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Wasatiyyah Islamiyyah and Reproductive Health Law: A Maqasid al-Shariah Framework for IUD Acceptability

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Abstract

The study aims to examine how the formal permissibility of intrauterine devices (IUDs) under Islamic law is interpreted and implemented at the community level in Semarang, as well as to develop a framework for Religion-Based Health Moderation based on its normative and empirical findings.

This study employs a normative-empirical legal design with a qualitative socio-legal approach. Normative data consist of studies of classical and contemporary fiqh, fatwas issued by Islamic scholars on family planning in 1972 and 1983, the views of Islamic organizations, and reproductive health regulations, while empirical data were obtained through semi-structured in-depth interviews with 20 purposively selected informants (10 family planning counselors and 10 contraceptive users, comprising five IUD users and five IUD refusers) across six community contexts.

The novelty This study identifies a gap in the transmission of religious legitimacy, namely formal permissibility mediated by the nearest religious authority, household decision-making, and the weak link between religious and biomedical counseling. This study also links maqasid al-shariah with the principle of wasatiyyah Islamiyyah and positions informed consent and reproductive autonomy as boundaries for religiously sensitive counseling.

Findings Four patterns emerged among informants: the nearest religious authority is more influential than formal fatwas; national fatwas are less well-known or less trusted by those who reject them; rejection is expressed through concerns about modesty, sustenance, and destiny, rather than the post-conception mechanisms debated by Islamic jurists; and counselors report limited capacity for religiously sensitive counseling and a lack of formal collaboration with religious leaders.

Study conclusions Formal religious permissibility does not automatically translate into religious legitimacy at the community level. This gap is shaped by how such permissibility is conveyed and interpreted through local authorities, households, and counseling institutions. The proposed framework includes proposals, which still need to be tested through intervention studies, for counseling that respects religious reasoning while upholding informed consent and reproductive autonomy.

Keywords: Maqasid al-Shariah; Wasatiyyah Islamiyyah; IUD Acceptability; Religious Legitimacy; Reproductive Health Law

Abstrak

Tujuan penelitian *ini mengkaji bagaimana kebolehan formal penggunaan alat kontrasepsi dalam rahim (IUD) menurut hukum Islam ditafsirkan dan diteruskan di tingkat komunitas di Semarang, serta menyusun kerangka Moderasi Kesehatan Berbasis Agama dari temuan normatif dan empirisnya.*

Metode Penelitian *menggunakan desain hukum normatif-empiris dengan pendekatan kualitatif sosio-legal. Data normatif berupa kajian fikih klasik dan kontemporer, keputusan ulama tentang keluarga berencana tahun 1972 dan 1983, pandangan organisasi Islam, dan regulasi kesehatan reproduksi, sedangkan data empiris diperoleh melalui wawancara mendalam semi-terstruktur dengan 20 informan yang dipilih secara purposif (10 konselor keluarga berencana dan 10 akseptor kontrasepsi, terdiri atas lima pengguna dan lima penolak IUD) di enam konteks komunitas.*

Kebaruan *Penelitian ini mengidentifikasi kesenjangan transmisi legitimasi keagamaan, yaitu kebolehan formal yang dimediasi oleh otoritas keagamaan terdekat, pengambilan keputusan rumah tangga, dan lemahnya hubungan antara konseling keagamaan dan biomedis. Penelitian ini juga menghubungkan maqasid al-shariah dengan prinsip wasatiyyah Islamiyyah dan menempatkan persetujuan tindakan (informed consent) serta otonomi reproduksi sebagai batas bagi konseling yang peka agama.*

Hasil Penelitian *Empat pola muncul pada informan: otoritas keagamaan terdekat lebih berpengaruh daripada fatwa formal; fatwa nasional kurang dikenal atau kurang dipercaya oleh para penolak; penolakan diungkapkan melalui kekhawatiran tentang aurat, rezeki, dan takdir, bukan mekanisme pascapembuahan yang diperdebatkan para fukaha; serta konselor melaporkan kapasitas konseling peka agama yang terbatas dan tidak adanya kerja sama formal dengan tokoh agama.*

Kesimpulan penelitian *Kebolehan formal menurut agama tidak otomatis menjadi legitimasi keagamaan di tingkat komunitas. Kesenjangan itu dibentuk oleh cara kebolehan tersebut diteruskan dan ditafsirkan melalui otoritas lokal, rumah tangga, dan lembaga konseling. Kerangka yang diusulkan memuat proposisi, yang masih perlu diuji melalui studi intervensi, bagi konseling yang menghormati penalaran keagamaan sekaligus menjaga persetujuan tindakan dan otonomi reproduksi.*

Kata kunci: *Maqasid al-Shariah; Wasatiyyah Islamiyyah; Penerimaan IUD; Legitimasi Keagamaan; Hukum Kesehatan Reproduksi*

1. INTRODUCTION

Indonesia has the world's largest Muslim population and a national family planning program that has worked alongside religious institutions for decades. Within that program the intrauterine device (IUD) is a long-acting reversible method with high clinical effectiveness.[1] It is also a minority choice. The 2017 Indonesia Demographic and Health Survey (IDHS), the official national survey, reports current use by method for currently married women, and an analysis of its data found that 1,422 of 34,086 respondents, or 4.17 percent, used an IUD; the denominator includes women who used no method.[2] Local studies of IUD selection report

[1] World Health Organization, "Family Planning/Contraception Methods," fact sheet (Geneva: World Health Organization, 2020), https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception.

