Humanizing Childbirth for Muslim Women: Call For a Shariah Compliant Guideline

Norazlina Abdul Aziz[1]*, Irini Ibrahim[2], Nurazlina Abdul Raof[3], Rozlinda Abdullah[4], Nur Asma Yahaya[5,] Nurullhuda Ahmad[6]

[1,2,3,4,5]Faculty of Law, Universiti Teknologi MARA,
40450 Shah Alam, Selangor.

*Corresponding Author
noraz_aa@yahoo.com.my

ABSTRACT

There are many complaints made by Muslim women on the dilemma that they faced during the childbirth process. Among the complaints is the issue of *aurah*, the rights for them to have female doctors and to be pre-informed on the usage of non-halal medicine. Currently there are no specific guidelines or regulations adopted by the public and private hospitals to uphold these rights of Muslim women during childbirth. Although the childbirth process can be categorized as the situation of *dharurah* or emergency where exception to the general Islamic rulings is applicable, yet the exception will be lifted when the situation of *dharurah* ceased to exist. Labour processes involve three stages that include the pre-childbirth, during childbirth and post-childbirth. The question is whether all three stages are qualified to be categorized as *dharurah* thus making it unnecessary to propose a guideline to address the issue of Muslim women during childbirth. In answering this question, the study will analyse the current practices in the private and public hospital during the three stages of childbirth with the aim of identifying the protection of rights given to the Muslim women in upholding their religious practice. The concept of *dharurah* will be discussed in applying it to the three stages of childbirth. The study adopts qualitative methods that involve arm-researcher method and semi-structured

interviews. The arm-researcher approach delved into the current guideline (if any) applicable to doctors and medical assistance during childbirth in the private and public hospitals and the relevant laws. Meanwhile semi-structured interviews were conducted with selective respondents consisting of the medical practitioner, legal practitioner, and academicians. The study proposed for a guideline that can govern the conduct of medical practitioners and childbirth assistance in attending Muslim women during the three stages of childbirth.

Keywords: Humanizing, Childbirth, Muslim Women, Guideline

1. Introduction

Childbirth is regarded as one of the most significant experiences in women's life, and it can in turn affect the rest of their life physically and emotionally. Thus assisting women in giving birth becomes an important process in ensuring that they are treated well by respecting their rights as human being. Researches have showed that there were many complaints made on the incidence of unethical conduct during the process. In early 20th century, childbirth was mostly attended at home by midwives (Rattner, 2009). The midwives were not guided ethically or procedurally on the methods of attending woman during childbirth. Later however, there was a growing trend for women to have their babies born at hospitals. As at end of the 20th century, more than 90 percent of births were carried out in hospitals (Rattner, 2009). The advances see medical interventions in the process of childbirth such as the use of electronic fetal monitoring (EFM), epidural analgesia, anatomy, induced labor, episiotomy, and elective caesarean section deliveries increased (Roxana, Marie, William, Lise, Masako & Chizuru, 2010).

Although the technic and equipment used had improved in reducing the morbidity and mortality rate, yet there is not much improvement on human conduct in the process of childbirth. There are continuous complaints on the unethical treatment that the women received during the process of childbirth. The complaints can be categorized under the

technological assistance and human conduct. Despite the technological advancement in the childbirth process, there are complaints on the deterioration of ethical values among the medical practitioners and the modern midwives during childbirth. In relation to this, many studies were done on the issue of unethical conduct and yet there is no specific study on ethical conduct during childbirth within the purview of Muslim women's need. Many Muslim women or their spouses' were complaining on the issue of *aurah*, the use of non-halal medicine and the right to have a female doctor. A tragic case had occurred in April 2016 near King Fahad Medical City, Riyadh where it was reported that a Muslim husband shot a Jordanian Obstetrician who helped his wife during the birth of their baby. The New Arab newspaper (The New Arab, 2016), revealed that the husband was against the practice of male doctors attending female patients during labour. This is closely related to his faith and believes on issue of *aurat* of a Muslim woman. Islamic bioethics emphasizes that patients must be treated with respect and compassion and that the physical, mental and spiritual dimensions of the illness experience be taken into account. In responding to this scenario the study analyses the concept of humanizing and respect to person together with the current guidelines used in the private and public hospitals for childbirth. The study also analyses the existing statute that are relevant to this area with the aim of finding the *lacunae* that can be filled in by the findings of this study.

