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Religious and sociological perspectives on reproductive rights: A qualitative case study of rural Muslim communities in Indonesia

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Abstract

This qualitative case study examines the fulfillment of reproductive rights among women during the childbearing period in a rural Muslim context in Indonesia. Data were collected through in-depth interviews with seven married Muslim women aged 20–45 years in North Lampung and were analyzed thematically using the Miles and Huberman framework. The findings reveal five main empirical themes: negotiated reproductive autonomy within Islamic family planning, structural and administrative barriers to reproductive health services, reliance on informal and religious sources of information, social pressure related to unplanned pregnancy, and limited recognition of reproductive and sexual coercion within marriage. Although participants showed growing awareness and adaptive agency, patriarchal norms, service constraints, and gaps in culturally responsive education continued to limit reproductive autonomy. These findings emphasize the need for gender-responsive and culturally sensitive reproductive health policies that integrate Islamic values, strengthen community-based education, and improve equitable access to reproductive health services in rural Muslim settings. (*Afr J Reprod Health* 2026; 30 [19]:104-117).

Keywords : reproductive rights; childbearing women; qualitative study; rural Muslim Indonesia

Résumé

Cette étude de cas qualitative examine l'exercice des droits reproductifs chez les femmes en âge de procréer, dans un contexte rural musulman en Indonésie. Les données ont été recueillies au moyen d'entrevues approfondies menées auprès de sept femmes musulmanes mariées, âgées de 20 à 45 ans, dans la région de Lampung Nord ; elles ont fait l'objet d'une analyse thématique fondée sur le cadre méthodologique de Miles et Huberman. Les résultats mettent en évidence cinq thèmes empiriques principaux : une autonomie reproductive négociée dans le cadre de la planification familiale islamique, des obstacles structurels et administratifs à l'accès aux services de santé reproductive, le recours à des sources d'information informelles et religieuses, la pression sociale liée aux grossesses non planifiées, ainsi qu'une reconnaissance limitée de la coercition reproductive et sexuelle au sein du mariage. Bien que les participantes aient fait preuve d'une prise de conscience croissante et d'une capacité d'agir adaptative, les normes patriarcales, les contraintes liées aux services et les lacunes en matière d'éducation culturellement adaptée continuaient de limiter leur autonomie reproductive. Ces conclusions soulignent la nécessité de politiques de santé reproductive sensibles au genre et à la culture, qui intègrent les valeurs islamiques, renforcent l'éducation communautaire et améliorent l'équité d'accès aux services de santé reproductive dans les milieux ruraux musulmans. (*Afr J Reprod Health* 2026; 30 [19]: 104-117).

Keywords: droits en matière de reproduction ; femmes en âge de procréer ; étude qualitative ; Indonésie musulmane rurale

Introduction

Gender is a construction of close social relations, with the distribution of roles, positions, and duties between men and women shaped by norms, cultures, and religions that vary across publics.¹ In a way, traditional construction socially places women

in roles of reproductive and parenting children, whereas men are more directed at the role of authority, House ladder and seeker living mainly. This role is often considered a nature that can be changed, even in a way.² No awareness. Keep going continuously; inherited good in the family and public-wide. Although there is already a lot of effort

in gender equality that is being echoed in society, norms and values, the cultural role women have attached to in society. Conditions: This limits a woman's role so that she can influence and make decisions only for herself and within the family.

Problems with reproductive health occur in developing countries, including in Indonesia. Problems. This is proven from the Maternal Mortality Rate (MMR) and the number of deaths among babies (AKB) tend to be tall^{3,4} case infection infectious sexual increase⁵ as well as low access to maintenance, health quality, and sexual and reproductive health. Conditions. This looks clear in Lampung Province, where the figures for maternal and baby are still high, cause main cause of maternal death is maternal covering bleeding, hypertension, and infection, as well as achieving unscheduled antenatal visits meet national targets. This data further shows that utilization of facility health is still low. This is related to the existence gap in literacy health reproduction to the public.

Real gender inequality is seen in the Family Planning (KB), where the use of contraception is still dominated by women. This is rooted in marginalizing gender ideology, women, and strengthen assumption that not quite enough answer reproduction only owned by them.^{6,7} The impact appears to be problematic health reproduction, such as socializing free teenagers, violence in the household (domestic violence), low exclusive breastfeeding coverage, a high number of deaths among mothers, and cases of bleeding during pregnancy.⁶

Reproductive health alone is understood as welfare, physical, mental, and social, not just free from disease.⁷ However, the benchmark measuring social and gender norms often hinders the fulfillment of rights. Survey Data Indonesia's Demographics and Health in 2021 shows a still high number of deaths among mothers, which is 15 thousand per year, or around two mothers die every hour. Besides that, the Central Statistics Agency reports the number of deaths of babies of 16.85 per 1,000 live births, improving compared to the previous year. This is a show of existence challenge in service health reproduction.^{3,4}

