

**What's Religion got to do with it?
Islam and Fertility in Senegal and Cameroon**

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ABSTRACT:

Religion has been proven to influence a wide range of individual outcomes, including gender-specific health experiences such as fertility. This study examines the role of religion in women's decision-making, both broadly and with a special focus on reproductive decisions. Quantitative analysis of Cameroon (2004) and Senegal's (2005) Demographic Health Surveys is combined with information from qualitative focus group discussions and interviews that were held in each country in 2011. These analyses were used to investigate 1) whether Muslim women have the same level of control over household decision-making as their non-Muslim counterparts; 2) whether the extent of Muslim women's participation in key household decision-making differ from their participation in reproductive decisions; 3) whether rates of contraceptive use and participation in reproductive decision-making differ between Muslims and non-Muslims; and 4) how Muslim women and men view the influences and prescriptions of religion on the practice of family planning. Cameroon and Senegal serve as fruitful locales in which to investigate these questions, as the former represents a more pluralistic society while the latter is predominantly Muslim. Findings suggest that religion continues to mediate women's relative control in different arenas of household decision-making, including family planning. Given international concern over achieving reproductive health, crystallized in Millennium Development Goal 5, future interventions will need to be sensitive to the role of religion.

1. INTRODUCTION

The purpose of religion is to shape moral and spiritual values (Finke and Adamczyk 2008; McQuillan 2004) and, to the extent that values and beliefs shape human behavior (Ajzen and Fishbein 1977), one expects religion to ultimately shape behavior. Based on this premise, a large body of literature in social science has examined the effects of religion across a wide range of outcomes such as health (Dwyer, Clark, and Miller 1990), gender role attitudes (Para-Mallam 2010; Read 2003; Sieveking 2010), and sexual health and fertility (Agadjanian, Yabiku, and Fawcett 2009; Bop 2004; Knodel et al 1999; McQuillan 2004). Indeed, a few studies have examined religious differences in human fertility in the US but also in a few developing settings such as Ghana (Doctor, Phillips, and Sakeah 2009), usually showing substantial differences in outcomes. Still, while shedding light on these different outcomes, much of the research has not clarified the fine mechanisms through which religion matters. In other words, why exactly does religion matter?

One popular but insufficiently tested explanation in the context of developing countries is mediation through gender relations. In particular, by shaping gender roles within the household, religion can affect a host of outcomes that require negotiation within families, and human reproduction fall squarely within this type of relationship. Literature on the fertility transition has focused on this issue of gender equity, arguing that high women's status is correlated with lower fertility (McDonald 2000). Furthermore, other areas of negotiation

within the family include health care, and there is ample support that women's involvement in these types of household decisions is associated with overall improved health outcomes for children (Fantahun et al 2007). In the wake of global fertility transitions and the slower fertility transitions often observed among Muslims (but also in light of broader interest in global dialogue between religions), there is significant interest in the media and academia today in understanding Muslim women's lived experiences.

This study aims to shed light on the complexity of Islam and women's relationships with their faith, and uncover how these relationships mediate women's relative control in different arenas of household decision-making. Focusing on this relationship at two levels – broad experiences in household decision-making and specific experiences regarding fertility decisions – this paper seeks to resolve theoretical assumptions about Islam and gender and actual experiences of Muslim women in sub-Saharan Africa.

In recent years, there has been much attention directed at the high fertility of Muslim societies. In the popular press, a recent CNN report stated that the worldwide Muslim population is on a sharply increasing trajectory. Soon, Muslims are expected to comprise 25% of the world population, while today Muslims make up about 20% of the world population, around 1.25 billion people (Roudi-Fahimi 2004, 1). This growth stems from the typically higher level of fertility among Muslim populations. This high fertility is itself assumed to derive from limited access to, or acceptance of, family planning and contraceptive services. However, there is little empirical consensus on the relationship between Islam and family planning, as Muslim scholars, writers, demographers, economists, and health planners throughout the world continue to debate the

stance of Islam on family planning. For instance, a paper by Omran questions the tendency to frame the debate on this issue along a simplistic “either/or” choice that implies that Islam could only be “for” or “against” family planning (1992, 203). As Heather Boonstra emphasizes, “Unlike Catholicism, for example, Islam does not have a central authoritative structure of religious interpretation. Instead, this religion plays out differently across cultures, and various schools of law and religious sects offer diverse understandings about how Islam should be practiced” (2001, 4). This is quite evident in the debate on family planning, and in the diversity of arguments on either side of the debate. Opponents of family planning in the Muslim community cite a wide variety of reasons why family planning is not in accord with Islam, from the notion that family planning programs are an attempt to decrease the Muslim population to the idea that contraceptives promote immoral behavior to the idea that contraception is *wa’d*, or murder (Omran 1992, 203). Proponents of family planning cite equally varied arguments, from the idea that spacing births prevents human suffering to the fact that the Prophet Muhammad used *coitus interruptus*, or withdrawal, as a method of birth control, setting a permissive precedent (Roudi-Fahimi 2004, 3).

In examining individuals’ lived experiences, it’s important to emphasize the wide cross-national variation in contraceptive usage among Muslim women. For example, in Iran, where nearly 100% of the population is Muslim, 73% of married women are on some form of contraceptives, a figure that is comparable to the United States (Boonstra 2001; Greene 2011). In Senegal, on the other hand, only 12% of married women use any method of contraception. Further, the figures for Senegal are not dramatically different from other non-Muslim countries with similar levels of socioeconomic development in Africa (DHS 2010)

Given that around 1.25 billion people in the world are Muslim, this diversity among Muslims should not come as a surprise. Muslim experiences vary across nationalities and regions, language, race, and type of government, whether secular or Islamic (Roudi-Fahimi 2004, 1).

While several studies have examined the relationship of Islam and family planning, few focus on Africa. My literature review showed numerous reports on the stance of Islam and Muslim religious leaders on family planning and multiple papers addressing family planning in sub-Saharan Africa, including *A Qualitative Study of Clandestine Contraceptive Use in Urban Mali*. However, only one paper directly discussed the actual perceptions and behaviors of Muslim women in relation to family planning (Bop 2005). Bop found, in Senegal, “a strong opposition, both from men and women, to women’s individual choice and control over her body as far as family planning, sexuality, or abortion are concerned” (2005, 1). What is fascinating about this attitude is that Senegal has a secular government and positive relations exist between the Muslim and Christian populations. Yet, compared to the Islamic State of Iran, Senegalese Islam appears to be significantly less permissive in terms of family planning when one looks at the statistics. This underscores the cross-national variation in Muslim women’s experiences in relation to family planning.

In “*The Squabble That Never Ends: Religion and Fertility*,” Basu (2004) provides a critical assessment. She argues that too often, fertility and family planning literature “demonize” a particular religion, often Islam, when in fact, a multitude of factors play into fertility decisions and behavior. As she argues:

We might come to the surprising conclusion that there is much more convergence with other groups than the publicized differences project. A more impartial examination of the

complexities underlying simple measures of fertility and population growth will also reveal that finally, we are all – Hindu, Muslim and Christian – driven by the same basic quotidian needs and constraints, and that our reproductive behavior is one important way of reflecting these desires and dilemmas (2004, 4296).

Her paper emphasizes the complexities of experience, asking to incorporate religious, economic, social, cultural, historical, educational, and other factors in analysis of behavior.

This paper thus investigates the possible effects of Muslim women's religious convictions on their perception and consumption of family planning services. I ask four specific research questions:

1. Do Muslim women have the same level of control over household decision-making as their non-Muslim counterparts in Cameroon and Senegal?
2. Does the extent of Muslim women's participation in key household decision-making differ from their participation in reproductive decisions? In other words, if these women do not participate in household decision, does this non-participation include reproductive health?
3. Do the rates of contraceptive use and participation in reproductive decision-making among Muslim women differ from those observed among non-Muslims?
4. What do Muslim women and men say about the influences and prescriptions of religion on the practice of family planning?

2. PREVIOUS RESEARCH

In this section, I review the previous research on the implications of religious affiliation generally for a range of individual outcomes, followed by an examination of the role that Islam, in particular, plays in shaping life outcomes. As a second step, I also consider the relationship between religion and sexual and reproductive health outcomes, focusing both on religion in general and Islam in particular. Finally, the section concludes with an examination of literature focusing on Muslim lived experiences in regards to sexual health.

Religion and Individual Outcomes

Numerous studies have found a relationship between religion and women's individual outcomes, including health, social roles, empowerment, and decision-making power (Doctor, Phillips, and Sakeah 2009; Agadjanian, Yabiku, and Fawcett 2009; McQuillan 2004; Gyimah, Takyi, and Addai 2006; Knodel et al 1999; Para-Mallam 2010). Emphasizing the strong institutional presence of religions, McQuillan (2004) specified that, "more than any other social institution, religions have elaborated moral codes that are meant to guide human behavior, and many of the great religious traditions have been given special attention to issues of sexuality, the roles of men and women, and the place of family in society" (27). Sacred scripture, as communicated by religious authority, speaks specifically to the aforementioned issues, and thus its influence is felt at both the community and individual level, through the normalization of specific social attitudes and roles.

This has been argued by many to perpetuate gender inequality, especially in developing countries. For instance, Para-Mallam (2010) studied pervasive

gender inequality in Nigerian society and found that, “Nigerian traditional, Christian and Islamic religious values exert a powerful influence over Nigerian social life in general and over the nature of gender roles and relations in particular” (459).

On the other hand, the positive impact of religion on women’s sense of empowerment has also been illustrated. Ultra-Orthodox Jews represent a conservative subset of their religion, marked by more traditional gender roles. Many more progressive Jewish communities view Ultra-Orthodox practices and gender norms as, “anachronistic, hierarchical and irrelevant to modern feminist values” (Ringel 2007, 26). However, participants in Ringel’s study communicated a sense of empowerment endowed on them by their faith, identifying their fulfillment through “their children, husbands, family and community, rather than through professional or individual endeavors” (Ringel 2007, 40). Respondents’ religious convictions shaped their lived experiences tremendously, leading them to adopt more traditional gender roles within which they felt powerful.

Islam and Individual Outcomes

While there is extensive research on all religions and gender, the case of Islam is perhaps one of the most compelling and controversial topics. Islam is generally perceived as a more conservative religion and, as argued by Read (2003), “women who belong to and participate in conservative denominations are typically more traditional in their gender role orientations” (207). Read’s study examined the experiences of both Christian and Muslim Arab-American women, focusing on differential gender role attitudes. His results found that Muslim

women tended to be more gender traditional than Christian women, even after controlling for educational attainment, age, and children (214). He also found that “religiosity is linked to inegalitarian views on gender, and the effects are especially strong for women who believe in scriptural inerrancy” (217). Thus, Read’s results demonstrate a significant difference between Christian and Muslim women in regards to their gender role attitudes, where Muslim women are more traditional. Furthermore, women who are more religious tend to adopt more traditional gender role attitudes.