2. Method

The study adopts qualitative methods that involved arm-researcher method and semi-structured interviews. The arm-researcher approach delved into the current guideline (if any) applicable to doctors and medical assistance during childbirth in the private and public hospitals. Meanwhile semi-structured interviews are conducted with the selective respondents consisting of the medical practitioner, legal practitioner, and academicians. The existing laws that are used to justify such interference and the laws specifically regulating women's rights in pregnancy and childbirth are also examined.

3. Results and Discussion

In the current legal vacuum on women's rights in childbirth, police officers and medical staff are too quick to conclude that they can do anything to a woman, as long as they believe it is for the baby's good. Health providers accomplish their tasks and standard procedures in accordance to hospital policy. They do not necessarily intend to meet the needs of mothers, such as being listened to, being able to be involved in decision-making, and being offered choices (Ho & Holroyd, 2002). Women activist condemned (Kalina, 2012) this act, stating that this is wrong and unacceptable. It gives privilege to anyone who may want to interfere with the birth process for whatever noble or misconceived reasons they may have, and it takes away the dignity and human rights of the women. In the medical model of childbirth, women have very little, or no voice in the childbirth, or the decision making process. If a woman does not follow the health provider's explanations, she can be held accountable for a poor pregnancy outcome, implying that it becomes the woman's liability (Davis, 2004; Jordan & Davis, 1993; Lazarus, 1994).

3.1 Issues of Unethical Conduct during Childbirth

A study by Daphne reveals that the twentieth century has witnessed a growing enthusiasm within the health sector development, where the technical component was privileged over the care component. (Rattner, 2009). Studies on unethical behavior during childbirth showed that not only Muslim women that require protection but all women also require their rights to be protected during childbirth. A study by D'Oliveira, Diniz & Schraiber (2002) has identified several categories of violence and unethical conduct of the healthcare provider that may happen during childbirth. They identified four forms of abuse that happen in birth: negligence, verbal and/or psychological abuse, physical and sexual abuse. These had greatly contributing to the perception that labor or childbirth is traumatic and painful.

Another discussion on ethical consideration during childbirth has been mentioned by Lo Cicero (1993) who focused on the psychological aspects of interaction between patient and obstetricians. Since the

approach to service follows a male logic and many obstetrical care providers are male, hence female vulnerability is exposed during childbirth, allowing the expression of that difference.

3.2 Humanizing Birth: Recognising Women's Right

The attention on the concept of humanized care is growing steadily around the world. The humanization of birth is an alternative model to the medical and technological childbirth models. Humanizing birth means considering women's values, beliefs, and feelings and respecting their dignity and autonomy during the birth process. Reducing over-medicalized childbirths, empowering women and the use of evidence-based maternity practice are strategies that promote humanized birth (Roxana, Marie, William, Lise, Masako & Chizuru, 2010). This model puts the woman in control of her own childbirth, in order to allow her to contribute to making all the decisions about what will happen to her, as well as to her baby (Page, 2000). The humanization of birth is supposed to enhance women's self-confidence, whilst aiding them to form a bond with their babies, and to be more competent in their roles as parents (Page, 2000). For Duarte et al. (2015), this industrial and technical approach regarding health care has also contributed to the development of hospitals as privileged places for the health service provision where one of the components of the process of care is the interpersonal relationship, to which it has been associated with the concept of humanization. Pope and Graham (2001) mentioned that the key principles for humanizing birth consist of choice, continuity, and control. The literature reveals different perspectives on the concept of the humanization of birth. They emphasized that humanizing birth should entail commitment to the ambience, working conditions and health care attendance improvement; respect for issues related to gender, ethnicity, race, sexual orientation and specific populations (Indians, maroons, riverine, settlers, etc.) (Rattner, 2009).