In Lampung Province, similar incidents also occurred. 2020 data showed 130 deaths, a mother of 154,967 births alive, improving from the previous year. The main causes of bleeding were covering bleeding (44 cases) and hypertension (24

cases). In North Lampung, the trend of maternal and baby deaths tends to rise, while coverage of antenatal visits K1 (94.6%) and K4 (88.7%) is still below the national target (North Lampung Health Service, 2020). The low literacy rate contributes to low utilization of health services.⁸

Problems. This does not let go of gender discrimination that still exists, taking root, as put forward in the EOCD report, that gender-based discrimination is rooted strongly in various social, both formal and informal, such as laws, norms, and cultural practices. Around 40% of women and children live in a country with high-level discrimination.⁹ Culture patriarchy puts women in a subordinate position, limiting access to the right to reproduction, and making them prone to exploitation. This is exacerbated by the bias of religious interpretation that places women only in the domestic sector, even though Islam itself emphasizes the principle of equality and human dignity (QS Al- Hujurat: 13). Islamic teachings place women in a position of honor, but social implementation often is not in line with these values.

Academic studies show the importance of a multidimensional approach to analyzing gender issues and the reproduction of rights. The first theory, Mubadalah, emphasizes the principle of reciprocity between men and women in understanding religious texts. The goal is to reverse patriarchal interpretations during this and to strengthen gender equality built on respect and welfare together.¹⁰ As a representation applicable from theory. This is in the relationship between husband and wife, who emphasize the principle mu'asyarah bill Ma'ruf, that is, each other completes, there is no dominance, and balance is maintained in rights and obligations. In The Construction of Social Theory, Berger & Luckmann introduce the idea that social reality is not naturally objective, but rather is formed by social interaction. Humans build collective perceptions through repeated communication and habits, which then form permanent, irreversible institutions, only to be shaken by the next generation.¹¹ Temporary theory structural functional emphasizes the role of institutions, policies, and social structures in supporting or hindering the fulfillment of rights and reproduction. According to Talcott Parsons (1951), health is an important factor in social stability. Sick individuals are considered to have become a

standard deviation (sanctioned deviance) because they are no longer considered productive members of society. Therefore, society, through the medical system, regulates patients' rights and obligations to ensure the system runs smoothly.¹²

Despite the growing body of literature on reproductive health, gender equality, and Islamic perspectives on family planning, existing studies have largely focused on policy analysis, normative religious interpretations, or quantitative indicators of maternal health outcomes. Limited empirical research has examined how reproductive rights are actually understood, negotiated, and implemented by women during the childbearing period within rural Muslim communities, particularly in low-resource settings such as Indonesia. Moreover, previous studies rarely integrate religious frameworks with sociological analysis to capture the interaction between gender norms, family dynamics, health services, and institutional structures shaping women's reproductive autonomy. As a result, there remains a lack of context-sensitive evidence to inform reproductive health policies and programs that are both gender-responsive and culturally grounded. This study addresses this gap by employing a qualitative case study to explore the implementation of reproductive rights among rural Muslim women in Indonesia and to propose an empirically informed model for fulfilling reproductive rights during the childbearing period.

Methods

Research design

This research employed a qualitative approach with a case study design. This approach was chosen because it was deemed appropriate for in-depth exploration of the experiences, perspectives, and meanings constructed by rural Muslim women regarding their reproductive rights within specific religious and socio-cultural contexts. The research was conducted in the Kotabumi Udik Community Health Center (Puskesmas) working area, North Lampung Regency, Lampung Province, Indonesia.

Population and research participants

The population in this study was married Muslim women residing in the Kotabumi Udik Community Health Center (Puskesmas) work area. Participants

were selected using purposive sampling, which involves deliberately selecting informants based on criteria established in accordance with the research objectives. Inclusion criteria included: (1) married Muslim women; (2) aged 20–45 years; and (3) direct experience with pregnancy, childbirth, and postpartum care. A total of seven women were selected as study participants. This number was determined based on the principle of data saturation, which means that when no new themes or information are identified from consecutive interviews, data collection is discontinued.

Data collection procedure: In-depth interviews

Data were collected through semi-structured in-depth interviews using a pre-developed interview guide. The interview guide covered key themes, including: reproductive rights, decision-making related to family planning, access to reproductive health services, and the influence of religious and social values on participants' reproductive practices. Each interview session lasted approximately 45–60 minutes and was conducted in a private setting to ensure participant comfort and openness. With participant consent, all interviews were recorded using an audio recorder. In addition to the recordings, the researcher also took field notes to document context, nonverbal expressions, and situational observations not captured verbally.

Data analysis procedure

All interview recordings were transcribed verbatim into written text. The transcribed data were then analyzed using thematic analysis, referring to the Miles and Huberman analytical framework, which consists of three main stages: (1) data reduction, namely the process of sorting and focusing relevant data; (2) data presentation, namely organizing data into meaningful categories; and (3) conclusion drawing and verification, namely identifying key themes that answer the research questions. The analysis process was carried out iteratively until a deep and comprehensive understanding of the phenomenon under study was obtained.