Ali et al. (2008) similarly explored the differential religious experiences of Christian and Muslim women in regards to feminism. Their Muslim participants demonstrated a similar sense of traditional gender role attitudes, stressing the complementarities of men and women’s roles. Women, they felt, are naturally more nurturing than men, and thus “should be the primary caregivers for the children” (43). In Nigeria, it has been argued that these types of gender attitudes rooted in Islamic tradition are the basis for female subordination, justifying “pervasive discriminatory treatment of women and girls, especially with regard to marital relations, inheritance . . . female autonomy and participation in intra-household and public decision-making processes” (Para-Mallam 2010, 463). Thus, Islam is identified as an oppressive force in women’s lives, perpetuating harmful gender role attitudes.

In contrast to the aforementioned findings, many argue that Islam is in actuality a feminist faith. While Ali et al. (2008) stressed the nurturing role of women, they also emphasized the fact that a high level of respect and value was associated with these roles (43). Moreover, an emphasis on more traditional gender roles does not necessarily mean a lack of autonomy. Sieveking (2007)

argued, “recent empirical studies have found no evidence that Muslim women have less autonomy than women belonging to other religious groups in the same society” (30). Furthermore, previous studies have argued that religious teachings on women are subject to change alongside societal transformation, since “religious ideas are produced in relation to the existing intellectual context of debates and back-and-forth arguments among diverse ideological producers” (Moaddel 1998, 126). Ultimately, individuals in particular social contexts determine the way religion is experienced, and thus it is a dynamic process. Consequently, Islam, like any faith, is experienced diversely, and can be used as a tool promoting women’s rights.

For instance, Maimouna Kane, founder of the Association of Senegalese Jurists (ASJ), claims, “Muslim religion, in contrast to what people think, defends the rights of women. It has set up a revolution in relation to the situation women had before. Islam is not opposing itself against progress; in fact it urges us towards science, towards progress” (Sieveking 2007, 35). In Senegal, in fact, different Islamic groups have used Islam to promote gender equality. Réseau Siggil Jigeen (RSJ), Sieveking shows for instance, began a campaign to reform Senegal’s family code – a set of laws drawing from *shari’a* law – using religious arguments in order to promote women’s rights. RSJ “supports the government in the areas of family planning and AIDS prevention, thereby representing positions . . . which are contested and even fiercely opposed by locally established religious authorities” (Sieveking 2007, 38).

Furthermore, it has been shown in Indonesia that “the growing role of Islam in the public sphere provides Muslim women with an important platform, facilitating their involvement in debates over issues like *shari’a* law, abortion and

pornography” (Rinaldo 2008, 1784) In this context, then, women use Islam as a tool to gain influence in their society by offering interpretations of the scripture that bolster their cause. Multiple understandings of Islam exist, providing a valuable opportunity for marginalized groups to gain a voice (Rinaldo 2008).

Similar movements in Tunisia and Morocco exist, providing women with a political platform from which to voice their concerns. According to Dalmasso and Cavatorta (2010), “a number of Islamic movements ideologically accept the necessity of changes with respect to women’s rights, but contend that the justification for such changes should be found in indigenous values and traditions rather than ‘alien’ ones imported from the west” (220). This statement demonstrates the ability to promote women’s rights within the context of Islam, rather than assuming women’s rights can only be achieved through secular means, in direct opposition to religious values and tradition (Dalmasso and Cavatorta 2010, 213).

Religion and Sexual Health

Moving from a more general dialogue between religion and women’s lived experiences, there is extensive literature on the topic of religion’s influence on sexual health, demography and fertility. For instance, religion has been found to be a significant factor in maternal health services usage (Gyimah, Takyi, and Addai 2006). Even after controlling for socio-economic variables, Muslim and traditional women in Ghana were significantly less likely to use maternal health services than Christian women (2930). Furthermore, Agha, Hutchinson, and Kusanthan (2006) examined the influence of women’s religious affiliation on HIV risk in Zambia. They sought to understand whether religious stances on pre-

marital sex and condom use impacted young women's exposure to HIV. However, contrary to previous claims that religion is relevant in shaping behavior relating to HIV (Gyimah, Takyi, and Addai 2006), this study found the influence of religion to be minimal (554).

Looking at fertility specifically, Hayford and Morgan (2008) established a link between a woman's religiosity and her fertility in the United States, claiming, "women who report that religion is 'very important' in their everyday life have both higher fertility and higher intended fertility than those saying religion is 'somewhat important' or 'not important,'" (1163) since those who are more religious represented more traditional family and gender attitudes than their counterparts, emphasizing their role as mothers first.

Doctor, Phillips, and Sakeah (2009) examined this linkage in Nigeria, assessing "the extent to which changes in religious affiliation among women is associated with concurrent changes in contraceptive use and parity" (113). Implicit in this statement are three hypotheses: that different religions exert their influence on contraceptive use and gender equality; that different religions have different influences; and that contraceptive use and gender equality are interrelated.

Taking issue with the tendency to establish a defined stance on one particular religion's influence on fertility, Alaka Basu studied fertility of Muslims, Buddhists and Hindus in India. While she concluded that the Muslim population does indeed have a higher fertility than other religious groups, "acknowledging these differences is not the same as understanding them and the recent politicking on the subject has not even millimetered us towards a greater understanding of the matter" (Basu 2004, 4295). Basu brings up a critical point.

Statistics have the power to tell compelling stories, enabling scholars and the population at large to better understand the social world. However, when statistics are not used critically, they can tell a skewed and inaccurate version of the truth. In Basu's example, establishing the influence of a particular religion – Islam – on fertility without looking at other contributing factors is a gross misuse of statistical evidence.

More recent research has also touched on this point, emphasizing that, while the importance of religious context has been established for a variety of gender-related topics, “the literature addressing the role of religion in reproduction typically compares either doctrines or individuals; contextual variations are rarely investigated” (Agadjanian, Yabiku, and Fawcett 2009; 469). Thus, their investigation focused on the religious composition of the communities they studied and the institutional presence of religion in each context, understanding that when contexts vary, experiences also change.

Islam and Sexual Health

While Islam clearly values procreation and fertility, as in Christianity and Judaism, Islamic texts are not an obstacle to contraceptive usage, and “many Muslim religious thinkers over the past quarter-century have maintained that . . . family planning is permitted and even encouraged by Islamic law” (Boonstra 2001, 4). In fact, the majority of jurists coming from eight out of nine legal schools support family planning (Omran 1992, 201), with the exception of permanent methods (sterilization) or abortion, as expressed by many religious leaders (McQuillan 2004, 28). One example of textual support for contraceptives is that withdrawal (*coitus interruptus*) was practiced as a contraceptive method

during the Prophet Muhammad's time, and he offered no prohibition to its practice. Furthermore, Islamic jurisprudence does not interpret this silence on the issue as an omission, because God is all-knowing (Morgan et al 2002, 518; Roudi-Fahimi 2004, 3).

A further support for family planning that is often cited is that spacing births supports a family's well being (Monifar 2007, 301). In fact, spacing births is addressed in the Qur'an in the discussion on breastfeeding. A religious leader in Iran, according to Monifar (2007) "claims that the Qur'an fixed the period of lactation at two full years . . . This argues in favour of allowing steps to be taken to prevent pregnancy during the period of breast-feeding" (302). Roudi-Fahimi (2004) also addressed this point, specifying that avoiding intercourse for two years in order to avoid pregnancy would be a hardship, and thus couples can use contraceptive means to avoid pregnancy (5). Not only do religious leaders in many diverse contexts support family planning, many have used the scripture to encourage the use of family planning methods in Islamic societies.

One of the most successful examples of family planning program implementation in the Muslim world is Iran, where the national family planning program is "considered a model for developing nations and other Muslim countries" due to its success in combating high maternal and infant mortality and encouraging contraceptive uptake. In fact, by 1997, contraceptive use was at 73% of married women (Boonstra 2001, 6). Iran's family planning program came as a necessity when the needs of the population were not being met (Roudi-Fahimi 2004, 5). In the ten years between the Iranian Revolution of 1979 and the creation of this program, contraceptives were viewed as a harmful western innovation, but the high population growth was soon recognized as an obstacle

to the well being of the Iranian people (Roudi-Fahimi 2002, 3). The success of Iran's family planning program is due in large part to the collaboration of religious leaders and institutions in legitimizing family planning within Islam (McQuillan 2004, Ahmadi 2007). Thus, the Islamic Republic of Iran provides a rich illustration of the permissibility of family planning within Islam.

Perception of Muslims on Islam and Sexual Health

Regardless of what any "official" stance Islamic religious leaders and jurists may hold regarding sexual health, Islam and Muslims are not synonymous. That is to say, understanding Islam and sexual health does not translate to understanding Muslims' behavior and experiences of sexual health. In Cameroon, one imam interviewed made this distinction, saying that there are three conceptions of Islam to consider: Islam as science, Islam as a religion, and finally, Muslims attempting to understand Islam and live their lives in accordance with Islam. This section summarizes the extant literature concerning the lived experiences of Muslims in regards to sexual health.

Before discussing Muslims' attitudes toward family planning specifically, it is important to recognize the incredible diversity of Muslims throughout the world. Chaundry (1982) articulated this point well, saying:

One of the problems with the Islamic explanation (of high fertility) is that it treats as monolithic a trait shared by close to a billion people worldwide, and that has adapted to, and been affected by, diverse regional contexts. The diversity in the doctrine and the cultural context of Islam calls into question the recourse to Islam as an explanation for demographic trends (1).

At the time of Chaundry's paper, the world Muslim population was even smaller than today. In fact, about one-fifth of the world's population - as of 2004 - was Muslim, well over one billion people (Roudi-Fahimi 2004, 1). Of this population,

Chaundry stressed, diverse races, ethnicities, languages, and degrees of religious conservatism are represented, and Muslims live under both secular and Islamic governments (1). Thus, to make a generalization about the fertility of so diverse a population is problematic, given that all these other contextual factors may influence fertility as well.

One study that examined the fertility behaviors of Muslim women in nine countries came to this conclusion, saying “the practice of Islam is neither a hindrance nor a stimulating factor in fertility decline, at the global level” (Mahler 1999, 4). The study’s inability to recognize a global pattern was due to variations in educational attainment, exposure to mass media, living environments, and several other influences (1). Diverse contexts create diverse experiences in relation to religion and family planning.

That being said, it is possible to examine the fertility attitudes and preferences of Muslims, so long as context is accounted for. Studying the outlook of Muslims on this issue is fascinating, because of the juxtaposition between their opinions and those of Islamic jurists, who are generally unified in their support of family planning (Barrett 2007, 2). McQuillan (2004) articulated this phenomenon, saying “While . . . surveys of religious leaders suggest general approval of fertility control, surveys in several Muslim populations nevertheless find that men and women frequently give religious reasons for not practicing contraception,” demonstrating the importance of differentiating between an official stance on an issue and the perceptions of the faithful in interpreting those lessons (28).