From previous literature (Kalina, 2013; Roxana, Marie, William & Chizuru,' 2013; Abdallah & A. Khittamy , 2001), we have come to the understanding that the humanization of birth does not remain restricted only to technical attributes, nor does it simply refer to providing care for

women in a humane manner (Jones, 2002). According to Lindsay, the aforementioned concept is not limited to just normal pregnancies but may extend to problematic pregnancies. This sometimes is associated with the modern view of a good responsible mother who is described as one who readily and gratefully accepts all kinds of medical assistance in the form of oxytocin drips, epidurals, repeated vaginal exams, caesareans, forceps, vacuums, episiotomies, and all other kinds of invasive and often unnecessary medical procedures. Women's competency as mothers is often judged solely based on their level of compliance with these procedures (Kalina, 2013).

Study by D'Oliveira, Diniz & Schraiber (2002) has also introduced the concept of humanization that need to be incorporated during the process of childbirth. They relate it to the requirement that will help in the reduction of mortality rate during childbirth. Literatures described the specific characteristics of a humanized birth as follows: One which promotes an active participation of women on decision making and other aspects of their own care; one which takes advantage of the expertise of both physicians and non-physicians and allows them to work together as equals.

The rights of woman during childbirth has also been studied by Roxana et al. (2013) that disclosed the first wave of feminist activist that has happened during the nineteenth and early twentieth centuries, argued persistently for women's rights to relieve their own suffering, and hence to gain control over the birth process, the right of extended choices during childbirth and having full control over their body, as well as their reproductive. The consequences of the struggle of the first wave of feminist activists were beneficial, as women gained the right to use pain relief drugs and to express their preference for or against it; however, women lost control over the process of childbirth, as well as allowing birth to continue to shift from home to hospital (Roxana et al., 2013).

In recent years, global attention has focused on how women in Muslim communities are revitalizing Islam by linking interpretation of religious ideas to the protection of rights and freedoms. In line with

this, a study by Esposito (1999) argued that social and cultural power have created the potential for claim based on awareness of the women's beliefs, practices, and experiences. Thus this study proposed some strategies that can be used to empower women and their care providers by taking into consideration humanized values such as the women's emotional state, their values, beliefs, and sense of dignity and autonomy during childbirth.

The preceding discussions conclude that there are few writings that have discussed on the Islamic perspective of childbirth that include issues on bioethics (Abdallah & A. Khittamy, 2001), human cloning, Assisted Reproduction Technology (Suleiman, Abubakar, Ahmad, Ali Reza, Mohammadreza & Fauzi, 2013), abortion and birth control. Even though the study has highlighted the importance to preserve a woman dignity during childbirth but the discussions are confined to the general concept and did not identify the specific unethical conduct that may encroach into the practice of faith for Muslim women during childbirth and there are limited studies on the rights of Muslim women during childbirth.

3.3 Humanizing Childbirth

The nine-month-pregnancy can be stressful to some women. They need to see the doctor regularly to monitor the health status of the baby. During this prenatal period, not many ethical issues were raised as most of the women are given the right to choose the doctor that they desire. Prenatal care is the regular health care women receive from an obstetrician or midwife during pregnancy. It also known as antenatal care that is a type of preventive healthcare with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child.

The concept of humanizing birth includes the capacity to understand, as well as to respect human beings in a different form of their existence (Backes, Koerich, & Erdmann, 2007). This concept also aids in the provision of physical and emotional privacy, and preparation

of a comfortable environment for the women during the prenatal care period (Kuo, 2005). Moura, Crizostomo, Nery, Mendonca, De Arajo & Da Rocha (2007) revealed that humanized assistance during childbirth privileges respect towards women's sense of dignity and autonomy, while reinforcing their active role in the birth process.