Ethical considerations

This research was conducted in accordance with the ethical principles of research involving human

subjects. Ethical approval was obtained from the authorized Health Research Ethics Committee before data collection began (Approval Number: 549/KEPK-TJK/XII/2024, dated December 10, 2024).

Before the interviews, each participant was given a complete and comprehensive explanation of the research objectives, procedures, potential risks and benefits, and their rights as participants. Written informed consent was obtained from all participants before participation began. Participation in this research is voluntary, and participants are free to refuse or withdraw from the study at any stage without any consequences.

To ensure confidentiality and anonymity, all personal identifiers are removed from the interview transcripts and replaced with pseudonyms. Research data are stored securely and are accessible only to the research team.

Results

Study This involved seven informant women from various backgrounds, aged 27–50 years, with status as mothers, pregnant, or who have once undergone pregnancy and childbirth. Most of our users serve health in the District of Kotabumi Udik, North Lampung, with level access information and support for various families. To what extent do the indicators fulfill rights reproduction, based on interviews with seven informants, based on an integrative approach, including a normative and social structural perspective, obtained findings as follows:

Islamic family planning: utonomy, norms, and service gaps

The participants demonstrated a comprehensive understanding of reproductive rights, encompassing the right to marry, have children, determine family size, and select contraceptive methods, derived from personal experience, health personnel, social media, and religious values.

In practice, these decisions are heavily anchored in the principle of mutual consultation (*musyawarah*) between husband and wife. Participants affirmed that determining the number of children is a shared right that must be agreed upon ("I know if amount child That right my

husband and I, we must *Agreed* (sepakat)"), though they stressed the husband's crucial consent for significant medical actions like sterilization, viewed as safeguarding life.

As P2 stated, "We are must deliberate, no Can wife refuse so just. But yes still may set child, origin agreed." Nevertheless, the actual exercise of these rights is constrained by economic limitations, uneven access to information, and pressure from the extended family regarding specific contraceptive choices. Regarding family planning implementation, a gap exists between awareness and reality. Some pregnancies occurred unplanned due to forgotten contraception or delayed recognition of early signs. Furthermore, a strong social stigma dictates the dominance of female contraceptive methods;

P2 noted, "It seems man use condom That shame, no Anyone want it admit it." Despite these barriers, the decision by some women to undergo sterilization, particularly those with high-risk health histories (e.g., hypertension, complicated labor), demonstrates their relative autonomy in making reproductive decisions, though always contingent upon spousal agreement. Partner support, such as husbands accompanying them to health facilities, is vital, while the extended family frequently serves as a source of social pressure.

Gaps are also evident in the access to and quality of health services. Most women opted for private services (midwives/doctors) rather than public facilities such as Posyandu and Community Health Centers, citing the latter as unfriendly and uninformative. P1 complained, "Health services can yeah Miss... what does it mean? if for example, check-check delivered to Home the country's sickness [Government Hospital]... still Lots complaint not enough friendly." This unfriendliness, coupled with limited information, geographic difficulty, and administrative challenges with *BPJS* utilization, pushed women toward more comfortable and informative private care.

To cope with these systemic limitations, women developed personal adaptive strategies, combining physical efforts (rest to reduce stress) with spiritual activities (prayer, *dhikr*, *istighfar*, and speaking with the fetus) as a personal and spiritual means of maintaining their own and their baby's reproductive health.

Reproductive health services: access, quality, and informational gaps

Participants' accounts revealed structural barriers that shape their reproductive choices and access to services. These barriers included administrative barriers related to BPJS (Social Security Agency for Health), geographic distance to public health facilities, and perceived hostility from health workers. One participant explained, "I have BPJS, but the private midwife clinic I usually visit doesn't partner with BPJS, so I still have to pay" (P5), while another stated, "At the community health center, they just weigh me and give me vitamins, without any explanation (a sign of education)" (P4). In addition, women reported gendered expectations within families that positioned reproductive responsibility primarily on women, particularly in contraception use. Such accounts illustrate how institutional practices and social norms interact to limit women's practical access to reproductive rights, rather than reflecting formal denial of services.

The quality of public services provided by Integrated Health Posts (Posyandu) and Community Health Centers is often evaluated negatively. Participants described the staff as unfriendly, with service delivery being purely procedural and lacking vital information. P4 lamented, "I'm going to the integrated health post, but the officer was rude, just weighing only, no explanation, nothing," while P7 noted a perceived inequity in resource distribution: "I haven't once been able to milk or get biscuits from the health center, even though friends in the next village can." Consequently, most participants preferred private sector care midwives or private hospitals which they assessed as more comfortable, informative, and responsive, highlighting the perceived value of patient-centered communication (e.g., P5: "I regularly to Doctor Mahmud, the midwife is also friendly and can ask questions").