This can be seen in several contexts. In the Gambia, for instance, Valente et al (1994) found that focus group respondents expressed the belief that Islam was

directly opposed to modern methods of contraceptives (96), an opinion that is echoed throughout Muslim communities. In Senegal, for example, Codou Bop met one nurse who expressed her frustration, explaining:

We have a hard time trying to convince people that Islam forbids limitation of births but does allow family planning when the goal is birth spacing. At the clinics, we receive so many women who do not want any more children, but who believe their husband would not let them use the pill because he is persuaded Islam opposes family planning (2005, 17).

This example demonstrates the variability within Islam. Indeed, Islam cannot be understood without recognizing its humanity. That is to say, “Religious leaders, government officials, and ordinary believers interpret, reinterpret, resist, manipulate, and synthesize religious texts and teaching as a part of daily life” (Barrett 2007, 1).

Castle et al (1999) encountered this interpretation in their study of clandestine contraceptive use in Mali. They explained this in terms of the belief in pre-destination, writing, “God or destiny is thought to predetermine the number of children a couple has, and seeking to change what such powerful forces have ascribed is considered irreverent or pointless” (234). They argued that this “erroneous” belief that predestination prohibits contraceptives is widespread in Islamic Mali.

It is possible, however, to recognize that this belief is not supported in all Muslim communities. Other literature has specified certain circumstances for which particular Muslim communities accept family planning. In Senegal, for instance, Bop (2005) found that couples were allowed to practice family planning in order to protect the mother and children’s health (18). However, this is the

only justification she encountered, and the majority of other studies are quiet on this particular topic.

3. THEORY

This paper is interested in the differential experiences of Muslim women in two opposing sub-Saharan contexts; namely, a majority Muslim society and a majority Christian society. While Senegal is a secular country, its population is 95% Muslim, whereas Cameroon is only 20% Muslim. Bearing this in mind, the study explores how a woman's religious context influences experiences of decision-making broadly, and health and fertility, specifically. There has been much discussion regarding the role of religion in shaping social norms and daily life, but throughout the extant literature, four main theories recur regarding religion and fertility. They are: the characteristics hypothesis, the particularized theology hypothesis, the interaction hypothesis, and the minority group status hypothesis. What follows is a brief discussion on these theories.

Calvin Goldscheider articulated the first two hypotheses in the early 1970s. He critically examined past approaches used to understand religion's role in fertility, noting that two arguments were commonly relied upon: the characteristics hypothesis and the particularized theology hypothesis (McQuillan 2004, 26) The characteristics hypothesis claims that it is factors other than religion that account for observed differences in religious groups' reproductive behavior. These other factors include socio-economic and demographic factors (Goldscheider 1971).

The particularized theology hypothesis, “holds that the presence or absence of specific religious tenets about contraception, abortion, and family size affect attitudes and behaviour . . . religion . . . prescribes a particular but more comprehensive normative structure that guides familial and social life” (Knodel et al 1999, 149). This hypothesis relates to different interpretations of family planning’s permissibility in light of the omission of such discussion in Islamic scripture.

The third hypothesis is the interaction hypothesis, which draws from both of the previous hypotheses in developing its own theory. The interaction hypothesis assumes that, regardless of religion, all groups are similar in their response to socio-economic change. Knodel et al. (1999) recognize a shortcoming in this hypothesis, stating that, “no allowance is made for differences in the nature of the relationship between socio-economic characteristics and reproductive behaviour and attitudes among groups” (149).

The fourth and final hypothesis is the minority group status hypothesis. Goldscheider developed this hypothesis in order to emphasize the social status of religious groups being examined (McQuillan 26). This hypothesis suggests that demographers must, when examining religion, include “the total content of that social organization, of which the particular theology is but one part and often not the most significant” (1971, 274), such as gender relationships. More specifically, the minority-group status “argued that minority groups often face barriers to full social and economic integration into the dominant society, and that one way to limit the effect of these barriers to achievement was to reduce fertility” (McQuillan 2004: 27). However, if groups feel strongly disadvantaged within their context, the response may be to ensure group preservation through

high fertility. Furthermore, devotion to group cohesion will facilitate a greater commitment to social norms specific to the group (Knodel et al 1999, 150).

4. RESEARCH CONTEXT

Senegal and Cameroon at a glance

Table 4.1 provides a brief comparison of Senegal and Cameroon. Although both countries lie in sub-Saharan Africa and have comparable population sizes (12.5 million in Senegal and 19.5 million in Cameroon as of 2009), they differ greatly in other characteristics, as table 4.1 illustrates. At a national level, 15% more of Cameroon's population resides in an urban area than Senegal. Interestingly, urbanization is often associated with improvements in other development indicators, such as life expectancy and infant mortality. This is not the case in comparing these two contexts. According to the World Bank, Cameroon's life expectancy is shorter than Senegal's; while its infant mortality rate is double that of Senegal (95 deaths per 1,000 live births versus 51 deaths). Cameroon does surpass Senegal in its literacy rate, however, with 76% of the adult population reportedly literate in comparison to Senegal's 42% (World Bank 2011).

The two countries vary in terms of other important characteristics, as well. The most important one to consider in the context of this study is religion. While Senegal is about 95% Muslim and 5% Christian, Cameroon is a pluralist country: only 20% of the population is Muslim, with Christians representing 40% and indigenous adherents making up the final 40% (CIA World Factbook).

Table 4.1. Comparative Country Characteristics, Cameroon & Senegal 2009

	Population ¹	Poverty ²	Urban Population ³	Life Expectancy ⁴	Infant Mortality ⁵	Literacy ⁶	GNI Per Capita ⁷
Senegal	12.5	-	43	56	51	42	1,040
Cameroon	19.5	40	58	51	95	76	1,190

¹(millions)⁵(per 1,000 live births)^{2,3}(% population)⁶(% of population 15+)⁴(years)⁷(Atlas method, US\$)

Another important factor to consider is fertility. As of 2011, Cameroon's birth rate was 33.04 births per 1,000 persons, while the total fertility rate is 4.17 children born/woman. Senegal's birth rate in 2011 was fairly similar, albeit slightly higher, with 36.73 births per 1,000 persons. Similarly, the total fertility rate reported is slightly higher than Cameroon, with 4.78 children born per woman (CIA World Factbook). This following section provides background into the female population of each nation.

Women in Senegal and Cameroon

Data from the Demographic Health Surveys (DHS) enables the formation of a recent snapshot of the female population of both Cameroon and Senegal in terms of relevant sociodemographic characteristics. DHS data is statistically representative, and so the findings below can be generalized for the entire female population of both countries. The following table and figures provide a summary comparison of the national context in which this study has been conducted based on the 2004 DHS survey in Cameroon and the 2005 DHS survey in Senegal. In particular, religious composition, urban population, wealth, and education are discussed.

Table 4.2 compares selected socio-demographic characteristics of Cameroon and Senegal in 2004 and 2005, respectively. The first comparison, percent Muslim, clearly demonstrates the unique religious context that each nation presents. Senegal represents a majority Muslim population, with almost 96% of the respondents identifying as Muslim. In contrast, Cameroonian respondents were only 9.5% Muslim, with the remainder of respondents identifying with a Christian or other faith.

Table 4.2. Comparative Socio-demographic Characteristics, Cameroon 2004 & Senegal 2005

	% Muslim	% Urban	% Married or cohabiting
Senegal	95.7	43.2	70.0
Cameroon	9.5	49.5	67.4

Examining the urban population in each country, there is only a slight variation, as Cameroon is 6.3% more urban than Senegal. Both countries are nearly 50% urban according to the DHS. Finally, respondents from both Senegal and Cameroon represent a similar story in terms of marriage and co-habitation. In both contexts, about 70% of respondents were either married or co-habiting with their partners.

Figure 4.1: Wealth Index, Cameroon 2004 & Senegal 2005

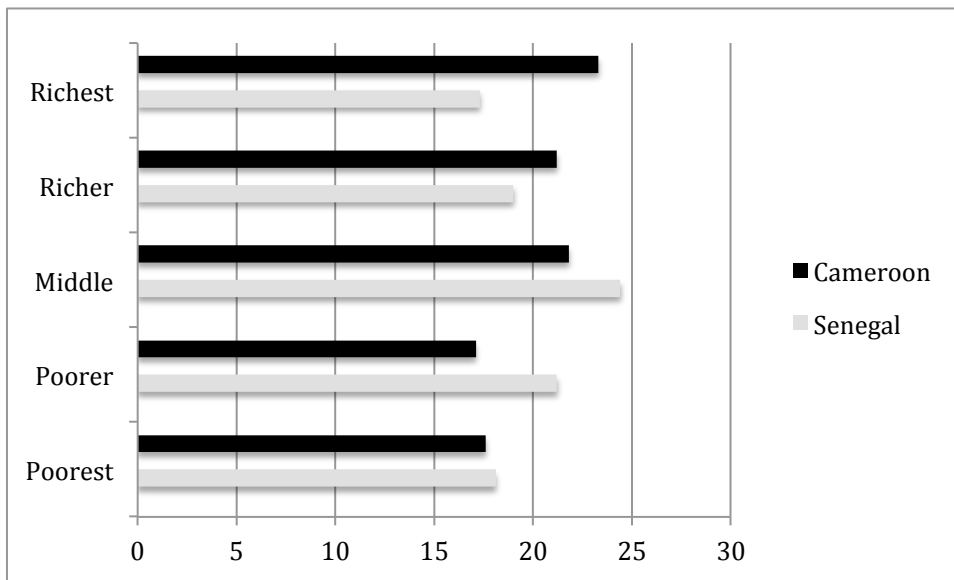


Figure 4.1 compares the wealth stratification of Senegal and Cameroon. In both contexts, about 18% of respondents were in the poorest wealth index category. In Cameroon, however, the highest percentage of the population (23.3% of respondents) represented the richest, whereas in Senegal, the highest percentage reported (24.4% of respondents) were identified in the “middle” wealth index category. The graph illustrates these divergent trends. The pattern in Cameroon shows a slight increase in population as wealth increases. In Senegal, however,

there is a more triangular structure, where the percent of population tapers off in the more extreme wealth indexes.