[2] Badan Pusat Statistik, Badan Kependudukan dan Keluarga Berencana Nasional, Kementerian Kesehatan, and ICF, *Survei Demografi dan Kesehatan Indonesia 2017* (Jakarta: BPS, BKKBN, Kemenkes, and ICF, 2018), 118 (table 7.8

religious considerations among the factors behind refusal,[3] and research on contraceptive decision-making in Muslim families in Indonesia points in the same direction.[4] Because these studies are local, the national premise rests on the survey figure and not on them.

The difficulty is not that Islamic law forbids the method. Since 1983 Indonesian ulama have held the IUD permissible under conditions, after setting aside an earlier prohibition on the ground that insertion exposes a woman's aurat.5 The difficulty lies in the gap between this formal permissibility and lived religious practice, in which the same method is often treated as doubtful. For a law journal the gap raises a specific question: how can reproductive health law accommodate religious belief, which shapes how many women decide, without compromising the right to information and to free reproductive choice? Two normative orders are involved. A fatwa is a non-binding religious opinion whose force depends on the standing of its issuer and on acceptance by those who consult it.6 State law, by contrast, frames contraceptive services in terms of information, consent and individual choice.7 A woman deciding whether to accept an IUD stands between the two, and neither order guarantees that it reaches her in a form she recognizes as authoritative. Semarang, the capital of Central Java, is a useful setting for studying this because traditionalist, modernist and urban-pluralist Muslim communities live within a single administrative unit.

Maqasid al-shariah has become the main vocabulary for debating contraception in contemporary Islamic legal thought. It was systematized by al-Syatibi around five objectives: the preservation of religion, life, intellect, progeny and wealth.8 Recent work uses it to reassess 'azl and modern contraceptive practice,9 and to read the preservation of progeny (hifz al-nasl) as a qualitative standard of family wellbeing and not as a mandate to maximize births.10

gives current use by method for currently married women), https://archive.org/details/LaporanSDKI2017. The percentage reported here was calculated by Nina Indriyawati, Kun Aristianti Susiloretni, and Najib, "The Current Use Contraception in Indonesia," *Jurnal Kebidanan* 9, no. 2 (2019): 174–177, https://doi.org/10.31983/jkb.v9i2.5309.

[3] Hasrita Octaliana, Nurul Fatimah Susanti, and Endah Purda Listya, "Faktor Pemilihan Metode Kontrasepsi IUD di Puskesmas Singkut Kabupaten Sarolangun," *Sehatrakyat: Jurnal Kesehatan Masyarakat* 4, no. 2 (2025): 161–175, https://doi.org/10.54259/sehatrakyat.v4i2.4243.

[4] Nurhayati et al., "Decision-Making in Family Planning: Women, Planned Children and Contraceptive Methods in Muslim Family," *Mazahib: Jurnal Pemikiran Hukum Islam* 23, no. 2 (2024): 667–698, https://doi.org/10.21093/mj.v23i2.6632.

[5] La Jamaa, "Fatwas of the Indonesian Council of Ulama and Its Contributions to the Development of Contemporary Islamic Law in Indonesia," *Indonesian Journal of Islam and Muslim Societies* 8, no. 1 (2018): 41–45, https://doi.org/10.18326/ijims.v8i1.29-56.

[6] Muhammad Khalid Masud, Brinkley Messick, and David S. Powers, "Muftis, Fatwas, and Islamic Legal Interpretation," in *Islamic Legal Interpretation: Muftis and Their Fatwas*, ed. Muhammad Khalid Masud, Brinkley Messick, and David S. Powers (Cambridge, MA: Harvard University Press, 1996), 3–32.

[7] Undang-Undang Republik Indonesia Nomor 52 Tahun 2009 tentang Perkembangan Kependudukan dan Pembangunan Keluarga, arts. 23(1)(a), 24(2), 25(1); Undang-Undang Republik Indonesia Nomor 17 Tahun 2023 tentang Kesehatan, arts. 54(2)(b), 55.

[8] Abu Ishaq Ibrahim ibn Musa al-Syatibi, *Al-Muwafaqat fi Ushul al-Syariah* (Cairo: Mustafa Muhammad, n.d.), 221.

[9] Neng Nurcahyati Sinulingga, Endah Rundika Pratiwi, and Wildan Ansori Hasibuan, "Exploring Al-ʿAzl and Contemporary Contraceptive Practices: A Maqashid Al-Shariah Perspective on Population Regulation and Reproductive Morality," *Pharos Journal of Theology* 106, no. 4 (2025), https://doi.org/10.46222/pharosjot.106.4012.

[10] Mustamam et al., "Reinterpreting Ḥifẓ al-Nasl in Contemporary Marriage Contracts: Navigating Islamic

Systems-oriented accounts treat maqasid as an open framework for contemporary ijtihad and not a closed list.11 In Indonesia the Ministry of Religious Affairs has promoted wasatiyyah Islamiyyah, or religious moderation, through four operative principles: tawassuth (moderation), tawazun (balance), tasamuh (tolerance) and tasyawur (consultative deliberation).12

An empirical literature on religion and contraception has grown alongside this normative one. Research on Muslim women in Türkiye links perceived sinfulness to contraceptive behavior,13 and qualitative work in Saudi Arabia documents how women's reproductive health knowledge and experience are shaped by religious and cultural context.14 An intervention study with Muslim university students in Türkiye reported high acceptability of a sexual health education program designed for Muslim countries.15 Qualitative evidence from Burkina Faso, Kenya and Niger examines how young contraceptive users perceive religion's influence on their use,16 and a study of Kazakhstan identifies mediating mechanisms between religion and contraceptive use.17 Studies of rural men in Pakistan and of women's household decision-making in Ghana point to spousal authority as a determinant of contraceptive negotiation.18 An evaluation in Nigeria associates exposure to family planning messages from trained religious leaders with higher modern contraceptive use.19

For Indonesia, Menchik traces how Islamic law and the national family planning program

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Normativity and State Law," *MILRev: Metro Islamic Law Review* 4, no. 2 (2025): 1258–1280, https://doi.org/10.32332/milrev.v4i2.11158.