Although the role of health workers and cadres is acknowledged as potentially important (e.g., assisting with BPJS registration or control visits), interaction is not intense. Many participants reported a lack of closeness with these personnel and instead sought independent information. P2 noted, "I do not too near The same cadres, most ask questions to a friend or just Google it." This reliance

on informal channels is further driven by the limited scope of formal reproductive education. Participants reported receiving minimal information from formal health providers, leading the majority to seek knowledge from social media and peer experiences. For instance, P7 stated, "I know about ovulation test from Facebook, not from midwife," and P3 explained, "I often watch medical videos, you know, method drink drug from there," indicating a significant dependence on the internet for critical health information.

Islamic reproductive education services: normative foundations and institutional gaps

Islamic values serve as a core foundation for most participants' reproductive decisions. These decisions, related to family size, contraception, and sterilization, are generally grounded in principles of deliberation (*musyawarah*), accountability, and familial benefit as taught in Islam. However, this religious framework does not entirely negate gender hierarchy, as some participants acknowledged husband domination; P1 noted the unevenness in reproductive autonomy: "said the husband equivalent That if it 's in Islam if problem piety ... but if problem decision reproduction of course man right above We One level" (P1).

Beyond its normative role, religion is crucially utilized by informants as a psychological coping mechanism during the challenges of pregnancy and childbirth. Participants actively employ spiritual practices to manage stress and uncertainty. P2 shared her strategy: "If I tired or I'm worried, I *dhikr* or study the Koran. No may angry let the fetus No follow stress." Similarly, P3 viewed sterilization through a religious lens of responsibility and effort: "I feel sterile That part from endeavor. If Allah gives exams, I also have to maintain my trust in my body."

Despite the profound influence of Islamic values on attitudes and decision-making, there is a distinct absence of formally organized Islamic-based reproductive education services. No participants reported attending a formal class (e.g., a pregnant mother class or family planning counseling) that explicitly integrated a religious approach. Education on these matters is received informally, through religious lectures on social media, *taklim* assemblies, or family advice. This informal reliance is problematic, as P3 noted: "I

often find information through medical videos that also discuss side effects of Islam, which seems a half-hearted answer, wife takes care of pregnancy.” The formal health system fails to integrate this spiritual dimension, with P7 stating, “No, Once There is counseling that discusses religion directly, usually only about vitamins, food, and controlling pregnancy,” and P4 adding that Posyandu services, “At most, only just weigh and distribute the vitamins.” This condition highlights a significant weakness in integrating spiritual values into reproductive education services, despite the clear need and openness of rural Muslim communities to a religious approach for normative, motivational, and psychological guidance.

The right not to be forced to marry or give birth

The right to reproduction is understood as the right to determine alone the number and distance of pregnancy, including the right not to give birth if risky. Some say the decision was taken together with the husband without pressure from the family, “Two child enough . My husband and I already planned from the beginning, ” (P2). Meanwhile, others choose sterilization because of health reasons, “I am sterile Because Already No able . Husband agree, no one forced me to have children again .” (P3). However, there are those who are still hesitant to speak out about their wish, “I’m a quiet person, sis ... so there isn’t any special effort.” (P2). Experience complications in medical conditions like hypertension and repetitive surgery decisions. For no pregnancy again, “In the past I entered the ICU because of a fault fourth . After That I decided to be sterile . If someone told me I’m pregnant again, me opponent .” (P3).

Social pressure on unplanned pregnancy

Although no, there is coercion. For Keep going, giving birth, participants face social pressure in the form of stigma against presumed pregnancy, no planned or “not ideal,” such as delivered, “Family big blame I Because pregnant again . Even though I No plan , this because KB forgot . But husband support .” (P3). Support a couple, and in a number of cases, a family, giving room for a woman to determine alone when to stop giving birth, especially in moments where there is a medical risk.

However, the social stigma still becomes an obstacle for women to realize their reproductive rights in a full way.

Protection against sexual violence

Explicit accounts of sexual violence were not directly disclosed by participants during the interviews. However, several women described experiences that indicate unequal sexual relations and limited negotiation power within marriage. These experiences were often framed as “not in accordance with expectations” or expressed through silence rather than explicit labeling as violence.

For example, one participant stated, “*In Islam, a wife should not refuse her husband one-sidedly, but everything should be discussed*” (P2), suggesting the normalization of marital sexual obligations. Another participant acknowledged avoiding confrontation to maintain household harmony, “*I am a quiet person... I just follow and avoid conflict*” (P2). These narratives indicate that while overt sexual coercion was not reported, gendered power relations and limited awareness of sexual consent may constrain women’s reproductive and sexual autonomy. The findings reflect implicit vulnerabilities rather than documented cases of sexual violence and should be interpreted within this contextual limitation.

While the findings point to structural and relational constraints affecting women’s reproductive autonomy, the study does not claim the prevalence of sexual violence or systemic oppression. Instead, it highlights contextual vulnerabilities and power imbalances as reported by participants.

