeks after I told my mother-in-law about it and she became very angry".

Islamic Law

Women's own (reproductive) decision-making takes place not only in the context of family relations, but is also crucially connected to women's forms of knowledge framed by religious ideologies. Many women in Chanda Nagar exercised their own interpretation of religious sources to attain their own personal contraceptive objectives, which often differed from the dominant discourse.

The respondents in my study, ordinary women and men as well as religious experts, all had differing ideas on the Islamic law in regard to contraception. The authoritative, dominant religious knowledge in Chanda Nagar represented by males - husbands, fathers or religious authorities - prohibited the practice of contraception. Publicly, women in Chanda Nagar may share and follow the above mentioned male perception. On my question on the position of Islam on contraception, women answered most of the time very brief and casual "This is not allowed in Islam" or "Our religion prohibits it". Women usually referred to children as gifts or provisions of God, believing the individual number of children to be destined by God, and only him deciding whether it will be a girl or boy. One thing all women agreed upon was the prohibition of permanent methods of contraception like sterilization[8] based on religious grounds. Women considered sterilization to be a greater sin than the practice of any other form of contraception. Reasons mentioned were that sterilized people could not make the *hajj* pilgrimage to Mecca, and that such people's daily prayers would be invalidated or their fasts during *ramzan* would no longer be accepted by God. The main arguments women brought forward were that a sterilized woman's funeral procession could not be performed and her soul would forfeit its place in paradise (see also Jeffery, Jeffery & Jeffrey 2008: 519-548).

> Shanaz, 30 years old, married, three daughters: "The operation is not allowed in our religion, therefore it is a great sin. The operation is prohibited by God. Children are a gift of God. God will not forgive you an operation. When a sterilized woman dies, her funeral prayers will not be recited; her soul will stay in the graveyard and cannot go into heaven."

[8] Women never called the sterilization or tubectomy by name, but labeled it as *nasbandi* („tube closing") or „operation".

Consequently, the use of contraceptive methods was considered to interfere with God's will, and regarded as a sin (*gunah*). Women considered in particular sterilization in the context of Islamic law as forbidden (*haram*). One reason, why this view might prevail amongst women in Chanda Nagar is the following: The majority of women did not get much exposure to Islamic legal tenets, and in addition barely were able to read the predominantly Arabic scriptures themselves. They did not know much about Islamic law related to contraception and what they knew as based on a misconception that Islam forbids any method of contraception[9]. A social worker of Chanda Nagar explained it as follows: "People here have a misconception regarding the Quran and contraception; they think it is forbidden to use contraceptive methods and if they make use of it they won't come to paradise, but this is neither written in the Quran nor in the *hadith* (the collected sayings of the Prophet Muhammad). Still many people believe that if they use condoms after death their soul will not receive the last funeral prayer."

However, a high number of sterilizations were prevalent in the research area. When I talked to women a few months later, a much more complex picture emerged. There was a difference between what women publicly said about contraception in the context of Islamic law, and what they told me in private interviews. Many women asserted that according to public opinion birth control is in contrast to Islam, but almost in the same breath complained about poverty and their inability to rear and educate numerous children properly. For many women the hope of living a slightly better life

[9] However, within Islam or Islamic legal tenets there are a variety of theological positions on contraception. From a historical point of view Islamic texts as such do not present a major obstacle to practicing contraception. Religious experts often do have different ideas on Islamic prohibitions related to contraception, and the Indian *ulema* (religious scholars) in particular has developed strong religious attitudes against its practice. But a certain level of incongruity between Muslim perspectives that reject family planning as contrary to Islam on the one side, and an Islamic legacy permitting family planning on the other side prevail, which is absolutely nothing knew as such. Pointing out the variety of theological positions within Islam, the complex relationship between theological doctrines and everyday social practices, and the varied demographic situations in countries with Muslim populations challenge relatively easily the cruder arguments about linking Islam with high fertility due to supposed religious practices and counter further the general misconception that Islamic scriptures and religious leaders have an undue influence on determining the reproductive behaviour of Muslims (Jeffery & Jeffery 2000).

was a sufficient reason to practice contraception. Due to socio-economic pressures women decided to have a sterilization – problems such as feeding and rearing children were considered as more essential than the violation of Islamic law.