Figure 4.2: Highest Education Achieved, Cameroon 2004 & Senegal 2005

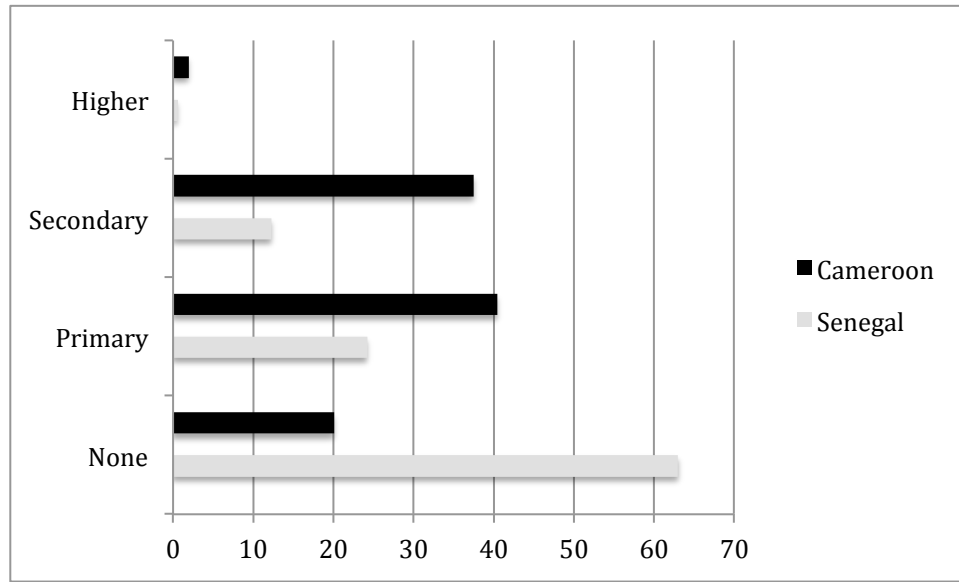


Figure 4.2 looks at the educational distribution of DHS respondents. This table illustrates one of the clearest differences between Senegalese respondents and Cameroonian respondents. While 20.1% of Cameroonian respondents reported no education, an astonishing 62.9% of Senegalese respondents had no education, while only .6% achieved a higher level of education. Cameroonian respondents overall demonstrated a much higher educational achievement than Senegalese respondents, with nearly 40% achieving secondary education in Cameroon.

While all of these statistics paint an aggregate picture of Senegal and Cameroon in recent years, they don't tell us much about the differential experiences of women within each country. It is unclear whether a particular group of women is more likely to achieve high levels of education or to

disproportionately represent a particular wealth index. The remainder of the paper delves more deeply into the differential experiences of women in both contexts, focusing specifically on their religious affiliation (Muslim or non-Muslim).

5. DATA AND METHODS

This study utilized a mixed methods approach, combining quantitative and qualitative research methods. Quantitative analysis sought to address research questions one through three, drawing from the Demographic and Health Surveys (DHS). The DHS are series of national representative surveys fielded over the last two decades in over 75 developing countries, primarily those in Africa, Asia, and Latin America. Started in 1984 and funded largely by the United States Agency for International Development (USAID), the DHS surveys collect information on topics such as fertility, family planning, maternal and child health, gender, HIV/AIDS, malaria and nutrition. Beyond the core data on fertility and health, surveys also include information on religious affiliation. The DHS are an ideal choice to investigate the relationship between religious affiliation and reproductive decision-making for three reasons. First, they include information on both religious affiliation and a host of decision-making questions; second, the samples are typically large, ranging from 5,000 (often seen in the early survey years) to 30,000 (seen in more recent surveys); and third, the replication of DHS across and within several countries creates an appropriate design for cross-national analyses. This study utilizes unrestricted county micro data files, specifically the woman file, which contains a line for each woman aged

15-49 in the sample. The study uses the 2004 micro data file for Cameroon and the 2005 micro data file for Senegal. The samples are both large: 14,602 respondents for Senegal and 10,656 for Cameroon.

The purpose of this data analysis is to explore the statistical relationship between religious affiliation and decision-making behavior within a larger context of women's general life experiences and to determine significance of the relationship, especially when controlling for other sociodemographic variables. A key feature of this analysis is to explore variation in multiple aspects of the women-decision-making equation. First, does one find evidence of religion-related differences in women's attitudes and control of household decisions? If such evidence exists, do similar differences appear in fertility-related decisions? In essence, health decision-making power is contrasted with women's control of purchasing, social mobility, education, and other household decisions. This process will help address the question of whether decision-making within the reproductive arena is a special case within Islam.

In order to more thoroughly illustrate the DHS findings, a field exploration involved conducting qualitative research in Yaoundé, Cameroon and Dakar, Senegal. The qualitative research served to provide illustrative insight into findings from the DHS data, a supplement intended to add richness to – and better understanding of – the quantitative data collected from DHS. This step included two components. The first component was a total of four focus group discussions with an average of twelve participants each in Dakar and Yaoundé. Participants in Dakar included both Muslim men and women of reproductive age; participants in Cameroon were all Muslim women of reproductive age. These discussions covered a wide variety of topics, beginning broadly with

questions targeting women's household decision-making power and subsequently focusing on attitudes toward fertility decision-making.

Additionally, several one-on-one interviews were conducted with health providers, community religious leaders, and individuals actively involved in their religious communities. These interviews sought to understand the perception of individuals and religious communities in regards to family planning. Several similar themes were explored in these interviews as in the focus group discussions. Furthermore, interviews with several Muslim religious leaders in Yaoundé shed light on the perception of Muslim authorities on all relevant topics while interviews with health providers targeted perceived trends and shifts in attitudes regarding family planning from the provider's perspective. All interviews and focus groups shed light on the immense complexity of the topic and the numerous sociodemographic factors influencing and shaping this relationship in both contexts. The following section explores the results of both the quantitative and qualitative analysis.

6. FINDINGS: ISLAM AND HOUSEHOLD DECISION- MAKING

1. QUANTITATIVE RESULTS:

Differential Characteristics of Muslim and non-Muslim Women

Table 6.1 begins to look more closely at the differential experiences of Muslims and non-Muslims in Senegal and Cameroon, addressing the questions of how being Muslim woman in these contexts correlates with one's educational status, urban residency, wealth, and marital status.

The first consideration is educational status. In both Cameroon and Senegal, the average Muslim woman has a lower educational status than her non-Muslim counterpart. For instance, the mean level of education achieved for Muslim women in Senegal is very basic primary schooling.

It's important to note that the average non-Muslim woman in Senegal also has a very low level of education (mean = 1.03, or incomplete primary). Educational attainment in Cameroon is slightly higher for all women, but the same pattern persists. In terms of urban residency, non-Muslim women in Senegal are more likely than Muslim women to reside in an urban area, and the pattern persists for non-Muslim women, as well. Furthermore, non-Muslim women in Senegal and Cameroon have a higher average wealth index than their Muslim counterparts. In Cameroon, the average wealth index score for non-Muslim women is 4.49, representing the wealthiest cohort. However, when looking at marital status, Muslim women in both Senegal and Cameroon are more likely to be married or cohabiting with their partner. All means differences are statistically significant at the .000 level.

Table 6.1. Means differences in control variables between Muslims and non-Muslims,

	Highest level of education ¹	Urban resident
Senegal		
Muslim	0.48	0.42
Non-Muslim	1.03	0.60
Cameroon		
Muslim	1.16	0.44
Non-Muslim	1.72	1.00

* All means differences are statistically significant at the .000 level.

¹ 0=No Education, 1=Incomplete Primary, 2=Complete Primary

² (1=Lo, 5=Hi)

Religion and Women's control over Household Decisions

A series of logistic regressions were used to examine the relationship between religion and women's control over household decisions in Cameroon and Senegal. Table 6.2 shows the effect of religion on a variety of outcomes, including women's control over deciding their own health, large household purchases, daily household purchases, visits outside of the home, and the food they cook daily. For each outcome of interest, I proceeded in a two-step fashion, first modeling the impact of religion on the main independent variable of interest alone, and then creating a second model that included standard socio-demographic controls¹. The main independent variable of interest in all models is whether or not the respondent is Muslim. A positive beta coefficient and odds ratio implies that a Muslim respondent is more likely to have *no* control over the decision at question. This regression incorporates controls for a variety of socio-demographic characteristics, which are: whether the respondent lives in an urban area, if the respondent is currently married or cohabiting with a partner, the

¹ Already, it's been argued that a narrow Islamic explanation of fertility differences has been proven as insufficient in numerous studies. What, then, may be the explanation for statistically significant differences between Muslim and non-Muslim populations? McQuillan (2004) touched upon this point in his paper, acknowledging the partial influence of Islam in encouraging pronatalist attitudes of Muslims, but also pointing out that the nature and extent of Islam's influence is conditioned by the context. Indeed, "other political, cultural, socio-economic, and historical factors interact with the relationship" between Islam and fertility, making it difficult to untangle and isolate religion's specific influence (161).

Furthermore, individual characteristics can influence a woman's fertility, such as education or place of residence (DeRose and Ezech 2010). It has been previously demonstrated in Senegal that "those who live in Dakar and are more educated are more favorable to woman's individual rights to use family planning." (Bop 2005, 19) Similarly, one study on the effect of radio promotion of family planning in the Gambia found that better educated individuals demonstrated an increased uptake in contraceptive services when compared to their less-educated counterparts (Valente et al 1994, 98) and the same relationship was found in Iran, as well. In Iran, female literacy has increased to over 75% of Iranian women, and this has been proven to contribute to the increase of contraceptive use (Roudi-Fahimi 2002, 6).

respondent's education level, the respondent's wealth index, and the respondent's age.

The first relationship examined was between religion and the respondent's control over her own health. Muslim respondents in Cameroon are 2.65 times more likely to have no control over their own health than non-Muslim respondents, whereas the relationship is the same, but weaker in Senegal. Senegalese Muslims are 2.19 times more likely to have no control over their own health than their non-Muslim counterparts. This differentiation remains the same after controlling for socio-demographic characteristics (wealth, education, relationship status, and age) although in both cases the influence of religion is lessened a small amount after taking these factors into account. In Cameroon, Muslim women are 2.38 times more likely than non-Muslims to have no control over their own health, versus Muslim women in Senegal, who are only 1.86 times more likely than their non-Muslim counterparts to have no control over making decisions regarding their own health. In both Cameroon and Senegal, the effect of being Muslim on deciding one's own health remains statistically significant, even after controlling for all socio-demographic variables included.

In regards to decisions about large purchases and visits, the trends are the same as in decisions regarding one's own health. Both before and after controlling for wealth, age, education, urban residence, and marital status, religion has a stronger influence on decision-making power in Cameroon than in Senegal. In both countries, Muslim women are more likely than their non-Muslim counterparts to have no control over the decisions, and the relationship is once again statistically significant across the board.

This trend varies slightly when examining decisions about daily purchases and cooking. Once more, the influence of religion is much stronger in Cameroon than in Senegal both before and after controlling for socio-demographic characteristics, but in Cameroon, the influence of religion becomes stronger after controlling for the variables. Muslim women in Cameroon are 3.61 more likely than their non-Muslim counterparts to have no control over daily purchases after controlling for wealth, age, education, urban residence, and marital status, whereas they were only 3.30 times more likely before introducing controls to the model. This is a divergent trend from all other contexts, and was not echoed in Senegal, where the strength of religion as a predictor decreased slightly once controls were introduced. Once again, the relationship of religion remained statistically significant in all cases.

In regards to decisions about cooking, the influence of religion on women's control over decision-making remains stronger in Cameroon than in Senegal, but in both cases, the relationship between religion and decisions about cooking became stronger after controlling for all socio-demographic characteristics. In Cameroon, the odds ratio increases from 1.62 to 2.39, a substantial increase, and religion remained significant throughout. Similarly, in Senegal the odds ratio increases from 0.96 to 1.07, a slightly smaller change, but notably a shift from being associated with more control over cooking decisions to being less likely to have control over cooking decisions. However, the relationship between religion and control over cooking decisions in Senegal is insignificant both before and after introducing the controls.