Discussion

This discussion section presents the empirical findings of this study within the framework of maternal health policy, service delivery, and reproductive rights-based care. The research findings align with global evidence showing that maternal health outcomes are not solely determined by clinical interventions, but also by the quality, dignity, and rights-based orientation of service delivery. Several studies published in reputable public health journals have demonstrated that women’s experiences receiving services, including respect, effective communication, and autonomy, are central factors in the effectiveness of maternal

health systems and policy implementation.^{13,14} In this context, integrating religious and sociocultural approaches into a rights-based maternal health framework has the potential to strengthen service responsiveness, particularly in rural Muslim communities where trust in health workers and cultural legitimacy play a crucial role.

Islamic family planning: Autonomy, norms, and service gaps

The research findings indicate that Muslim women interviewed have a strong understanding of pregnancy and childbirth management based on the principles of benefit (al-maslahah), deliberation (al-musyawah), and moral responsibility towards the family. According to Islamic teachings as stated in the Al-Qur'an, the fulfillment of reproductive rights is rooted in maqāsid al-syarī'ah, especially the protection of the soul (ḥifz al-nafs) and offspring (ḥifz al-nasl), as emphasized in the QS. Al-Baqarah: 195. Women interpret reproduction as a trust that must be safeguarded through personal health and responsible family planning.

Several studies confirm that this understanding aligns with the principle of maqāsid al-syarī'ah, where family planning in Islam aims to safeguard the rights of the nafs (self), the rights of the nasl (self), the rights of the mal (self), and the rights of the deen (self). Therefore, family planning is carried out with full awareness of family welfare from an Islamic perspective.¹⁵ Thus, these Islamic concepts go beyond simply regulating the number of children, but also emphasize the synergy between religious values, health, and women's rights.

However, in practice, women still face limited access to family planning information, stigma against contraception for men, and pressure from the family environment. Despite this, women demonstrate significant adaptive capacity through spiritual practices as a health protection strategy. These findings align with previous research showing that religious coping can reduce anxiety levels during pregnancy.¹⁶ A qualitative study in Indonesia found five main themes in women's spiritual experiences during pregnancy and childbirth: submission to God, spiritual meaning, self-control, belief in His help, and a sense of self-control.¹⁷ These findings align with the narratives of several informants in this study regarding spiritual coping as a buffer against the stress of pregnancy.

The implication of these findings is that health services need to integrate Islamic-contextualized reproductive education so that women can experience pregnancy and family life in a balanced, healthy, and dignified manner.

Reproductive health services: Access, quality, and information gaps

The findings of this study demonstrate a tendency for women to prefer private health services, while utilization of public service facilities through the BPJS (Social Security Agency) and health cadres remains relatively low. Dalinjong stated that acceptance of public health services is strongly influenced by the attitudes and behavior of health workers, the cleanliness of the facilities, and satisfaction with the overall quality of service.¹⁸ Many informants reported that services in public facilities are often merely procedural, including weighing, blood pressure measurements, and vitamin administration, without informative, empathetic, or empowering communication. Women's questions often go unanswered or are even ignored.

This situation is a serious problem. The National Commission on Violence Against Women (Komnas Perempuan) emphasizes that the right to information is an inseparable part of the right to reproductive health.¹⁹ Unequal communication within the health system can create informational vulnerability, a condition in which women make critical decisions without an adequate foundation of knowledge.²⁰

Regarding the role of health cadres, although they have the potential to bridge women's access to reproductive services, low levels of closeness and trust lead many women to prefer seeking information independently. Olaniran's research confirms that cadre effectiveness is largely determined by training, community trust, and the quality of relationships. Therefore, cadres need to be positioned not simply as extensions of the bureaucracy, but as agents of dialogue who understand the cultural and emotional context of the community.²¹ Similarly, Gupta's research also emphasizes the importance of community-based interventions that ensure cadres can function as responsive, contextual mediators.²²

Despite formally having BPJS (Social Security Agency for Health), many women do not

utilize it because the procedures are considered complicated or because trusted facilities are not partnered with BPJS. This situation reflects administrative exclusion, a situation where services are formally available but inaccessible due to non-medical barriers.²³ The universal health insurance system is designed to ensure equitable reproductive access, regardless of literacy level, geographic location, or social status.

It is worth noting that the women in this study were not passive in the face of the system's limitations. They actively seek information through social media, choose services that align with their personal needs and beliefs, and rely on religious practices and social solidarity. This reflects *reproductive agency* women's ability to manage their reproductive health in a system that is not yet fully responsive.²⁰ This finding is reinforced by Simonovich's study, which found that Muslim women tend to use spiritual coping and social networks as a complement to formal medical services, especially when access to or quality of services is low.²⁴ Thus, ideal reproductive health services are not merely medical services, but rather a social system that respects women's rights, choices, and dignity. Health care reform must move towards a rights-based, relational, and context-based approach, so that reproductive health can truly be enjoyed equally by all women.