> Asma, 37 years old, deserted, two children: "The operation is prohibited in Islam and this is written in our scriptures. However, I had an operation, because two children are enough in these days. Children are expensive and I do not have the money. If you have much money, it is possible to have more children. When my son was just a baby, his father and my husband left our home and the family. Till now we don't know where he is. That year I did undergo an operation. I had an operation, because my husband had left me but might return any time. He didn't do any work, so I decided to get myself operated."
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> Roshan, married, two children, 40 years old: "I use a Copper-t (IUD) because there is not enough money to feed and clothe more children: even though the *maulana* and the elders are telling that in Islam birth control is prohibited. In Islam birth control is not good. But we have lots of sorrows on how to raise and feed our children therefore I use a Copper-T. However, I will not have an operation (sterilization), because this is a very big sin and the soul will not go up to heaven."

Other women expressed understandings of Islam that highlighted egalitarian values, and argued that it was actually not Islam that hampered women's rights and was to be blamed, but rather men caused women's oppression. Some women cited Quran verses proclaiming it a sin to have children and not being able to raise them properly. Here women referred to a verse in the Quran in which the quality of children rather than having any children is emphasized (Quran 37: 100). So these women, by pointing to the fact that it goes against Islamic law to have children if one is unable to raise them, used their own interpretation of the textual sources.

> Imrana, 25 years old, married, four children: "We use something (condoms) because we do not want to have more children. A child needs food, clothes and an education. Since two months I have stomach pain, but no money for treatment, how should we feed another child? It is a sin in Islam, if you have children and you cannot feed or educate them. If you can raise your children properly, it will be Allah's blessing."
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> Anisa, 36 years old, married, four children: "It is a sin to have an operation (sterilization), but all women here go for it. And it is a sin to use the oral pill. But it is also a sin to have too many children and if you can't provide for them clothes, food and education."

Another woman asked a religious leader for advice and confirmation whether her practice would be conforming to Islam. And other women believed their use of contraception (temporary as well as permanent) was religiously permitted because they had been diagnosed with health problems and it therefore was regarded as a necessity. Women also explained that God would understand their behavior because they were forced by external circumstances like their socio-economic situation to act accordingly. In these cases the Islamic legal rule "necessity knows no law" can be invoked.

> Farida, 30 years old, two children, married: "The one above knows that we do not have any money, therefore the safai karna (abortion) was necessary (majburi). With God my abortion is agreed. I believe and I know God will understand that I had no choice. Allah knows the limitations and situations that compel to do so."

Women understood and interpreted Islamic religious proscriptions regarding contraception differently and therefore not only were able to circumvent the prevailing public opinion, but also to act contrary to what the general Islamic norms in Chanda Nagar prescribe. Utilizing their personal religious interpretation to legitimize their contraceptive practices and to justify their situation to themselves, women were able to make their own reproductive decision-making based on the perception of what was best for them, and achieved their goal of stopping childbearing. In other words, women viewed, interpreted and manipulated their understandings of Islam in their own pragmatic ways.

This is not to say that Islam did not have an important place within women's narratives. Women emphasized that their use of contraceptive methods had nothing to do with being a good Muslim and that they lived an Islamic way of life. When talking to Ruksana (39 years old, deserted, four children) about contraception and Islam's view on it, she explained: "We do our daily prayers (*namaz*), we do the fasting, we read the *Quran* and we make the profession of faith (*shahada*). The fact that someone is sterilized has nothing to do with being a good Muslim." Women explained that although Islam was one of the most important issues in their life; they did not always agree on how it worked for them. Islamic doctrine was central to many aspects of women's everyday life, however not necessarily in regard to the issue of contraception.