Some aspects of the humanized birth model were presented in a report by the British Government in 1993 (Angela, 2013). These were based on the following three key principles: 1) Women must feel that they are at the centre of maternity care to make decisions, to have control over their labour, and to have discussed matters with their health care providers. 2) Maternity services must respond to mother's needs. They should be effective and easily accessible. 3) Women should be involved in maternity services planning in order to ensure that they are tailored to the needs of women in society (Page, 2000). One of the most important aspects of humanized birth is to be able to look at a pregnant woman as a person and not a patient, and to be able to establish a real human connection with her. The connection between the care provider and the woman is an important principle of humanized birth approach (Davis-Floyd (2001).

3.4 Issues Relating to Muslim Women in Childbirth

3.4.1 *Aurah*

Aurah is a term used within Islam which denotes the intimate parts of the body, for both men and women, which must be covered with clothing. Exposing the *aurah* is unlawful in Islam and is regarded as sinful. The exact definition of *aurah* varies between different schools of Islamic thought.

Prophet SAW said, "No man should look at the *aurah* of another man, and no woman should look at the *aurah* of another woman." [Reported by Muslim]

Neither men nor women should uncover their genitals at any time except when in privacy. Men and women should at all times wear

garments that are loose and made of material that is not transparent enough to see the skin colour and shape of the other (male or female). Not only that, they must also protect their gaze from the aurah of those unlawful for them (Shaykh Muhammad Saalih al-Munajjid , 2017).

"O children of Adam, We have bestowed upon you clothing to conceal your private parts and as adornment. But the clothing of righteousness - that is best. That is from the signs of Allah that perhaps they will remember" (Al-Quran, 7: 26)

3.4.2 Rights to Have a Doctor

Women giving birth are often muddled between choosing a doctor that they favour and forced to deliver the baby safely. During the critical time of delivering the baby these women are usually not able to make serious medical decisions quickly and having a limited understanding of the process involved. It can be easy to forget that assisting a woman who is in a process of giving birth is not merely attending human body that need to be assisted, but this is a human with emotional needs and rights.

Doctors are, by definition, medical experts. In normal situation, they can use their expertise to diagnose patients' illness and recommend courses of treatment. However, patients should always remember that the decision to treat or not ultimately resides on them. Similarly, a woman in labour can be attended by any gynecologist decided by the hospital at times of emergency but the ultimate decision lies on the woman herself or her husband to request for female doctor. Of course the best way for the woman to assert her right is to plan ahead. In the midst of emergency, it is not the right time to make such assertion of getting what one required. After all, Islam allows for a female patient to be attended by a male doctor at times of emergency. Fortunately, there are steps a woman can take to make decision ahead of time. Once she knew how she would like to be treated in time of labour, she can make a booking for the doctor she wished to have.

3.4.3 Usage of Non-Halal Medicine

Muslims believe that every human need to be supplied with good foods, good surroundings and good Islamic daily practices from the womb to the grave in order to develop into a person with good characters and soul. The belief is stated in several Islamic law sources. A verse from the Quran states:

> "Let the human reflect on the food he eats" (al-Quran, 80: 24)

The understanding of above revelation implies that the consumption of haram food is perceived to develop bad and unscrupulous behavior which will be the damaging factor for a person and his family in this world and hereafter. Consuming liquor, for instance, is said to lead to addiction, misbehavior and negative impact on health. It will magnetized wrongful act such as corruption and immorality and give rise to unexpected eternal doom in the hereafter.

In a study conducted by Lee, Lee & Ng (2012) shows that the willingness of patient to take insulin is very much influenced by his religious belief. The controversies of non-halal insulin for diabetic patient have contributed to the low intake of insulin, where the patient has diverted to consume complimentary medication. Similarly Muslim patients and consumer's sensibility have emerged to demand for halal enzyme in the food and medical production.