Islamic reproductive education: Normative foundations and institutional gaps

This study reveals that although Islamic values are very influential in the lives of Muslim women, to date there has been no formal service system that accommodates the need for Islamic-based reproductive education. The Islamic values held by women also serve as psychological mechanisms for managing stress, fear, and uncertainty during pregnancy and childbirth. Informants reported that practices such as prayer, dhikr, and spiritual communication with the fetus were intended to foster psychological calm.²⁴

Spiritual coping practices during pregnancy have been shown to positively impact women's mental resilience and contribute to maternal and fetal health. Chehrazee recommends that healthcare providers integrate spirituality into prenatal care as a strategy to promote healthy lifestyles.²⁵

The lack of structured Islamic reproductive education leaves women reliant on informal sources such as religious studies, social media, and traditional traditions, which carry the risk of bias due to their lack of validated standards. Therefore, it is necessary to develop a reproductive education curriculum based on valid Islamic knowledge, aligned with modern health services, and contextualized to the realities of religious communities.²⁶ This kind of integration not only increases the effectiveness of services but also strengthens women's participation as active and empowered subjects in managing their reproductive health.

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The right not to be forced into marriage or childbirth

An analysis of women's rights not to be forced into marriage or childbirth shows that although there has been progress in women's awareness of bodily autonomy, its implementation is still hampered by unequal power relations, deep-rooted patriarchal values, and a weak legal protection system. This condition is rooted in a social construction that has long positioned women as instruments for fulfilling the demands of family and society, so that their reproductive autonomy is limited and their bodies are controlled by norms that do not originate from themselves.

A woman's right to refuse pregnancy for reasons of physical health or mental readiness is a fundamental right that must be guaranteed by the state, health workers, and society. Therefore, interventions are needed that focus not only on providing health services but also on strengthening

reproductive literacy, equalizing relationships within the household, and protecting women from legal coercion in marriage and pregnancy.^{27,28}

Social pressures on unplanned pregnancy

This research reveals that women face complex realities in managing their reproductive experiences. Although individuals have the capacity to make autonomous decisions, social pressure and stigma surrounding unplanned pregnancies present significant barriers to fulfilling reproductive rights. Stigma surrounding unwanted pregnancies and contraception has been shown to hinder women's access to reproductive health services.²⁹ Therefore, protecting reproductive rights is inseparable from educational efforts, social and cultural transformation, and the creation of safe spaces for women to express and pursue their reproductive choices with dignity.

Protection against sexual violence

Sexual violence is a serious violation of women's human and reproductive rights. Within the domestic sphere, this practice is often hidden behind the legitimacy of marriage, making it difficult to recognize and report, as it is considered a wife's obligation.³⁰ Research findings in Kotabumi Udik show that although women experience unequal power relations, they do not always recognize these situations as sexual violence. Low literacy regarding the principle of consent *in* reproduction reinforces the normalization of coercion, as many women view their reproductive role as an obligation as wives and do not recognize that it constitutes coercion.³¹ In patriarchal cultures, reproductive pressure from husbands or families contributes to low use of modern contraception and high rates of unwanted pregnancies.³²

These findings reflect a social structure that conceals domestic sexual violence. Inequality in gender relations, the normalization of sexual coercion, and the lack of education about the principle of consent are major factors that perpetuate violence. Although women exercise *agency* in responding to less-than-ideal conditions, this capacity remains limited and is not supported by formal protection from the existing system.

Therefore, structural transformation is needed, including education on sexual and

reproductive rights, legal reform that recognizes sexual violence within marriage, and strengthening services for victims at the grassroots level. Without these measures, sexual violence will continue to persist in silence, and women will continue to be victims of a system that fails to protect their bodies and dignity.

An integrative theoretical framework: Towards a model for fulfilling reproductive rights

Research conducted with seven Muslim women informants indicates that gender understandings and practices within the household are not static or entirely dominated by one party. Women are beginning to take an active role in decision-making and are demonstrating a growing awareness of their bodies and reproductive rights. However, reproductive rights as part of human rights are still often hampered by patriarchal culture, even when there is normative awareness that women have the right to their own bodies.

Mubadalah theory emphasizes the principle of mutuality and mutual respect in reproductive decision-making.^{10,33} However, in practice, deliberations that should be equal often end up being dominated by husbands. From a Social Construction perspective, patriarchal norms shape women's reproductive identities in such a way that they often defer decisions to men, even though personal experience and education have the potential to foster greater autonomy.³⁴ Meanwhile, the Structural-Functional approach highlights the role of families, communities, and health services in supporting reproductive rights, although these functions often do not function optimally due to male dominance and low service quality.