[11] Jasser Auda, *Maqasid Al-Shariah as Philosophy of Islamic Law: A Systems Approach* (London: International Institute of Islamic Thought, 2008).

[12] Kementerian Agama Republik Indonesia, *Moderasi Beragama* (Jakarta: Badan Litbang dan Diklat Kementerian Agama RI, 2019), 17–25.

[13] Figen Alp Yılmaz, "Family Planning Among Muslim Women in Türkiye: The Role of Sinful Beliefs, Sexual Function, and Violence," *Journal of Religion and Health* 64, no. 5 (2025): 3823–3835, https://doi.org/10.1007/s10943-025-02418-z.

[14] Noura Alomair et al., "Sexual and Reproductive Health Knowledge, Perceptions and Experiences of Women in Saudi Arabia: A Qualitative Study," *Ethnicity & Health* 27, no. 6 (2022): 1310–1328, https://doi.org/10.1080/13557858.2021.1873251.

[15] Özlem Karatana, Abdullah Beyhan, and Ayşe Ergün, "Effectiveness and Acceptability of a Sexual Health Education Program for Muslim Countries: An Intervention Study," *Archives of Sexual Behavior* 54, no. 4 (2025): 1617–1626, https://doi.org/10.1007/s10508-025-03111-8.

[16] Ilene S. Speizer et al., "Examination of Adolescent and Youth Modern Contraceptive Users' Perceptions on How Religion Influences Contraceptive Use and Their Rationale and Circumstances of Use: Qualitative Evidence from Burkina Faso, Kenya and Niger," *Journal of Population Research* 42, no. 1 (2025): art. 9, https://doi.org/10.1007/s12546-025-09362-5.

[17] Maxim Kan, "Religion and Contraceptive Use in Kazakhstan: A Study of Mediating Mechanisms," *Demographic Research* 50, art. 21 (2024): 547–582, https://doi.org/10.4054/DemRes.2024.50.21.

[18] Nazish Kanwal, Muhammad Ammad Khan, and Anaya Manahil, "Unveiling the Untold Narratives: Unraveling Rural Men's Perspectives on Family Planning in Pakistan," *Journal of Population Research* 42, no. 3 (2025): art. 23, https://doi.org/10.1007/s12546-025-09376-z; Francis Arthur-Holmes et al., "Safer Sex Negotiation Among Ghanaian Women in Sexual Unions: Does Women's Household Decision-Making Capacity Matter?," *Archives of Sexual Behavior* 52, no. 4 (2023): 1379–1387, https://doi.org/10.1007/s10508-023-02546-1.

[19] Sunday A. Adedini et al., "Role of Religious Leaders in Promoting Contraceptive Use in Nigeria: Evidence from the Nigerian Urban Reproductive Health Initiative," *Global Health: Science and Practice* 6, no. 3 (2018): 500–514, https://doi.org/10.9745/GHSP-D-18-00135.

accommodated one another over time.20 Triandani and colleagues analyze the tension among morality, religion and rights in Indonesian abortion law, which bears on the line fiqh draws between preventing conception and ending a pregnancy.21 A study of Betawi ulama documents the reasoning of the authorities that communities consult directly,22 and work on Kampung KB (family planning village) programs reads community-level family planning through maqasid and social capital.23

Read together, this literature leaves three gaps, stated relative to the sources reviewed here and not as an exhaustive survey. First, normative studies of jurisprudence and empirical studies of contraceptive behavior rarely meet in one analysis of a single contested method, so the formal permissibility of the IUD and its informal rejection are explained separately, if at all. Second, household and religious authority are repeatedly identified as determinants of contraceptive choice, but in the Indonesian setting the role of local figures such as kyai and ustadz is described more often than theorized. Third, wasatiyyah Islamiyyah is central to official religious policy, yet in these sources it appears mostly as a conceptual orientation and not as an analytical framework for reproductive health law tested against fieldwork.

This article responds with a concept and a framework. The concept is religious legitimacy transmission: the process through which a formally valid religious ruling becomes, or fails to become, an authoritative reason for action in a community, mediated by trusted local figures, households and counselling institutions. The framework, called Religious Health Moderation, relates maqasid al-shariah, the four wasatiyyah principles and this transmission mechanism to counselling practice, and sets informed consent and reproductive autonomy as limits on what religion-sensitive counselling may do. To the authors' knowledge, a combination of normative maqasid analysis with interview data on a single contraceptive method in an Indonesian urban setting has not been reported.

The article asks three questions. First, how does Islamic jurisprudential reasoning, read through maqasid al-shariah and hifz al-nasl, construct the permissibility of the IUD, and how do the ulama rulings of 1972 and 1983 and state regulation position it? Second, how is that formal permissibility received, interpreted and contested by IUD users, refusers and family planning counselors in six community contexts in Semarang? Third, what framework follows from these findings for religion-sensitive counselling that preserves informed consent and

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[20] Jeremy Menchik, "The Co-Evolution of Sacred and Secular: Islamic Law and Family Planning in Indonesia," *South East Asia Research* 22, no. 3 (2014): 359–378, https://doi.org/10.5367/sear.2014.0220.

[21] Salsabila Triandani, Windiahsari, Ali Masyhar, Aprila Niravita, and Rizqan Naelufar, "Abortion Laws in Indonesia and Islam: A Clash of Morality, Religion, and Rights," *Contemporary Issues on Interfaith Law and Society* 3, no. 2 (2024): 283–308, https://doi.org/10.15294/ciils.v3i2.31407.