3.5 Concept of Dharurah and Childbirth

Dharurah in Arabic is derived from *darar*, which means an injury that cannot be avoided (Saim, 2010). Abdur Rashid (2010) extends the definition of *darar* to mean to harm, impair, damage or hurt. It is the opposite of benefit (Mansour, 1997). The principle of *dharurah* gains its legality from certain explicit textual evidence. Although the evidence mainly deals with life and death situations, such as the case of starvation, the jurists argued that the specific permission to eat unlawful meals can be extended to other emergency cases (Yasmin, 2010; Idris, 2000). Many researchers (Yusuf Al Qaradawi, 2001; Securities Commission

Malaysia, 2009; Consumers Association Penang, 2006; Abd Rahman, 2012; Harmy et al., 2011; Jabatan Mufti Kerajaan Brunei, 2007; Aznan, 2011; Hasballah, 2010) who have conducted studies on halal and haram acknowledge that necessity will lift the prohibition to use and consume haram goods thus necessity permits prohibited things. They quoted the following divine words of Allah SWT:

> *"Why should you not eat of (meats) on which Allah's name has explained to you in detail what is forbidden to you- except under compulsion of necessity"*(Al-Quran, 6 : 119)(Abdullah Yusuf Ali, 2007)

> *"He has only forbidden you dead meat, and blood, and the flesh of swine, and that on which any other name has been invoked besides that of Allah. But if one is forced by necessity, without willful disobedience, nor transgressing, due limits- then is he guiltless. For Allah is Oft-Forgiving Most Merciful".* (Al-Quran, 2:173)) (Abdullah Yusuf Ali, 2007)

Jurists from the Shafi'i school explain that the scope of necessity is not confined to avoiding loss of life but covers the necessity to avoid disease or suffering due to disease (Abd Rahman, 2012; Yusuf al Qaradawi, 2003). The consensus of the jurists is that necessity in this case signifies the need for food to alleviate hunger when no food other than the prohibited food is available, some jurists (Yusuf Al Qaradawi, 2001) holding the opinion that at least one day and one night should pass without food. In such a situation a person may eat as much will satisfy his hunger and thus save himself from death. Said Imam Malik, "The amount of it is what will alleviate his hunger, and he should not eat more than what will keep him alive." This, perhaps, is the meaning of Allah's words, "neither craving nor transgressing," that is, neither desiring it nor eating more than necessary.

The facility of applying the prohibition at times of *dharurah* should adhere to the following conditions: (Mansour, 1997; Saim, 2010)

1. One may use or consume the haram in event of real necessities (Abdur Rashid, 2010) till the necessities fade. Once the

necessities diminish the original rule of haram will submerge (Mansour, 1997). Therefore there will be no necessity if there is availability in the society (Yusuf Qaradawi, 2011; Sayyid Abu A'la Mawdudi, 2011).

2. The amount of consumption is limited to escaping necessities or emergency (Abdur Rashid, 2010). The Prophet was asked about hanging fruits and answered, "Who is in dire need can take it but he cannot make provision from it". This hadith again is that the permission is only for a real necessity and such consumption is limited to what can satisfy hunger. This limit is clearly indicated by the prophet by the word "he cannot make provision from it" (Yasmin, 2010).

3. There must be effort to find halal alternatives prior to the usage of haram items under necessities.

4. Suggestions to consume haram substances or the performance of treatment using the haram substances must be done by Muslims with Islamic laws knowledge.