Table 6.2. Logistic Regression Results of Relationship Between Religion and Women's Control

CAMEROON

	Respondent has no say in their....																													
	Own health				Large purchases				Daily purchases				Visits				Cooking													
	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.										
Religious Variables																														
Respondent is Muslim	0.98 ***	2.65	0.87 ***	2.38	1.04 ***	2.82	0.96 ***	2.60	1.19 ***	3.30	1.29 ***	3.61	0.97 ***	2.65	0.93 ***	2.53	0.48 ***	1.62	0.87 ***	2.39										
Respondent socio-demographic characteristics																														
Lives in urban area			-0.31 ***	0.73			-0.18 ***	0.84			-0.18 ***	0.84			-0.24 ***	0.79			-0.01	0.99										
Currently married or cohabiting			0.18 ***	1.19			-0.25 ***	0.78			-0.84 ***	0.43			-0.30 ***	0.74			-1.55 ***	0.21										
Highest education level			-0.24 ***	0.78			-0.30 ***	0.74			-0.36 ***	0.70			-0.26 ***	0.77			-0.09 *	0.91										
Wealth index			-0.03	0.98			-0.03	0.97			-0.06 *	0.94			-0.03	0.97			0.00	1.00										
Age			-0.09 ***	0.91			-0.09 ***	0.91			-0.11 ***	0.90			-0.09 ***	0.92			-0.11 ***	0.90										
Partners* socio-demographic characteristics																														
Highest education level																														
Constant	0.52	3.61	0.52	3.91	-0.01	4.23	-0.03	3.09	-0.78	3.06																				
Numer of Cases	10656	10656	10656	10656	10656	10656	10656	10656	10656	10656																				
-2 Log likelihood	13420	11866	13358	11672	14238	11608	14410	12776	13477	10106																				
Nagelkerke R	0.03	0.22	0.04	0.23	0.06	0.34	0.04	0.22	0.01	0.38																				

SENEGAL

	Respondent has no say in their....																													
	Own health				Large purchases				Daily purchases				Visits				Cooking													
	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.										
Religious Variables																														
Respondent is Muslim	0.79 ***	2.19	0.62 ***	1.86	0.55 ***	1.74	0.11 ***	1.56	0.42 ***	1.52	0.38 ***	1.47	0.49 ***	1.62	0.41 ***	1.51	-0.04	0.96	0.07	1.07										
Respondent socio-demographic characteristics																														
Lives in urban area			-0.47 ***	0.63			0.07 ***	0.63			-0.27 ***	0.76			-0.15 ***	0.86			0.07	1.07										
Currently married or cohabiting			0.31 ***	1.36			0.07 ***	0.73			-0.82 ***	0.44			-0.37 ***	0.69			-1.83 ***	0.16										
Highest education level			-0.18 ***	0.84			0.04 *	0.92			-0.06	0.94			-0.14 ***	0.87			0.00	1.00										
Wealth index			0.02	1.02			0.03	1.01			-0.04	0.96			-0.03	0.97			-0.04 *	0.96										
Age			-0.08 ***	0.92			0.00 ***	0.93			-0.07 ***	0.93			-0.06 ***	0.94			-0.07 ***	0.93										
Partners* socio-demographic characteristics																														
Highest education level																														
Constant	0.81	3.34	1.34	0.16	1.01	4.10	0.53	2.89	-0.16	3.00																				
Numer of Cases	14602	14602	14602	14602	14602	14602	14602	14602	14602	14602																				
-2 Log likelihood	13470	12311	11475	10457	14462	12894	16972	15762	20066	15801																				
Nagelkerke R	0.01	0.13	0.00	0.13	0.00	0.16	0.00	0.12	0.00	0.34																				

2. QUALITATIVE RESULTS

Qualitative results stem from the focus group sessions conducted in both Cameroon and Senegal. A variety of themes emerged during the discussions that were relevant to understanding the relationship between Islam and decision-making processes within the household. These themes, discussed in detail below, include Muslim women's decision-making influence; the importance of partner dialogue; children's health and economic decisions; and economic decisions. This section concludes with a discussion of regional variations in these patterns.

Muslim Women's Decision-making Influence in Cameroon and Senegal

The focus group discussions and individual interviews shed significant light on the question of Muslim women's status in Cameroon and Senegal and on the complexity within this question. In Cameroon, both local religious leaders and individual women spoke to this concern, offering dissimilar explanations based on subtle differences in interpretations of their religion. For instance, local religious leaders in Yaoundé provided somewhat paradoxical assessments. Cheikh Baba Moussa stated that, "The status of women in the Muslim community here is fairly evolved. She goes to school, she is employed, and is an integral part of society," whereas his colleague emphasized the domination and authority reserved for men in relationships, stating that a woman, "should obey you in strict compliance with recommendations of Islam. You become mutually accountable for your actions and the woman must have confidence in your protection and authority. She must not go out without permission," implying an overall hierarchical relationship between men and women. However, the

restrictions mentioned appear to contradict the subsequent statement that, “In marriage, both spouses . . . are equal before God. The man should not take the opportunity to keep his wife a prisoner in the home as a captive. He must allow his wife to visit his parents, friends and acquaintances . . . to attend prayers at the mosque ... If she wants to lead a revenue generating activity, he must also grant her permission.” While there seem to be inconsistencies in these statements, they were not viewed as such by Muslim religious leaders interviewed in Yaoundé, who specified that Islam fundamentally recognizes the equality of men and women, while simultaneously giving to each a very precise role.

In terms of a woman’s decision-making power, subtle disagreements emerged in terms of whether or not women are implicated in decision-making. In Cameroon, focus group participants expressed a few common threads. For instance, several women expressed the opinion that, “women don’t have decision-making power in their families. They don’t participate actively. The priority is generally left to the man: one says that he has authoritative power.” This was rooted in religion through various other statements that emphasized the overall authority of men over women. As another participant emphasized, “concerning Islam, in the home, the woman doesn’t have a decision to take because Islam has decided all. The woman has her rights and duties. Islam prescribes what the man must do and what the woman must do. We know that the woman in her home must take care of the house and of the children.” Another woman echoed this sentiment, stating, “Generally, women don’t make decisions. That is the domain reserved for men. They participate only in managing the house as the mother and woman of the household.” These voices are in accordance with the religious leaders who argued that, while men and

women are equal before God, their equality does not indicate sameness. Women hold a different role in their families and communities than men, and that role exists in the home.

Furthermore, while women do play a role, they must always be in agreement with their husbands on key decisions. This reflects the regression results summarized in Table 6.2, which showed that being Muslim is associated with less of a voice in key household decisions. This is accepted as a natural dynamic, which is demonstrated by female focus group participants like one individual who stated, “as far as I am concerned, the woman can make all the decisions if and only if there is agreement in the couple.” Cheikh Baba Moussa in Cameroon agreed with this sentiment, stating that “the last word naturally falls to the man; but there must be dialogue between the man and his wife because he is not the only one in the house; the man and the woman are both responsible for the home.” The emphasis on dialogue does imply that women have a say in household decisions, but with the stipulation that men always have the last word.

Similar threads were seen in the Senegalese context. It’s important to note that in Senegal, focus groups included several male participants, which makes it more difficult to compare findings from each country. However, the points brought up in Senegal still have illustrative value when looking at how they compare to the data analysis, which revealed a low level of decision-making power for Muslim women, as in Cameroon. As one male participant said, “religion has a big impact, and it influences [decision-making] a lot. A really religious family, it is in this family that the decision is most of the time made by a man.” However, it is critical to distinguish causation and correlation. While

religion appears to exert this effect on women, it is not necessarily the religious doctrine responsible, but religious persons interpreting scripture in one particular way. Many participants expressed concern over the ways in which their religion is interpreted and how it influenced women's experiences. As one female participant articulated:

This is a problem in Senegal. We talk a lot about religion, but we don't know it well, the Holy Qur'an. Islam says you should follow your husband if he leads you in the right way, but if your husband tells you 'go and buy alcohol, we're going to drink and dance,' you don't have to follow him. If he tells you 'go and buy sexy clothes, or sell yourself,' you don't have to do it . . . Even if it is time to pray, he doesn't have the right to ask you to come and cook for him. You are not an animal. If he is leading you in the right way, follow him. If he doesn't, even divorce is acceptable in Islam. If he is behaving like a non-Muslim, you have to leave him.

This particular participant made an important point that was similarly expressed by religious leaders in Cameroon. There is a difference between Islam and Muslims. It is not Islam that enforces particular social roles and relationships, but adherents to Islam attempting to interpret and live in accordance to the scripture. This can partly account for the tremendous diversity in interpretations regarding women's roles, and how Islam has been used as a tool in both fundamental and progressive movements throughout the Muslim world.

Demonstrating the diversity of opinions on this subject amongst Muslims, some focus group participants in Senegal offered an even more progressive interpretation of Islam's stance on women. Instead of emphasizing a women's requirement to gain approval from her husband in decision-making, one participant felt that every decision involves equal cooperation:

Concerning decision-making in the household we know that for Islam there is not a unilateral decision, neither the husband nor the wife . . . takes a decision. All rests on the agreement, the spouse and her husband must agree, there is not a decision to make all alone.

Despite speaking of a masculine authority, it is not to say that the man must decide because he is the head of the household. Every part of a couple has a responsibility.

While many women expressed this opinion, there were several others who argued in favor of women's influence within the household via discussion and dialogue, and this was often tied directly to Islam. One female participant in Cameroon claimed, "In Islam, the man and the woman are complementary. It isn't a question of the authority or the question of being subordinate to someone. When a man has a decision, he shares it with his wife." The idea of complementarities was echoed throughout all four focus groups in both Cameroon and Senegal.

In Senegal, one male focus group participant went as far as to claim the authority of women over their husbands, saying, "'I think most of the time . . . women take the decisions. Because, they say that wives have their secret weapons to convince their husbands . . . I think that man is the weaker sex. What is important in the family is the dialogue between husbands and wives." This quote illustrates two important points. First of all, it reiterates the theme of dialogue between man and wife that came up throughout all focus groups, regardless of who has the last word. More importantly, however, it suggests a strong influence of women on household decisions. That being said, one woman's opinion directly opposed this argument. A married Muslim woman made the following statement:

People are talking about women's emancipation, but you can see in some fields, and how I understand it is . . . it stops at the front of your house. It doesn't go inside the house because that's the religious belief. Man, even if you are richer than your husband, you are always behind him. That's how we were educated. And if you learn the Qur'an, it tells you that you have to follow your husband

because the paradise of a woman is in his husband's hand. That's what the Qur'an says.