[22] Aida Humaira et al., "Betawi Ulama's Perception of the XXI Century Against Contraception Law Controversy in Population Control," *Samarah: Jurnal Hukum Keluarga dan Hukum Islam* 6, no. 2 (2022): 934–953, https://doi.org/10.22373/sjhk.v6i2.12936.

[23] Nur Lailatul Musyafa'ah, "Analisis Program Kampung Keluarga Berencana Perspektif Maqasid Al-Syari'ah (Studi di Kampung Logam Ngingas Waru Sidoarjo Jawa Timur)," *Al-Manahij: Jurnal Kajian Hukum Islam* 13, no. 2 (2019): 259–279, https://doi.org/10.24090/mnh.v13i2.3132; Klaudia Evinta Siregar et al., "Utilization of Social Capital in Managing Family Planning Village Programs in Rural Communities in Indonesia," *Forum for Development Studies* 50, no. 2 (2023): 351–370, https://doi.org/10.1080/08039410.2023.2178501.

reproductive autonomy? The contribution is twofold. Theoretically, it distinguishes information failure from competing normative authority as separate reasons why a permissive fatwa does not produce acceptance. For legal and policy practice, it states conditions under which religious actors can be engaged in reproductive health counselling without displacing the woman's own decision.

2. METHOD

This study uses a normative-empirical legal research design with a socio-legal qualitative approach.[24] The normative dimension examines classical and contemporary Islamic jurisprudence, the ulama rulings on family planning of 1972 and 1983, positions of Islamic organizations reported in the literature, and Indonesian reproductive health regulation. The empirical dimension examines how the formal permissibility of IUD use is received, interpreted and contested at the community level in Semarang. The Religious Health Moderation framework was developed through a synthesis of the two, by relating the empirical themes to maqasid al-shariah and the four principles of *wasatiyyah Islamiyyah*.

Semarang City, Central Java, was chosen because Nahdlatul Ulama traditionalist, Muhammadiyah modernist and urban-pluralist Muslim communities coexist within one administrative unit, which allows variation in religious orientation to be examined within a single urban context. The fieldwork covered six community contexts, labelled A to F.

Participants were selected purposively according to their direct involvement in IUD counselling or contraceptive decision-making. Twenty informants took part: ten family planning counselors (midwives, coded TK-01 to TK-10) and ten contraceptive acceptors. The acceptors comprised five IUD users (AK-P01 to AK-P05) and five women who had refused the IUD (AK-N06 to AK-N10). Table 1 shows how the informants were distributed across the six contexts.

Table 1. Community contexts, counselor tenure and informant distribution (Semarang field sites)

Community context	Counselor (tenure)	Acceptor informants
Community A, Semarang	TK-10 (12 yrs)	AK-P01 (user); AK-N07 (refuser)
Community B, Semarang	TK-08 (10 yrs)	AK-N06 (refuser)
Community C, Semarang	TK-01 to TK-05 (wave 1)	AK-P02 (user); AK-N08 (refuser)
Community D, Semarang	TK-09 (6 yrs)	AK-P03 (user); AK-N09 (refuser)
Community E, Semarang	TK-06 (14 yrs)	AK-P04 (user)
Community F, Semarang	TK-07 (17 yrs)	AK-P05 (user); AK-N10 (refuser)

Source: Authors' data.

Semi-structured in-depth interviews were conducted in July 2026 with an interview guide

[24] Soerjono Soekanto and Sri Mamudji, *Penelitian Hukum Normatif: Suatu Tinjauan Singkat* (Jakarta: RajaGrafindo Persada, 2015); Peter Mahmud Marzuki, *Penelitian Hukum* (Jakarta: Prenada Media, 2017).

covering religious reasoning, sources of religious information, counselling experience, perceptions of the national fatwa and household decision-making. Quotations from the interviews are reproduced below in English translation. Interview data were analyzed thematically through transcription, initial coding, categorization and the development of cross-case themes. The normative and empirical findings were then integrated to identify the mechanisms through which formal religious permissibility was transmitted, interpreted or contested.

Credibility was supported through source, method and theory triangulation and member checking, following established criteria for qualitative trustworthiness.25 Participant identities were protected through anonymization and coded identifiers. All informants took part voluntarily and gave their consent after the purpose of the study was explained to them. No ethics committee clearance number was issued for the study, so informed consent and anonymization were the only safeguards applied, which is a limitation.

The design has limits that shape what the findings can support. The sample is small and purposive, drawn from one city. Acceptors were women, and husbands and religious leaders were not interviewed, so accounts of household decisions and of religious authority are the informants' own representations. The findings describe patterns in these accounts and are not statistical or generalizable to other regions.

3. DISCUSSION

3.1. The Normative Baseline: Permissibility in Islamic Legal Reasoning and State Law

The normative sources reviewed for this study treat the IUD as permissible in principle. A limited consultation of ulama convened by the Department of Religious Affairs on 26–29 June 1972 concluded that the family planning program was permissible (*mubah*) under Islamic law, and distinguished the regulation of births (*tanzhim al-nasl*) from their restriction (*tahdid al-nasl*).[26] The ruling that addresses the IUD directly came later. In 1971 eleven ulama had prohibited the device because insertion requires a male doctor to see the woman's *aurat*. A National Conference of Ulama on Population, Health and Development held in Jakarta on 17–20 October 1983 then held family planning justified for the health of mothers and children and the use of the IUD permissible under conditions on who inserts it, which corrected the earlier ruling.[27] Among Islamic organizations, the 1989 national congress (Muktamar) of Nahdlatul Ulama allowed the spiral together with *'azl* or other contraceptives,[28] and the Majelis Tarjih of

[25] Yvonna S. Lincoln and Egon G. Guba, *Naturalistic Inquiry* (Beverly Hills, CA: Sage Publications, 1985).