The novelty of this research lies in the simultaneous integration of the Qur'anic perspective and three theoretical foundations *Mubadalah*, Structural-Functional, and Social Construction in a single, unified analytical framework, particularly in the context of fulfilling mothers' reproductive rights during childbearing in Muslim families. This integration produces a model for implementing the fulfillment of reproductive rights that contains four contemporary theoretical dimensions: *Feminist Agency Theory*, *Ethics of Care*, *Feminist Social Reproduction Theory*, and *Progressive Islam*.

These four theories can be operationalized as follows:

Feminist agency theory^{35,36}, which aligns with *Mubadalah theory*, demonstrates how women can make informed decisions about their bodies and reproductive health, grounded in religious and social values. Its implementation model includes reproductive health training based on local and religious values in women's Islamic boarding schools, as well as premarital counseling based on mutual values.

The ethics of care theory³⁷ places dialogue and empathy at the center of reproductive decision-making, including as a collective process between couples and families. Its implementation model includes community clinics with counseling services, empathy-based couples training, and capacity building for health workers in empathetic communication.

Progressive islamic feminist theory supports the view that Islam not only allows women to manage their bodies and reproduction, but also encourages reciprocity and justice in domestic relations and the public sphere. The implementation model includes the development of a reproductive health fiqh module with inclusive interpretation, as well as support for religious fatwas regarding contraceptive rights and maternal health.

These four theories can be integrated in the form of a holistic transformative model which demands: (1) gender education across all social layers (*Mubadalah + Agency + Ethics of Care*); (2) changes in economic structures and public services (Social Reproduction + Structural-Functional); and (3) reform of religious interpretations and social norms (Progressive Islamic Feminists + Social Construction).

This model is implemented through three channels for fulfilling reproductive rights, namely: (1) Islamic-Based Gender Education; (2) Family Services and Counseling; and (3) Public Policy that is responsive to gender and cultural context.

Implications for maternal health policy and services

The findings of this study have important implications for maternal health policy and service delivery in rural Muslim contexts in Indonesia. The experiences of informants show that the fulfillment of reproductive rights during childbearing is not

solely determined by the availability of services, but rather by how these services are provided, accessed, and communicated. Structural barriers such as administrative limitations related to BPJS, geographic distance, and minimal communication between providers and service users reflect the gap between existing maternal health policies and women's actual experiences at the service level.

From a service delivery perspective, the preference for private midwifery practice underscores the importance of respectful communication, continuity of care, and trust in maternal health services. These findings suggest that public maternal health services including community health centers (Puskesmas) and integrated health posts (Posyandu) need to strengthen person-centered and culturally responsive care, particularly in rural areas. Training health workers in gender-sensitive communication and integrating reproductive education that recognizes women's social and religious contexts is expected to improve service utilization and satisfaction.

From a rights-based care perspective, this research demonstrates that women's reproductive rights are often negotiated within unequal gender relations and constrained by limited access to information. While formal policies have recognized women's right to maternal health services, these findings reveal gaps in its implementation at the household and community levels. A rights-based approach to maternal health care, therefore, requires not only the provision of services but also the empowerment of women as rights -holders through accessible information, informed consent, and equal decision-making. Integrating these principles into maternal health policies and frontline service delivery is essential to ensuring that reproductive rights are meaningfully fulfilled during pregnancy, childbirth, and the postpartum period.

In accordance with the description above, the novelty of this research particularly regarding the integration of four theories in one analytical framework in the context of fulfilling mothers' reproductive rights during childbearing in Muslim families is presented briefly in Figure 1.

Research limitations

This study has several limitations that should be considered when interpreting the findings. First, the