This individual's statement articulated a distinction between women's parity in the community or society and women's parity within her household. In her opinion, and in the opinion of several other participants in Senegal and Cameroon, both women and men, women do not have the same authority within their household as their husbands, and this is due to specific interpretations of the Qur'an and the doctrine of Islam.

Partner Dialogue

In discussing patterns of decision-making in both Senegal and Cameroon, the need for dialogue emerged as one persistent theme. Many individuals stressed the importance of partner dialogue when making decisions. Both men and women in Senegal emphasized this ideal, as illustrated in one man's assertion that, "marriage is going to be like a partnership. Health is something that concerns both – the woman and the husband." Several other participants expressed this sentiment, like one man who looked forward to sharing all decisions with his spouse, saying, "decisions should be shared by both the husband and wife. I think there should be a consensus in decisions, because the benefit is being shared by women and men." Several male participants similarly emphasized their desire to share decisions with their partners.

However, despite the progressive attitude demonstrated by focus group participants in Dakar, it was also emphasized that this was not a universal tendency. One woman opposed the opinion that genuine cooperation and dialogue exists within households, saying:

People don't apply parity, maybe when it comes to learning, but when it comes to life in the couple, the men are more powerful than women. Don't forget that we are in Africa, we are Senegalese . . . Despite all of the struggle to better life for women, it is in vain. Look at the way our mothers are treated.

The diversity in opinions expressed above underscores the complexity of the issue at hand. It also demonstrates the importance of context. Participants in these focus groups tended to be highly educated and young and all lived in Dakar, Senegal's capital city. Their experiences differ from those without formal education living in a rural region of the country. However, gaining an understanding of the ways in which individuals interact with their context is important in grasping the meaning behind statistical trends and relationships.

Children's Health and Education Decisions

In both focus group discussions in Cameroon, education was identified as a key area in which women exhibit substantial influence and control. Focus group participants held the role of educator in high regard, as evidenced by statements like, "Muslim women participate in a grand measure where they are the primary educators of the children. Educating the children is nothing easy," and:

Islam grants the woman a job more noble and important, which is to educate the children . . . the woman produces the men and women for the society of tomorrow. I think that it is more important than that of the man . . . she has her place and that place is truly very important in the home.

In the context of Cameroon, caring for the children was seen as the primary, and perhaps the only, domain exclusive to a woman. One focus group participant illustrated this singular role when she said, "the Muslim woman makes fewer decisions than the man in terms of the household. She participates, however, in making decisions for educating the children." Another participant backed her

position up, saying, “In terms of the household affairs, the woman can make a decision regarding the health or the education of the children. The other domains are the man’s.” These statements emphasize the precise roles perceived as belonging to men and women according to interpretation of Islam. Religious authorities echoed this sentiment as well. For instance, Cheikh Baba Moussa asserted that the woman’s role is to give birth and subsequently educate the children, since the “first education of the children is in the home.” There was no disagreement expressed in regards to this particular role.

In Senegal, health decisions played an equally large role in focus group discussions. The emerging theme in regards to control over health decisions was that women tend to exert control over their children’s health because they spend the most time with them. One male focus group discussant said, “Fathers, they are busy. The mothers stay with the children, so it is the mothers who take the decision to bring the children to the hospital.” This distribution of responsibility was often attributed to the woman’s thorough understanding and concern for her children. For instance, another participant stated that fathers are responsible for family decisions in Senegal, but the mother is the one who is most worried about the child and accordingly takes action on a child’s health. Thus, he articulated, “it shows that [women] have a really great role in our society. Sometimes the men seem to be in control, but to me, women play a greater role in the family” due to their responsibility toward the family’s health.

While the husband’s approval over decisions remained an important theme, one male focus group participant told a story that illustrated the influence his mother played in ensuring his health as a child:

In my case, when I was a child I was very sick and I used to go with my mother to the hospital. One day I had to be operated on, but my father said we had to . . . believe in God, and if I believe, I will live, but if I die, we cannot change it. But my mother said she had to follow what the doctor said, that the only thing that could save me would be to take me out of the country . . . by her own way of thinking and her own involvement, she brought me out of Senegal, and that's why I am here.

If his mother had not acted in opposition to her husband's wishes, that participant would not have survived to adulthood. Clearly, his mother exerted tremendous influence over his health. This particular participant emphasized that his mother was enabled to act in this way because she lives in Dakar. Urban women, he argued, have more agency than rural women in regards to these types of decisions.

Economic Decisions

In both contexts, the role of women in economic decisions was given some attention, and there was little apparent disagreement on the topic. In Senegal, one male participant identified precise and complementary economic roles for both the husband and wife, saying, "for finance, generally the father brings home the money and he gives it to the mother and the mother makes all the plans for what the family needs." Thus, the father generates the income and the wife delegates the finances in order to care for the household. This statement implies that the woman has complete control over necessary household purchases. However, this contradicts the regression results, which implied that Muslim women in the Senegalese context are significantly less likely to have authority in regards to household purchases.

The influence of religion on women's purchasing power was not as strong in Senegal as in Cameroon. Despite these quantitative results, qualitative

discussion painted a slightly different picture. One participant in Cameroon specified that women contribute in economic decision-making, especially when their husbands aren't generating much income themselves. In fact, "this is proven in the Muslim community where one sees many more women who practice in the informal sector." This is an interesting assertion, which clearly diverges from the regression results. Not only does this participant claim that women manage household income, it also implies the role of women in generating income. Another participant agreed with this opinion, stating:

For Islam like the Prophet Muhammad said, the man is destined to work outside and to bring money into the home; the woman must take care of the children, her husband, and the home. All that the man brings in, the woman manages. In our home, the man has the responsibility to work but that doesn't mean the woman can't work.

Both of these statements define the specific roles of men and women, but they also imply women's influence over household finances, as well as the permissibility of women's employment. In processing this contradiction, it is important to note that the women making these statements live in Yaoundé, Cameroon's capital city. As previously discussed, contextual factors are incredibly important to consider when examining any relationship.

Regional Variation

As previously mentioned, an important consideration to take into account is that all qualitative work was conducted in the capital cities of Senegal and Cameroon. In discussing decision-making with participants, the unique context in which they were embedded played a large role in dialogue. Generally, participants emphasized a divide between urban and rural experiences of women's status. This was an especially strong theme in Senegal, where participants presented a

slightly negative opinion of their rural counterparts. One male participant emphasized the urban-rural divide in terms of women's experiences when he said, "in the cities, you can see both the wife and the husband go to work. If you go to the village, it is not the same." In many ways, women residing in Dakar were believed to have greater opportunities. Another male participant echoed this when he explained, "In Dakar, things are changing right now. Women are more involved in the family decisions, contrary to in the countryside where women don't have school. They just follow their husbands; they don't have the right to make decisions." Decision-making power, he argued, depends on one's region and the dominant cultural influences there.

One prominent component of this regional and cultural differentiation is ethnicity. In Senegal's capital the dominant ethnic group is the Wolof. However, in rural areas, other ethnic groups predominate. Thus, the two factors – rural/urban and ethnicity – are slightly confounded and are difficult to disentangle. One male focus group participant

In terms of decisions, it is different from one ethnic group to another. For example, if you go to the North of Senegal, and the Pular ethnic group . . . within these communities, decisions are most of the time made by men, because it is part of the culture. The people in the North are closer to the religion and the religion say, in the Qur'an, that the women are always behind. It is different from the Wolof ethnic group.

Clearly, religion is believed to play a large role in determining women's decision-making power. However, it is impossible to understand this influence without looking at region, ethnicity, education, and several other socio-demographic factors, as demonstrated in the diversity of opinions expressed on the topic.

7. FINDINGS: ISLAM AND FERTILITY

1. QUANTITATIVE RESULTS

Examining questions of religion, gender and decision-making control provides a framework in which to examine more specific decision-making patterns, specifically relating to fertility in this study. Table 7.1 directly pertains to family planning in Cameroon and Senegal. In both contexts, around 90% of respondents reported having knowledge of modern methods of contraceptives (i.e. the Pill, IUD, etc.). Despite a high level of awareness of contraceptive methods, consumption of modern contraceptive methods was significantly less in both cases, especially in Senegal. In Cameroon, 14.0% of married women reported current use of a modern method of contraceptive. While this is a relatively low figure, it is double the usage in Senegal, where only 7.2% of all respondents reported using a modern contraceptive method.

The data available on fertility decisions is limited, unfortunately, making it impossible to mimic the decision-making regressions. However, there is data available on fertility outcomes, attitudes, and knowledge, which are used now to examine the effect of being Muslim on fertility experiences in Cameroon and Senegal.

Table 7.1. Knowledge & Use Contraceptives, Cameroon 2004 & Senegal 2005

	% Knows Modern Method	% Uses Modern Method
Senegal	90.1	7.2
Cameroon	90.7	14.0

The logistic regression results of the relationship between religion and women's fertility knowledge and attitudes in Cameroon and Senegal are summarized in Table 7.2. This table shows the effect of religion on women's knowledge and use of modern contraceptive methods, husband's approval of family planning, respondents' approval of family planning, and fertility outcomes (total children ever born). The independent variable in this regression is whether or not the respondent is Muslim. A positive beta coefficient and odds ratio implies that a Muslim respondent is more likely to exhibit the behavior implied by the dependent variable. As in the previous regression findings, models were built in a two step approach: first solely controlling for religious affiliation and then building a second model that included controls for the following socio-demographic characteristics: whether the respondent lives in an urban area, if the respondent is currently married or cohabiting with a partner, as well as the respondent's education level, wealth index, and age.

The first regression examines the effect of being Muslim on contraceptive use. Before introducing variables, Muslim women were significantly more likely to use modern contraceptive methods than their non-Muslim counterparts in Cameroon (OR = 1.867). After controls, however, the significance of the relationship was diminished. In Senegal, both before and after controls, Muslim women were significantly less likely than their non-Muslim counterparts to use modern contraceptive methods (OR = .39; .494, respectively).

The second regression looks at how being Muslim affects knowledge of modern contraceptive methods. In Cameroon before controls, Muslim women were once again significantly more likely than their non-Muslim counterparts to know of a modern method (OR = 7.01). Despite this strong correlation before

controls, once introduced to the model, the relationship and significance were diminished. In this mode, education level was significantly implicated (OR = 7.74), implying education's influence rather than religion. In Senegal, Muslim women were significantly less likely to know of modern contraceptives (OR = .341) prior to controlling, and this once again remained significant after controls.

In looking at attitudes toward family planning, regressions were run on both the husband's approval of family planning and the respondent's approval of family planning. In Cameroon, Muslim respondents were significantly more likely to have husbands who approved of family planning (OR = 1.94). Once again, however, the control variables diminished significance. In Senegal, the picture remains quite different. Muslim women in Senegal were significantly less likely to have husbands who approved of family planning (OR = 0.43), a relationship that persisted after controls (OR = 0.59).

In terms of the respondent's approval of family planning, Cameroonian Muslim respondents were more likely than their non-Muslim counterparts to approve of family planning (OR = 1.819). After controlling, however, Muslim women were significantly less likely to approve of family planning. In Senegal, both before and after introducing controls, Muslim women were significantly less likely to approve of family planning than their non-Muslim counterparts.