[26] Rista Laily Prestyana and Gandhung Fajar Panjalu, "Pembatasan Keturunan (Tahdid Al-Nasl): Studi Komparasi Fatwa MUI dan Putusan Majelis Tarjih Muhammadiyah Perspektif Maqasid Syariah," *Maqasid: Jurnal Studi Hukum Islam* 6, no. 2 (2017), https://journal.um-surabaya.ac.id/Maqasid/article/view/1364.

[27] La Jamaa, "Fatwas of the Indonesian Council of Ulama," 41–45. La Jamaa attributes the 1971 ruling to the Indonesian Ulema Council (MUI). MUI was founded in 1975, so this article describes the 1971 ruling as one issued by eleven ulama, and it treats the 1983 conference fatwa as the national fatwa on the IUD that informants associated with MUI.

[28] Abdul Hakim, Ridzwan Ahmad, and Syed Mohd Jeffri Syed Jaafar, "The Methodology of Reforming Islamic Law Fatwa Bahthul Masail Nahdhatu Ulama in Family Planning (KB) in Indonesia by the Maqasid Shari'ah Approach," *Al-*

Muhammadiyah permits preventing or spacing pregnancy in an emergency, such as a risk to the mother's life or health, with the consent of both spouses.[29] What remains open for the IUD is the classification of its mechanism. Classical jurists accepted *'azl* because it acts before fertilization, so a method is licit where it is understood to prevent conception and doubtful where it is understood to act after fertilization, which brings it close to abortion.[30] Legal analysis of abortion in Indonesia and Islam describes the tension among morality, religion and rights in which that line is drawn.[31]

Maqasid reasoning shifts the weight of the analysis. *Hifz al-nasl* can be read qualitatively as protecting the wellbeing of children already born and of the family, and not as a duty to maximize births. On that reading birth spacing serves the objective.[32] Maternal protection falls under *hifz al-nafs*, the preservation of life, and the maxim that averting harm takes precedence over securing benefit supports giving weight to a mother's health in contraceptive choice.[33]

A fatwa, however, is not legislation. It is an opinion given by a qualified jurist or body in answer to a question, and its authority depends on the standing of the mufti and on the acceptance of those who consult it.34 State law works differently. Indonesian population and health legislation frames contraceptive services in terms of access to information and counselling,35 medical procedures require the patient's consent,36 and Indonesia has accepted the obligation to ensure women's right to decide freely and responsibly on the number and spacing of their children and to have the information to do so.37 The normative baseline therefore has two parts: a religious permission that carries moral authority for those who accept its source, and a legal framework in which the woman's informed consent is the condition of the procedure. The empirical question is not whether permission exists but how, and whether, it reaches the woman who decides.

3.2. Religious Reasoning among Informants in Semarang

The findings below describe the twenty informants and make no statistical claim. All five IUD users described obtaining some form of religious reassurance before they decided to have the device fitted. AK-P01 described the sequence plainly: she heard a worrying rumor at her local recitation group (pengajian), then took the question to a religious teacher she trusted.

"At first I was quite hesitant. I had heard at the pengajian that the IUD was not good

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Manhaj: Jurnal Hukum dan Pranata Sosial Islam 5, no. 1 (2023): 940, https://doi.org/10.37680/almanhaj.v5i1.2934.

[29] Prestyana and Panjalu, "Pembatasan Keturunan."

[30] Sinulingga et al., "Exploring Al-ʿAzl."

[31] Triandani et al., "Abortion Laws in Indonesia and Islam."

[32] Mustamam et al., "Reinterpreting Ḥifẓ al-Nasl," 1270.

[33] Mohamad Daud Ali, *Hukum Islam* (Jakarta: Raja Grafindo Persada, 2005), 64.

[34] Masud, Messick, and Powers, "Muftis, Fatwas, and Islamic Legal Interpretation."

[35] Undang-Undang Nomor 52 Tahun 2009 tentang Perkembangan Kependudukan dan Pembangunan Keluarga, arts. 21(1), 23(1)(a); Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan, art. 55.

[36] Peraturan Menteri Kesehatan Republik Indonesia Nomor 290/MENKES/PER/III/2008 tentang Persetujuan Tindakan Kedokteran, arts. 2(1), 16(1).

[37] Convention on the Elimination of All Forms of Discrimination against Women, December 18, 1979, 1249 U.N.T.S. 13, art. 16(1)(e); ratified by Indonesia through Undang-Undang Nomor 7 Tahun 1984.

because it disturbs the womb. But I asked the ustadz in my neighbourhood directly, and he happened to be fairly open-minded. He said family planning is allowed if it is for the good of the family and does not end offspring permanently. After hearing his explanation, my heart was at ease and I finally dared to have the IUD fitted (AK-P01)."

The reassurance came through different channels. AK-P05 found it in a women's recitation circle, where peers who already used the device shared their experience and their reading of its legal status. AK-P03 heard it from her sister, who took part in religious study sessions and explained that recognized scholars treat birth spacing as permissible when the intention is sound. AK-P02 and AK-P04 relied on young preachers on Instagram and TikTok and on written fiqh material, without consulting a local authority in person. None of the five users reported hostility from neighbors, family or recitation peers afterward. AK-P01 had told her recitation friends in advance that she had consulted an ustadz, and in her account this removed objections before they arose.

The five refusers also reasoned in religious terms, but their reasoning pointed the other way, and their objections fell into three moral idioms. The first concerned the exposure of the aurat besar during insertion. This is the ground on which eleven ulama prohibited the device in 1971 and which the 1983 conference later corrected,[38] so the objection appears to have outlived the ruling that answered it. AK-N06 traced it to a religious leader she follows.