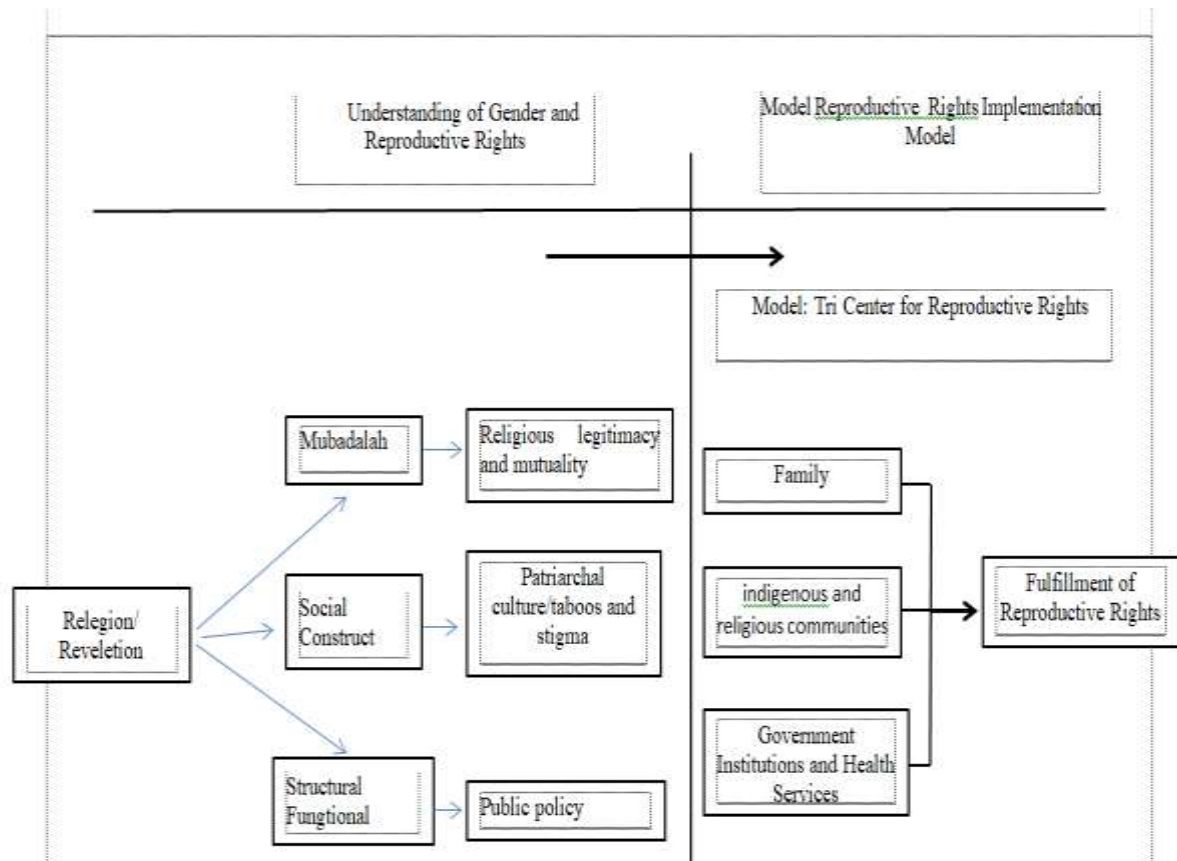


Figure 1: Model for implementing fulfillment of reproductive rights in childbearing families

use of a qualitative case study design with a limited number of informants, namely seven married Muslim women in the Kotabumi Udik Community Health Center (Puskesmas), North Lampung, means that the research findings cannot be statistically generalized to the broader population. These findings are contextual and reflect the specific experiences of the rural Muslim community in the region.

Second, data collection relying entirely on in-depth interviews has the potential to introduce self-report bias, where informants may not fully disclose sensitive experiences—such as domestic sexual violence or reproductive pressure due to prevailing social and cultural norms. This is particularly evident in the section on protection against sexual violence, where no informants explicitly identified their experiences as violence, despite indications of unequal power relations.

Third, all informants came from a single community health center (Puskesmas) working area, so the diversity of reproductive experiences of Muslim women from other rural areas in Indonesia

is not yet represented. Further research with a wider geographic scope and more diverse data triangulation methods such as participant observation and focus group discussions is needed to strengthen and expand the findings of this study.

Conclusion

Fulfillment rights of reproduction mothers in North Lampung still face a big obstacle that comes from the structural social norms, cultural norms, gender inequality, and weak institutional functions. Although there is a confession right formally, its implementation is no walk in the park. Dominance men, miscarriage trauma, access to limited services, and social stigma become the main challenges in realizing healthy reproductive health.

Fulfillment model rights reproduction can be developed by integrating several corner views (theory mubadalah, theory construction, social and structural functional theory) to be contemporary theories, where this approach demands: 1) Gender understanding at all social levels, 2) Change the

structure of the economy and public services, and 3) Reform of religious interpretation and social norms.

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Conflicts of interest

The authors declare that this research was conducted in the absence of any commercial, financial, or personal relationships that could be construed as a potential conflict of interest. This study received no external funding from any governmental, commercial, or non-profit organization. The research was conducted independently by the authors, and no sponsor or funder played any role in the study design, data collection, data analysis, interpretation of findings, or the decision to submit this manuscript for publication. All authors have read and approved the final manuscript and confirm that there are no competing interests to declare.

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Data availability

The data that support the findings of this study consist of audio recordings and verbatim transcripts of in-depth interviews with research participants. In accordance with the ethical principles applied in this study including participant confidentiality,

anonymity, and the terms of the informed consent obtained the raw data are not publicly available. However, de-identified and anonymized data may be made available upon reasonable request to the corresponding author (lisasuarni@poltekkes-tjk.ac.id), subject to ethical review and approval.

Author contributions

Lisa Suarni contributed to the conceptualization of the study, development of the research methodology, data collection, data analysis, interpretation of findings, and preparation of the original manuscript draft. Marzuki Noor contributed to theoretical framework development, critical review, and manuscript editing. Nilawati T. Sobri, Rini Setiawati, and M. Mawardi J contributed to data validation, thematic analysis, and critical revision of the manuscript. Bambang Budiwiranto contributed to supervision, conceptual guidance, and final manuscript review. All authors have read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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