The final regression examined fertility outcomes of Muslim women in both countries. Being Muslim was negatively correlated with having more children in Cameroon, an outcome that is perhaps surprising based on previous studies. In Senegal, however, being Muslim was positively correlated with having children before controls. However, significance was diminished once controls were introduced to the model.

Table 7.2 Logistic Regression Results of Relationship Between Religion and Fertility

CAMEROON

	Respondent...																			
	Uses Modern Method				Knows Modern Method				Husband approves of FP				Respondent approves of FP				Total Children Ever Born			
	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	B		
Religious Variables																				
Respondent is Muslim	0.62 ***	1.87	-0.11	0.89	1.95 ***	7.01	-0.29	0.75	0.66 ***	1.94	-0.14	0.87	0.60 ***	1.82	-0.31 ***	0.73	-1.06 ***	-0.34 ***		
Respondent socio-demographic characteristics																				
Lives in urban area			0.30 ***	1.35			0.52 ***	1.68			-0.15 **	0.86			-0.08	0.92		-0.13 **		
Currently married or cohabiting			0.13	1.14			0.66 ***	1.93							0.16 **	1.18		0.66 ***		
Highest education level			0.74 ***	2.09			2.05 ***	7.74			0.91 ***	2.49			1.11 ***	3.04		-0.45 ***		
Wealth index			0.26 ***	1.30			0.33 ***	1.40			0.28 ***	1.32			0.24 ***	1.27		-0.14 ***		
Age			0.01	1.01			0.02 ***	1.02			-0.01 ***	0.99			0.00	1.00				
Constant	-1.89		-4.21		2.19		-1.27		-0.54		-1.94		0.49		-1.56		2.87	-2.17		
Number of Cases	10656		10656		10656		10656		10656		10656		10656		10656		10656	10656		
-2 Log likelihood	8577		7790		6467		4657		9473		8278		13936		11888					
Nagelkerke R	0.01		0.14		0.02		0.36		0.01		0.22		0.01		0.25		0.01 ^a	0.60 ^a		

SENEGAL

	Respondent...																			
	Uses Modern Method				Knows Modern Method				Husband approves of FP				Respondent approves of FP				Total Children Ever Born			
	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	O.R.	B	B		
Religious Variables																				
Respondent is Muslim	-0.94 ***	0.39	-0.71 ***	0.49	-1.08 ***	0.34	-0.74 ***	0.47	-0.84 ***	0.43	-0.52 ***	0.60	-0.58 ***	0.56	-0.31 ***	0.73	0.41 ***	-0.13		
Respondent socio-demographic characteristics																				
Lives in urban area			0.59 ***	1.81			0.54 ***	1.72			0.44 ***	1.55			0.36 ***	1.43				
Currently married or cohabiting			2.53 ***	12.60			1.43 ***	4.17							0.88 ***	2.41		2.75 ***		
Highest education level			0.62 ***	1.87			0.70 ***	2.01			0.64 ***	1.89			0.54 ***	1.72		-0.63 ***		
Wealth index			0.22 ***	1.25			0.24 ***	1.27			0.22 ***	1.24			0.10 ***	1.10		-0.14 ***		
Age			-5.42 ***	0.00														-0.13 **		
Constant	-1.68				3.26		0.95		-0.47		-1.88		0.30				2.34	1.87		
Number of Cases	14602		14602		14602		14602		14602		14602		14602		14602		14602	14602		
-2 Log likelihood	7490		6476		9365		8494		10700		9764		19962		18887					
Nagelkerke R	0.01		0.17		0.01		0.13		0.01		0.14		0.00		0.10		0.00 ^a	0.27 ^a		

^a Denotes r-squared. Results for this model stem from a standard OLS regression, since the outcome variable (CEB) is continuous. This is also why there are no odds ratios reported for this model.

2. QUALITATIVE RESULTS

In discussing fertility attitudes and decisions in Cameroon and Senegal, multiple questions were examined. Fertility decision themes that emerged included whether fertility preferences were discussed and who had the authority to make fertility decisions. Topics relating to fertility preferences included the permissibility of family planning according to Islam and the ways in which education, polygamy and regional differences factor into these discussions. Below, I present the findings as they emerged from various questions.

Is family planning discussed?

Whether or not family planning is discussed amongst spouses played a larger role in Senegalese focus group discussions than in Cameroon. However, one participant in Cameroon expressed the opinion that, “generally the number of children is not mentioned in discussions between couples who practice my religion (Islam).” In general, participants in Cameroon seemed to be more united in their opinions on family planning and fertility control, which may account for the absence of discussion on this topic during focus groups. This was not the case in Senegal, however, where participants debated this issue in both discussions.

When asked whether or not spouses discussed family planning, one informant agreed it was critical to have, “discussion between you and your husband because if you don’t have your husband’s blessing you don’t do it [family planning] . . . It’s a marriage decision, between you and your partner so you have to discuss.” As was observed in examining household decision-making dynamics, this opinion illustrates the themes of partner dialogue and ultimate submission to the husband’s wishes. If the husband is opposed to family

planning, she said, then the wife must obey his wishes. However, another male participant spoke to the wife's ability to influence fertility decisions, further underscoring the importance of discussion: "It is up to the wife to speak with her husband and to explain the problem to him. And if you love your wife, if you deeply share your life with her, you've got to understand her. And having this kind of process creates a nice familial atmosphere." Throughout all discussions and interviews, participants raised this idea, demonstrating once again a more progressive attitude toward marital relationships than might be expected based on data alone.

Who decides?

In examining general household decisions, dialogue was emphasized in both countries. However, the man's opinion remained dominant in most cases, as evidenced by the regression results and several focus group participants. Does this trend remain when examining fertility decisions?

As is to be expected, participants disagreed on this point. However, many women in Cameroon expressed a sense of agency and autonomy in regards to family planning decisions. As one woman explained:

More and more, women are strongly implicated in making the decision because they are the ones who carry the children. It is their health that is the question. For my part, I can plan my births without talking to my spouse if he cannot understand that it is for my health and the well being of the children.

This woman felt that she had control because each pregnancy directly affected her physical health. She expressed a sense of control over her own body, a sentiment supported by another woman's assertion that, "the woman must also

make the decision about the number of children that she wishes to have because it is she who suffers with the children.”

This opinion was not universally shared, however, as articulated in the statement that, “contrary to what my sister said, it is always the man who decides the number of children under the pretext that it is he who brings home money. She participates more in the health plan and the education because of her position close to the children.” Here, the man’s position as household head and provider strengthens his authority in most decisions, including fertility.

In Senegal, the most commonly expressed opinion was that the husband maintains control over fertility decisions. One female participant said, “I think it is the man . . . Women are trying to have their voice, and it is very difficult, and that’s why there are many divorces today. Men are not psychologically prepared to accept this kind of situation and women are tied to follow their husbands.” Another female participant provided insight into the consequences of this dynamic, saying:

It is man who has authority. We were in a village, and we saw women with lots of health problems like anemia because they don’t eat well, they don’t feed themselves properly and they have many children, but they can’t reduce the number of children they have because they just have to go on what the husband says, so they keep giving birth even if they know that it is not healthy for them.

Although this type of situation was acknowledged as a reality in Senegal, many participants expressed their disapproval of this dynamic. The general consensus was that, in matters of health, the woman should be enabled to exert control over her own fertility, regardless of her husband’s wishes.

Is family planning permissible according to Islam?

The permissibility of family planning according to Islam is a highly controversial topic amongst individuals, despite the overall approval of family planning by Islamic jurists. Many informants in Cameroon believe that Islam expressly prohibits family planning, as one woman explained when she said, “The utilization of preservative, taking pills and other injections are prohibited because it is Allah who gives the children. In his mercy, the needs of the man are always provided.” Because the Qur’an says God will provide all for his adherents, many Muslim individuals believed it would be wrong to control fertility, which essentially expresses doubt in God’s ability to provide for the faithful. Another woman echoed this, saying “The Muslim woman cannot limit births. All is the will of Allah, to Allah to decide what he wants for us, without the need of our consent.” Participants in Cameroon generally accepted this opinion, although a few specific exceptions were articulated.

One circumstance in which family planning was deemed permissible was in the case of a mother’s health. As one woman explained, “There is a condition . . . for which religion is in favor of family planning. That is the case where health is at risk. If a new pregnancy will endanger the life of the woman, a doctor must take that under consideration.” Protecting the mother’s health was universally agreed upon as a reason to use family planning.

Additionally, some women believed temporary methods of birth control are permissible for the purpose of spacing pregnancies. For example, one woman argued that, “if family planning signifies spacing births and not limiting them, to do that there are certain methods that are permitted like *coitus interruptus* [withdrawal], condoms, pills and Norplant.” However, all participants rejected permanent measures like sterilization.

The opinion of religious leaders in Cameroon differed slightly both from the women surveyed and from one another. One imam expressed very strict guidelines to contraceptive use:

The religion is against these methods that are not natural. And the methods must not be taken by young, unmarried girls. In the marriage, there are methods that could be medically recommended. The woman cannot make the decision without her husband's consent. Between two births, there is a very reliable birth spacing method that has been proven: breastfeeding.

However, in the same religious community, Cheikh Baba Moussa articulated a much more permissive stance on family planning, in contradiction to his colleague. The Cheikh believed that Islam did not forbid family planning in any circumstance, save limiting births, once more underscoring the diversity of opinions and interpretations that exist among Muslims.

One important specification made by both individual women and the religious leaders was that family planning is only permissible for married women. It was agreed that no unmarried woman should use family planning, because that implies she is having sex out of wedlock, which was generally forbidden. One woman stated that, "it is essential to specify that Islam is not against family planning. Religion disapproves of the young who are not married using family planning. It is reserved for married women." For unmarried women, "the only type of method she can use is abstinence," according to multiple participants.

The discussion on family planning permissiveness in Senegal brought up several similar opinions. However, one point that got emphasized in this context was how men view family planning in their religious context. One male participant, a sociologist, explained his observations from surveying couples on

this topic, saying, “In Dakar, Pikine . . . there are some women that talk about why their husband didn’t agree about family planning. . . . there are many, many men who think that family planning is not compatible with Islam.” This gender dimension comes in to play when couples make fertility decisions.

Another theme that got significant attention in Senegal was the importance of enlarging the prophet’s family. Several participants brought this up as a reason to forbid family planning. According to one woman, “in the Qur’an it is said if you have many children . . . it’s kind of enlarging the prophet’s family.” Another man shared this view, stating, “[family planning] is not allowed by the religionIn the Qur’an they say, they want to increase the number of Muslims in the world, that’s why they are going to have two or three or four wives.” If the Qur’an encourages enlarging the Prophet’s family, then family planning acts in direct opposition to this goal.

What is the role of education?