"The ustadz who leads our pengajian once said that fitting a device like the IUD involves the aurat besar that ought to be guarded, so it is better avoided if another method exists. I believe him completely, because he has long been a role model in my community. I have never heard of that MUI fatwa (AK-N06)."

The second idiom framed the IUD as a barrier to rezeki, the sustenance God has apportioned, including in the form of children. AK-N07 and AK-N08 reasoned this way, and neither could name the authority behind the claim. AK-N07 had absorbed it from short sermons circulating on Facebook and in WhatsApp groups. The third idiom cast the device as resistance to takdir, the divine decree over how many children a family will have. AK-N09 and AK-N10 held this view, and AK-N09 drew it from a strict study circle in her community.

The clinical concern that dominates scholarly debate, that the IUD may act after fertilization and so resemble abortion, did not surface in those terms in any refuser's account. The refusers spoke of modesty, sustenance and destiny and not of implantation. Two further patterns ran through the group. First, all five refusers were either unaware of the national fatwa or did not trust it, and AK-N07 said the emotional pull of a social media sermon outweighed an official ruling she could not verify. Second, four of the five said they would reconsider if a religious figure they trusted explained that the IUD is permissible, preferably with a clear scriptural basis. Only AK-N09 held firm, because she treats her takdir-based objection as more basic than any single ruling. In every case the women described the decision as shared with husbands and family members who held the same view.

The ten counselors confirmed the demand side of the problem and added an

[38] La Jamaa, "Fatwas of the Indonesian Council of Ulama," 43–45.

institutional one. Religious objections were routine in their practice. TK-08, at a community health center in Semarang, estimated that most of her patients resist the IUD at first, and she attributed this to the influence of religious leaders.

> *"There is no formal cooperation at all. The religious leaders here run their own recitation circles, and we at the health center run our own programs. Yet they have an enormous influence on people's decisions, even greater than our explanation as health workers (TK-08)."*

All ten counselors, across the community contexts studied, reported that no formal collaboration existed between their health facility and local religious figures. They also agreed that a purely medical explanation rarely moves a patient who has already decided on religious grounds. TK-06 said her clinical account of the device passes by like a breeze, heard and nodded at, then set aside, and TK-10 described patients who listen politely and decide as before. Without institutional support the counselors improvised. TK-06 anchored her counselling in the dominant legal school among her patients while acknowledging that her own command of fiqh was thin. TK-09 named recognized scholars and rulings to borrow their authority and still felt she needed support from a source the community trusts more than a midwife. TK-07 and TK-10 preferred a patient, personal approach to direct argument. In the counselors' accounts none of these approaches came from formal training.

3.3. Analysis: How Formal Permissibility Fails to Become Community Legitimacy

The findings can be read through the distinction between law in the books and law in action, which directs attention to the gap between a rule's formal standing and its practical operation.39 The distinction needs care here because the national fatwa is not state legislation. It has no sanction and no enforcement apparatus, and it binds only those who accept the authority of its source.40 The article therefore uses the distinction analytically, to separate a formally valid religious norm from the religious practice of the communities studied, and not to equate the fatwa with a statute. Legal pluralism supplies the complementary point: where several normative orders operate in one social field, the order a person follows in a given decision depends on which she recognizes as authoritative.41

In the Semarang accounts, acceptance and refusal both flowed from the nearest trusted voice and not from the national council. The same mechanism produced opposite outcomes. AK-P01's open-minded neighbourhood ustadz moved her toward the device, and AK-N06's cautious religious leader moved her away from it. What differed was the stance of the proximate transmitter and not the doctrine available to either woman. TK-08 reached the same view from the counselor's side when she judged religious leaders' influence to be greater than her own. The comparative literature is consistent with this reading in general terms: studies of local religious authority, religious leaders' messages and household gatekeeping treat the messenger and the household as important to contraceptive outcomes.42 A study of Betawi

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[39] Roscoe Pound, "Law in Books and Law in Action," *American Law Review* 44 (1910): 12–36.

[40] Masud, Messick, and Powers, "Muftis, Fatwas, and Islamic Legal Interpretation."

[41] John Griffiths, "What Is Legal Pluralism?," *Journal of Legal Pluralism and Unofficial Law* 18, no. 24 (1986): 1–55.

[42] Octaliana, Susanti, and Listya, "Faktor Pemilihan Metode Kontrasepsi IUD," 168; Adedini et al., "Role of Religious

ulama shows whose reasoning communities consult most directly, and it leaves open how far that reasoning converges.[43]

The findings also separate two mechanisms that are easily conflated. The first is information failure: the ruling does not reach the woman. AK-N06 said she had never heard of the fatwa. The second is competing normative authority: a ruling is available, or could be, but a more trusted voice outweighs it. AK-N07's account of a sermon whose pull outweighed an official ruling she could not verify fits this second pattern. The interview material does not allow the five refusers to be apportioned between the two, and no ratio is claimed. The distinction matters for what follows from it. Information failure calls for better dissemination. Competing authority calls for something harder, which is building recognition of the ruling's source among those whose trust it lacks or, more realistically, involving the figures who already hold that trust. We describe the combined phenomenon as a gap in religious legitimacy transmission: formal permissibility does not automatically become community-level legitimacy, and the intermediaries through which it must pass shape what arrives.