Despite the often-represented opinion that Muslim women live in a context were Islamic rulings regulate their lives and in particular their fertility, women in Chanda Nagar manipulated, adopted or rejected Islamic legal tenets in regard to contraception to achieve their own goals. My research has shown that religion has a rather limited impact on women's fertility patterns. In addition, various surveys confirm that there is substantial practice of contraception among Muslims in India (Kulkarni 2010: 103). Socio-economic constraints are the main factor influencing women's reproductive decision-making.

Poverty

Chanda Nagar is a predominantly low-income settlement and poverty leads to the decision of a woman to have less children. In this research, poverty is not seen as just another variable with equal weight to other factors influencing women's reproductive decision-making process, but is depicted as one of the most important components permeating every level of a woman's live. Women stated that they desired a limited number of children and the reasons cited were mainly economic in character - they had to provide and secure food, education, medicine, and clothing to the children, which were costly. Any woman did not regard having many children as economically rational, and their explanations were always connected to the ubiquitous expression that it was very difficult these days to nurture and nourish children and to raise children properly.

Reasons to have fewer children also included the fact that children were no longer regarded as an additional labour power by their parents. Despite the fact that some children earned money and worked productively for their parents, they were seen rather as an economic burden than as financial contributors. Parents also tried to avoid having more than two daughters because of the high costs of dowry.

> Farida is 30 years old, married and has three sons and one daughter. She lives with her husband, four children and her mother-in-law in one and a half rooms of the size of 20 square meters. Her husband worked as a painter. He was self-employed but nowadays he is without work. Farida earned a little amount of additional money by doing embroidery at home; however at the moment she also had no orders to stitch clothes. When I asked her about her children, Farida told me: "Please note down how difficult the life for us women is here. The women here have many problems and sorrows. I cannot work, I do not earn money and I do not find any job. My husband gets 150 Rs (2,80 Euro) daily and from this amount my husband, our four children, my mother-in-law and me have to live. How can we pay for the school of the children, how can I pay the water, the electricity, the daily household items? My husband and I are using contraception because we do not want another child. A child needs good food and education. It has to learn to read and write. How should I in this situation nourish another child?“

Women's poor state of health and their use of contraceptive methods

Not only the impossibility of rearing numerous children properly due to economic constraints, but also the harm caused to a woman's health by repeated child-bearing, fears of maternal mortality, and the costs of medical interventions during childbearing affected the women's contraceptive practices. There was a high number of anaemia and malnutrition among women. The common ailments women mentioned they suffered from were back pain, headache and weakness. Women could not afford to buy medicine; diseases were not treated at all or only at an advanced state. Poverty

and lack of financial resources were powerful factors affecting the health of a large number of women in Chanda Nagar, younger and older ones alike. Accordingly, one reason why women desired to limit their number of children was their poor state of health.

Due to the urban location of Chanda Nagar a wide range of providers offering contraceptive methods exist and are easy accessible to most women. Women's sources of information on contraception range from "other women" to "female kin", "husband", "hospital", "health centre", "NGO", "village", "radio and television". It must be emphasized that the centralized family planning program in India has very visible promotional tactics. Consequently it is not surprising that most women have heard of contraceptive methods.

Nearly all women of the sample used contraceptive methods. The majority of them received methods and contraceptives, which were freely distributed by the government. The Family Welfare Program promoted sterilization (tubectomy), pills and IUDs (Intra-Uterine Devices) as the main methods. It comes as no surprise that majority of women received particularly these methods by government institutions (hospital, urban health care centers) and NGOs.