As is to be expected, participants believed that education plays a role in attitudes about fertility and the women’s autonomy in fertility decision-making processes. As one woman in Cameroon stated, “the degree of implication lies at the level of emancipation or education. The intellectual Muslim woman more easily adopts contraceptive methods than those who did not attend school.” Women are both more likely to accept family planning and to determine their own use of contraceptive services if they are educated.

Furthermore, the education of a woman’s husband plays a role. According to some women, an educated woman won’t have control over her fertility unless

her husband is likewise educated, because “a Muslim man who didn’t attend school will not accept all of that [family planning].”

While the influence of educational attainment is a universal factor in a woman’s control over fertility, Muslim women were perceived as more restricted than their counterparts because of an overall lower level of education. One woman stated, “The Muslim woman is less implicated than women of other religions. It it’s the result of low levels of access to education.” Another woman echoed this, saying that Muslim women use family planning less than Christians, because of a “misunderstanding of Islam and also the submission of Muslim women because of their level of education.” Recalling the demographic data summarized earlier on in this paper, Muslim women in Cameroon were significantly more likely to be educated than their non-Muslim counterparts. However, that is an aggregate statistic, and the urban respondents in this study may experience a different reality, where non-Muslim women in urban areas are more highly educated as a group.

Education also played a role in rural-urban differences of perceptions of family planning, according to several women. Many times, when the differential situation of rural women was brought up, it was tied into differences in educational attainment. For instance, one woman explained that, “there exists a difference in perception between rural areas and urban areas. The rural woman is consulted very little and also has little education.” Supporting this statement, another woman specified that the three types of women most likely to use family planning are, “educated women, women living in an urban area or those who are in prenatal consultation during pregnancy.”

A similar theme was expressed in Senegal. Across all focus groups and interviews, the positive correlation between education and family planning use was established. One woman explained the rationale behind this connection, saying, “if you are educated, you know that success is very important. Having children is good, but if you have children, you put them in good conditions,” demonstrating an awareness of economic limitations to fertility.

Another way in which education came up in discussion in both contexts was the importance of providing children with a good education. In Senegal, one male participant argued that a couple’s ability to provide for their children should be a consideration when discussing fertility. He acknowledged, “If you are poor and you have a lot of children . . . they won’t get a good education because there are so many. Their father did not give them a good education.” This would be a problem, because “in the Qur’an, it says you should give them a good education, but if you have many children, how can you give them a good education?”

This sentiment wasn’t conveyed in Cameroon, where one woman stated that family planning was only permitted for health reasons, “but when speaking of finances, Islam forbids family planning, even when it’s for the children’s education.” This can be attributed to the belief that God will provide all resources necessary to support, feed, and educate the children.

What is the role of polygamy?

An interesting point brought up in both Cameroon and Senegal was how polygamy plays into fertility attitudes and decision-making. In Cameroon, polygamy was seen as a type of family planning. One woman explained this

particularly well when she said, “the woman can decide to space births if her husband understands and consents. And in the case where he is not in agreement with that decision, the alternative is polygamy: if she is not against that situation, polygamy is essential.” Thus, if the woman wants to control her fertility while her husband wants to have more children, he can take on another wife with whom to continue procreating. Another participant went as far as to claim that, “the method already understood by the Muslim religion for spacing births is polygamy.” Thus, in Cameroon, polygamy was seen as a natural form of birth control.

In Senegal, polygamy was brought up in a different light. Polygamy, it was argued, encourages women to increase their fertility, because “for the heritage, the more children you have, the more land or inheritance you get. The more boys – and the boys are very important. A boy represents two girls.” Thus, in order to gain more inheritance than a co-wife, a woman is encouraged to continue having children, specifically boys. Also, if a woman only has girls, this tradition of distributing inheritance encourages her to continue bearing children in order to have one or more male children.

Are there regional differences?

In Senegal, one factor that came up once more in discussing fertility was region. Villages were assumed to have lower use of contraceptives by all participants because, “if you go to the village, it’s better to have a large family. They live from what they work, and it’s not smart to have a big field there and a small family, because it won’t help you to succeed in your farm.” In agricultural areas, having a large number of children is an asset, because children provide

labor. Another participant thought that, in this case, having many children “is noble.” However, he recognized that, “the problem is, even if they have a lot of children to grow the land, they don’t think about the health of their wives. We need to go and sensitize them to this.” This individual, while recognizing the economic advantage to having many children, believed the health consequences outweighed the benefit, and took a very pro-family planning stance. This represents an apparent shift in thinking in urban areas like Dakar, where younger generations strive to pursue competitive careers and provide adequately for smaller families. In the city, large families were described as a burden rather than an asset. For example, one man said, “Dakar is not the same. We think that if we have two children it’s better, because it’s expensive.” The high cost of living in an urban area, coupled with the industrialized setting, makes large families questionable. Furthermore, capital cities such as Dakar and Yaoundé are not representative of the rest of the countries being studied, due to a number of factors including increased exposure to other parts of the world, which may influence attitudes and perceptions of residents. For these reasons, the findings here cannot be generalized for the entirety of the countries in question, let alone the Muslim world; rather, they represent the specific experiences of Muslim men and women in the capital cities of Cameroon and Senegal.

8. DISCUSSION

Using both quantitative and qualitative methods, this paper examined a set of four questions concerning religion’s influence – and more specifically, Islam’s

influence – on women’s decision-making power in terms of household and fertility decisions in Senegal and Cameroon. These questions are:

1. Do Muslim women have the same level of control over household decision-making as their non-Muslim counterparts in Cameroon and Senegal?
2. Does the extent of Muslim women’s participation in key household decision-making differ from their participation in reproductive decisions? In other words, if these women do not participate in household decision, does this non-participation include reproductive health?
3. Do the rates of contraceptive use and participation in reproductive decision-making among Muslim women differ from those observed among non-Muslims?
4. What do Muslim women and men say about the influences and prescriptions of religion on the practice of family planning?

In order to answer these questions, a mixed methods approach was utilized. Quantitative research was conducted using the DHS surveys microdata for Cameroon (2004) and Senegal (2005). In regards to question one, logistic regressions were run looking at the effect of being Muslim on household decision-making. The quantitative analysis on household decision-making suggested that being Muslim has a significant effect on women’s involvement in household decision-making in both Senegal and Cameroon. In both countries, Muslim women were significantly less likely than their non-Muslim counterparts to have a say in their own health, large purchases, daily purchases, and visits. This significance remained even after controlling for wealth, education, urban residency, marital status, and age, underlying the strong influence of religious

affiliation on individual outcomes. It is also important to note that this relationship was stronger in Cameroon than in Senegal in all cases, indicating that Muslim women are more strongly impacted by their religious affiliation in Cameroon than in Senegal. While not explicitly tested, this difference may stem from the religious composition of the population. The significance of being a Muslim may be heightened in a pluralistic setting where Muslims may be perceived as minorities. This supports Goldscheider's minority group status theory, which stipulates that minority groups who feel discriminated against may experience a greater commitment to group-specific social norms in order to ensure group cohesion and preservation.

Qualitative research conducted in Dakar, Senegal and Yaoundé, Cameroon, provided an opportunity to examine these trends more closely. Qualitative methods consisted of four total focus group discussions (two per location) and personal interviews with individuals, health care providers, and religious leaders. Many themes emerged from these focus groups relating to Islam and household decision-making, such as the importance of partner dialogue for all household decisions. However, despite this emphasis, men were widely believed to have the final say in all decisions and it was thus the women's job to convince her spouse of her opinion if he disagreed, or else follow her husband's lead. Rarely did participants cite a situation where women have complete control over decision-making. In both contexts, this belief was rooted in interpretations of the Qur'an. However, there were areas in which women were perceived as principal decision-makers, including children's health and education. This was attributed to the time women spend with their children in

the home. This role was generally respected, and many participants argued that taking care of the children is the noblest role in society.

Looking at questions two, three, and four, the quantitative analysis on religion and fertility indicated different fertility experiences for Muslim women in Cameroon versus Senegal. Before controls, Muslim women in Cameroon were significantly more likely to know and use modern contraceptive methods, to have a husband who approves of family planning, to approve of family planning themselves, and to have fewer children than their non-Muslim counterparts. However, religion may have had less of a role in these patterns than other variables, since Muslim women in Cameroon were also significantly more likely to be wealthy, live in urban areas and have higher levels of education than non-Muslims, and the introduction of these variables diminished the significance of the original relationship examined. In Senegal, Muslim women (both before and after introducing controls) were significantly less likely to know and use modern contraceptive methods, to have a husband's approval of family planning, and to approve of family planning themselves. Muslim women in Senegal also had more children than non-Muslims, although this relationship reversed once controls were added to the model, indicating a lesser influence of religion on this outcome.

The qualitative examination of these questions revealed an ambiguous effect of religion on fertility. Results from Cameroon seemed to support the characteristics hypothesis that socio-demographic factors other than religion account for differences in religious groups' reproductive behavior (Goldscheider 1971), since significance dropped in most regression models once controls were

introduced. Education, wealth, and urban residency maintained strong relationships with the outcome measured.

In terms of family planning, many participants believed the man had a final say in using family planning, although a shift in this may be occurring, especially in urban areas and amongst younger generations. Several young, male participants in Senegal expressed support for allowing the woman more of a say in her own reproduction.

Another thematic area of discussion was the permissibility of Islam in regards to contraceptives. The qualitative research indicated that many Muslims believe Islam forbids modern contraceptive methods, although all believed Islam is in favor of spacing births and several conceded that family planning is still practiced by Muslim individuals. In general, women with a higher level of education who lived in urban areas were assumed to be most likely to use modern contraceptive. In all fertility-related discussion, there was substantially more disagreement than in decision-making discussion.

What do these findings mean? As was expected, religion (specifically Islam) informs the lived experiences of women in Cameroon and Senegal, especially in regards to involvement in household decision-making. Furthermore, religion mediates fertility experiences by defining the morality and values of individuals and communities, especially relating to sexuality. Thus, efforts to reduce fertility amongst groups characterized by strong religious convictions must focus on defining the goals within the religious context. As the director of Marie Stopes Senegal – a family planning organization present across the world – articulated in an interview, “you have to work with [the religious]

message and you have to work with local religious leaders, because they can make it or break it for you.”

Working within Islam and with religious leaders proved incredibly effective in the Islamic Republic of Iran, where over 70% of married women use modern contraceptive methods today. One substantial difference between Iran and Senegal – where less than 10% of married women use modern contraceptives – is that there is widespread belief among Senegalese Muslims that Islam forbids contraceptive methods such as the pill. If policymakers want to achieve Millennium Development Goal 5b – universal access to reproductive health services - effective policy needs to simultaneously take into account these factors to encourage an uptake in contraceptive knowledge and access, and thus an improvement in overall maternal health (United Nations Development Programme 2011). As Mahler (1999) concluded, Islam neither hinders nor encourages contraceptive use on a global level. It all depends on the particular interpretation of family planning’s permissibility within the religious scripture. Policymakers can work alongside religious leaders to disseminate the permissive interpretations of Islam in regards to family planning.

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