A related observation concerns the form of the objections. The question that occupies jurists, whether the device acts before or after fertilization, was absent from the refusers' accounts, which turned on modesty, sustenance and destiny. One reading is that the jurists' concern had been translated into vernacular moral language on its way down. Another is that lay informants never held the technical concern. The data cannot decide between these readings. Either way, the counselors were answering a clinical question while the women were asking a moral and theological one, as TK-06's remark about her explanation passing like a breeze suggests. A description of how the device works does not address a fear about divine sustenance. Maqasid reasoning offers a reply in the same register. Read qualitatively, hifz al-nasl protects the wellbeing of children already born, so spacing births can be presented as serving the objective and not offending it, and the maternal protection that falls under hifz al-nafs supports the same conclusion.[44]

The decision unit was usually the household. The women described deciding with husbands and relatives, and users described supportive husbands who often joined them in watching the same online sermons. Refusers described husbands and relatives who shared their view. These are the women's reports. Husbands and religious leaders were not interviewed, so the household findings show how women represent their decisions and not the husbands' own reasoning. Research on contraceptive decision-making in Muslim families in Indonesia and on women's household decision-making in Ghana points to the same unit of analysis,[45] and it implies that counselling aimed only at the individual woman addresses one member of a deciding unit.

On the provider side, the counselors' own descriptions show limited preparation for

Leaders."; Kanwal, Khan, and Manahil, "Unveiling the Untold Narratives."

[43] Humaira et al., "Betawi Ulama's Perception."

[44] Mustamam et al., "Reinterpreting Ḥifẓ al-Nasl," 1270.

[45] Nurhayati et al., "Decision-Making in Family Planning."; Arthur-Holmes et al., "Safer Sex Negotiation."

religion-sensitive counselling and no formal channel to religious leaders. This is a finding about the ten counselors and the facilities they serve in Semarang, and whether it holds in other regions is an empirical question this study cannot answer. A systematic review of counselling quality reports low counselling skill as a recurrent barrier to contraceptive uptake across settings,46 but the Semarang data do not measure competence. They record what counselors said about their own.

3.4. The Religious Health Moderation Framework

The Religious Health Moderation framework turns these findings into an analytical model with a design implication, and it is not a list of recommendations. It has four elements and one limit. The first is the normative baseline: maqasid al-shariah, read through hifz al-nasl as child and family welfare and hifz al-nafs as maternal protection, supports the permissibility of the IUD (section 3.1). The second is the transmission mechanism: formal permissibility reaches women through proximate religious authorities, households and media, and arrives as legitimacy or fails to arrive (section 3.3). The third is the set of wasatiyyah principles, which serve as diagnostic categories and as design criteria. The fourth is religion-sensitive counselling, the practice through which the first three reach the individual encounter. The limit is reproductive autonomy and informed consent, which none of the four elements may override (section 3.5).

As diagnostic categories the four principles locate where the Semarang data show a deficit. Tawassuth, moderation, is visible in the patient, personal approach of TK-07 and TK-10, which avoids both confrontation and capitulation. It is practiced without training and lacks the fiqh literacy to be complete.47 Tasyawur, consultative deliberation, is the principle the data most plainly show to be missing: all ten counselors reported no forum in which they meet religious leaders. Tawazun, balance, speaks to the tension between state targets that can feel coercive and religious authority that can feel obstructive, and to the balance between household authority and the woman's own consent. Tasamuh, tolerance of ikhtilaf, addresses the hardest case in the sample, AK-N09, whose takdir-based refusal will not yield to a competing ruling presented as the only correct one. Treating one contested reading as the whole of Islamic law produces what Azni and colleagues discuss as pseudo-maslahah, a claim of public interest resting on an unexamined shortcut.48 Accommodation and not coercion is the course consistent with both the principle and the woman's conscience.

Table 2 sets out the chain from finding to mechanism, normative resource and proposed intervention. The last column states propositions. None of the interventions was tested in this study.

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[46] Kemal Nazaruddin Siregar, "Role of Quality of Care to the Contraceptive Use in Asia and Africa: A Systematic Literature Review," *Indian Journal of Public Health Research & Development* 11, no. 4 (2020): 602–606.

[47] Kementerian Agama, *Moderasi Beragama*, 17–25.

[48] Azni et al., "Pseudo-Maslahah and Epistemological Failure in Marriage Dispensation at Indonesian Religious Courts," *Jurnal Ilmiah Peuradeun* 13, no. 2 (2025): 1399–1420, https://doi.org/10.26811/peuradeun.v13i2.2047.

Table 2. From empirical findings to proposed interventions in the Religious Health Moderation framework

Empirical finding (Semarang informants)	Mechanism (interpretation)	Normative resource	Proposed intervention (proposition, untested)
Proximate religious figures (ustadz, study-circle leaders, peers, online preachers) shaped both acceptance and refusal.	Transmission through the nearest trusted voice; the transmitter's stance and not the doctrine decided the outcome.	*Tasyawur*; *hifz al-nasl* read as child and family welfare.	Standing consultative forums joining the city health office, the religious affairs office, religious organizations and neighbourhood religious leaders; short briefings on contraception fiqh for local leaders.
Refusers were unaware of the national fatwa or did not trust it.	Information failure and competing normative authority, two distinct mechanisms.	*Tawassuth*; *tasamuh* toward *ikhtilaf*.	Carry the ruling through trusted local intermediaries and verified digital content; do not present one reading as the only Islamic position.
Refusal was voiced as *aurat*, *rezeki* and *takdir*; the post-fertilization concern was not voiced.	Jurisprudential concern absent or re-expressed in vernacular moral idiom (two possible readings).	*Hifz al-nasl*; *hifz al-nafs*; averting harm before securing benefit.	Counselling that answers in the woman's own moral register: female providers and privacy measures for the *aurat* objection; birth spacing explained as child welfare for the *rezeki* objection.
Counselors reported no formal collaboration with religious leaders and limited fiqh literacy of their own.	No institutional link between biomedical and religious counselling.	*Tawassuth*; *tasyawur*.	A religion-sensitive counselling module with informed-consent safeguards; referral to a religious leader offered as an option and never as a precondition.
Women described decisions as shared with husbands and relatives.	The household as decision unit, as represented by the women.	*Tawazun*: balance between household authority and the woman's own consent.	Couple-oriented sessions with the woman's consent; private time for her own questions; consent obtained from her directly.