However, in the conversations women hardly ever referred to or mentioned any positive experiences with temporary contraception (oral pill, IUD, condom). Women mentioned medical side effects as well as perceived health hazards, which can be attributed to ethno-physical concepts assigned to temporary contraceptives. These perceptions were derived from the different forms of contraceptive knowledge women had, ranging from explanatory models rooted in traditional medical systems to interpretations or information gleaned from biomedical practitioners. For example, the majority of women believed the oral pill would dry up the blood in the body and lead to weakness, consequently they rejected it. Women additionally complained about not being told the advantages, disadvantages and complications of the contraceptives they opted for. So women's inadequate knowledge regarding these temporary contraceptives and their application was a major factor affecting its use. This and the various difficulties and inconveniences women had with the use of modern temporary contraceptives after some time led to the discontinuity or permanent change of temporary methods to a permanent method of contraception.

One prominent aspect of the contraceptive trajectories of women in the sample is therefore, that more than half of them had obtained sterilizations. Thus, even though some women explained that they could not obtain sterilization due to religious prohibition, they opted for it. Most women were forced to use government institutions, which provide different kind of reproductive health services for free as they could not afford to pay for the services provided by private hospitals or gynecologists. However, these governmental institutions were often marked by an inadequate quality of service and sometimes-coercive character in delivering services. A heavily criticized feature of the Family Planning Program was its preoccupation with sterilizations (Gupta 2000: 278). According to critics the Family Planning Program in India promoted sterilizations (tubectomies) over other methods since the latter require a better education and more monitoring; thus they are more troublesome than inducing women to terminate childbearing once and for all. Despite it's declared "cafeteria approach" which might have given women an option to choose from whichever form of contraception they wanted, such choices in reality were restricted by primarily promoting sterilizations, preventing usage of reversible methods, and inadequate facilities and information (Seal 2000). In addition, women explained that they have received monetary incentives after having a sterilization. These limitations of government services posed not only problems for women's reproductive choices, but for women's health in general. Thus, contraceptive services made available to women seem to capitalize upon their poor socio-economic status and gender situations.

CONCLUSION

In Chanda Nagar, women's reproductive decisions and practices, down at the level of the day-to-day realities, are determined by socio-cultural norms, socio-economic constraints, women's poor state of health and their use of governmental health facilities. My research has shown that Islam and its prescriptions is not the main driver for fertility patterns of women of this settlement colony. In other words, Islamic legal tenets do not necessarily have an influence on women's reproductive decision-making. Thus women construct reproductive lives that challenge overly deterministic understandings of the relationship between Islam and contraceptive practices (cf. Hussain 2008; Krehbiel Keefe 2006; Seal 2000; Unnithan-Kumar 2006). Further, various factors such as changes in costs of child rearing and perceived value of children have lowered desired family size and therefore led to a fertility decline amongst women of this low-income settlement.

Examining only quantifiable elements like number of children does not necessarily render a full picture of women's reproductive decision-making. Therefore I have also described the context and the specific conditions in which women's lives are embedded, as one has to understand the circumstances within which women's reproductive decisions take shape.

The narratives of Chanda Nagar women demonstrate that their lives were bound by a set of constraints, which were related to their social positioning and dependent on their husbands and extended families. Despite these constraints, women had their own chances of agency, e.g. when it came to contraception – this was true for their religious as well as their social context alike. The decision for the use of contraceptive methods, despite prevalent social or familial objections, was a way for women to achieve their own reproductive goals. In spite of all the hurdles that dominated women's lives, women were able to glean some kind of contraceptive information, network with other women with similar agendas and obtain for example a sterilization so they could make a reproductive choice. Women's agency is also crucially connected to their forms of knowledge framed by religious ideologies. Women's decision to practice contraception, even against religious objections, as well as their individual religious outlook and

thinking, enabled them to make their own reproductive choices based on the perception what was best for them.

Finally, this paper focuses on Muslim women; still my research has shown that socio-economic poor women of other religious identities such as Hindus or Christians in this low-income settlement shared almost the same social and demographic characteristics. Therefore I argue that poverty – not religion – is the main factor influencing women in Chanda Nagar in their reproductive decision-making and practices.

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