Source: Authors' analysis. The last column states propositions for testing and not demonstrated effects.

Evidence from elsewhere suggests that engaging religious leaders can matter. A study of the Nigerian Urban Reproductive Health Initiative found that exposure to family planning messages delivered through trained religious leaders was associated with higher modern contraceptive use, after accounting for background characteristics and prevailing myths and misconceptions.[49] Indonesian work on Kampung KB programs reads community-level family planning through social capital and maqasid.[50] These are associations and program studies in other settings. They support the plausibility of the proposed forums but do not show that the forums would work in Semarang.

The framework also relies on a point about rights. Contemporary readings of maqasid al-shariah al-ʿammah, the general objectives of Islamic law, identify human dignity, freedom of action (al-hurriyyah), natural disposition (al-fitrah) and equality (al-musawah) as general objectives of the law itself, following Ibn ʿAshur.[51] If so, a woman's entitlement to informed,

[49] Adedini et al., "Role of Religious Leaders."

[50] Musyafa'ah, "Analisis Program Kampung Keluarga Berencana."; Siregar et al., "Utilization of Social Capital," 360.

[51] Ulul Umami and Abdul Ghofur, "Human Rights in Maqāṣid al-Sharīʿah al-ʿĀmmah: A Perspective of Ibn ʿĀshūr,"

religiously reasoned contraceptive choice need not be imported from a secular rights discourse, and it can be derived from within maqasid theory. This is an argument of legal theory and not a finding, and the framework does not depend on it. It does allow the framework to treat protecting hifz al-nasl and protecting the woman's welfare as expressions of one objective and not as a concession by one side to the other.

3.5. Legal Implications: Counselling, Informed Consent and Reproductive Autonomy

Because the framework is addressed to reproductive health law, its legal content has to be stated. Its central rule is that religion-sensitive counselling is not religiously directed decision-making. Counselling that takes account of a woman's religious reasoning is a way of delivering accurate information in a form she can use. Counselling that treats a religious leader's endorsement as a precondition for contraception, or that presents religious permissibility as a reason she ought to accept the method, converts a permission into a pressure. The first is consistent with the informed-consent requirement in Indonesian regulation and with the right under CEDAW to information and to free and responsible decisions on the number and spacing of children.52 The second is not.

Four safeguards follow from this rule and are proposed as conditions for any protocol built on the framework. First, medical information is given in full and accurate terms whatever the woman's religious position, and religious reasoning is offered as an additional resource and not as a replacement. Second, refusal on religious or other grounds is treated as a valid decision, including a takdir-based refusal like AK-N09's. Third, consent is obtained from the woman directly, including when her husband takes part in the session. Fourth, religious leaders who join forums or counselling act as advisors and not as gatekeepers, and the success of an intervention is judged by informed choice and not by IUD uptake alone. These safeguards matter because the channels that raised acceptance among the users could narrow choice if they were used with an uptake target in mind. A framework that uses religious legitimacy as a lever must state that legitimacy is a condition for choice and not a substitute for it.

The empirical base is twenty interviews in six community contexts in one city, with women acceptors and midwife counselors as informants. The patterns described are patterns in these accounts. They indicate mechanisms worth testing elsewhere and do not establish prevalence. The framework and its interventions are propositions that require intervention-based testing, for instance a pilot of the counselling module and the counselor-ulama forum with pre-specified measures of informed choice.

4. CONCLUSION

Formal religious permissibility does not automatically translate into community-level religious legitimacy. This is the main finding of the study. The normative sources reviewed treat the IUD as permissible in principle, and the national fatwa on family planning has not been withdrawn. Among the twenty informants in six community contexts in Semarang, however,

Al-Ahkam 32, no. 1 (2022): 87–108, https://doi.org/10.21580/ahkam.2022.32.1.9306.

[52] Peraturan Menteri Kesehatan Nomor 290/MENKES/PER/III/2008, art. 2(1); Convention on the Elimination of All Forms of Discrimination against Women, art. 16(1)(e).

decisions to accept or refuse the IUD followed the stance of the nearest trusted religious voice, refusals were voiced in the idioms of modesty, sustenance and destiny, refusers were unaware of the national fatwa or did not trust it, and the ten counselors reported no formal collaboration with religious leaders and limited fiqh literacy of their own. Two mechanisms lie behind the gap, information failure and competing normative authority, and the data do not allow their relative weight to be estimated. The article answers its three questions as follows. Read through maqasid al-shariah, and hifz al-nasl and hifz al-nafs in particular, the sources reviewed construct the IUD as permissible, while the fatwa that states this permission is a non-binding religious opinion and not state law. At the community level the permission is received through proximate authorities and households, and it is interpreted and contested in vernacular moral idioms. The Religious Health Moderation framework follows from these findings. It links maqasid al-shariah, wasatiyyah Islamiyyah, proximate authority and religion-sensitive counselling, and fixes informed consent and reproductive autonomy as limits that religious engagement may not cross. For policy, the findings suggest that the Ministry of Religious Affairs, the Ministry of Health and BKKBN consider counselling protocols and standing counselor-ulama forums in settings like those studied, with the safeguards set out in section 3.5. These are proposals and not tested outcomes. Future research should test the framework through intervention studies, interview husbands and religious leaders to complement the women's accounts used here, extend the design to other regions and contraceptive methods, and examine whether the same transmission gap appears in other contested public health domains such as vaccination.

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