One good example of *dharurah* is as follow: In the old days, insulin was produced to help diabetic patients to control the excess of glucose in the blood system. At that time, the most effective insulin was derived mainly from swine and bovine sources and there were no other alternatives. In 1983, the Malaysia National Fatwa Council in its 6th Meetings on October 10 1983 decided that the ruling on the insulin is admissible (*Harus*) for the bovine based only. Unfortunately, many patients suffer side effects from the use of the bovine based insulin as compared to the use of the swine based insulin. This can be construed as the event of necessity or *dharurah*. The diabetic patient depends their lives on the insulin, without which it may cause damaging effects to the body system, thus this is a call for necessity. However nowadays, scientists have harvest some bacteria and produced new types of insulin that are more suitable to the human body. Therefore the concept of *dharurah* is no longer applicable with the new discovery.

In the context of childbirth, it involves pathological processes that require intensive monitoring by a physician during pregnancy and of

course during delivery of the baby. During labour, women face the life and death situation, meaning that death is a possibility particularly to those who have complication.

Childbirth includes both labor (the process of birth) and delivery (the birth itself); it refers to the entire process as an infant makes its way from the womb down the birth canal to the outside world. Thus the majority of Islamic scholars agreed that there is the existence of situation of *dharurah* during the childbirth stage. Nevertheless, the duration of emergency shall only be confined to the childbirth stage. In normal pregnancy till childbirth, women are exposed to pre-natal check-ups and post- natal check-ups. The pre-natal and post-natal check-ups do not involve possibility of life endangering. Thus the rule of *dharurah* shall not be applied.

Another question is, in situation where there is insufficient number of female gynecologists and medical assistance during childbirth. Can this be considered as situation of *dharurah*? It can be said that in such situation the issues of *aurah* and the rights of a woman to elect for a female doctor ceased to exist if this situation is categorized as *dharurah*. However the use of non-halal medicine depends on the availability of halal medicine.

It can be summarized that the rule of necessity is only applicable where first; there is a real and actual necessity. Which mean, there is no alternatives solution to stop the emergency? Secondly, doing the prohibited proportionate only to discard the emergency. The ceased of emergency will disqualify the Muslim to continue doing the prohibited such as consuming the non halal drugs or food. Thirdly, in receiving treatment or medication advice, the adviser (doctor) must be a Muslim who has knowledge in medical and religious field.

3.6 Existing Guidelines

Currently the guidelines for giving birth is general and for all women regardless of religion. There is no specific guideline for Muslim women in giving birth even though the concept of shariah-compliant hospital

is mushrooming. Article 3.3 of Good Medical Practice Guidelines of the Operational Policy in Obstetrics and Gynecology (O & G) services produced by Medical Development Division, Ministry of Health Malaysia, provides that:

> "A doctor must always examine a patient, whether female or male, or a child, with a chaperon being physically present in the consultation room, with visual and aural contact throughout the proceedings."

These requisites are designed to allow a doctor to proceed with clear, unhampered clinical examination of the patient, as he deems appropriate for the purpose of arriving at a proper diagnosis, without later having to defend his actions.

Learning from Others' Jurisdiction

The legal framework of other jurisdiction can be referred to in making appropriate reformation of our current practice. In Australia, The Healthcare Providers' Handbook in Muslim Patients (2010) has shed some lights for the protection of Muslim patients. Even though there is no specific provision on the prenatal care for Muslim women, yet there are acknowledgement on Muslim needs and their ability to preserve their faith while receiving treatment in the hospital. For example section 1.6 of the handbook provides that the healthcare providers are required to arrange for same sex medical officer attending a Muslim woman patient wherever possible during medical examination.

The handbook also recognized on the basic need of Muslim patient to be prescribed and treated by halal medicines. It is stated in the book that 'Some medicines may not be suitable for Muslim patients because they contain alcohol or are of porcine or non halal origin'. The handbook quote the usage of 'The Queensland Health Guideline on Medicines/ Pharmaceutical Products of Animal Origin' that states "the health care providers should inform patients about the origins of their proposed medication if it is derived from animals and no suitable synthetic alternative exists". This is indeed to make the patients informed before making decisions regarding their treatment.

4. Discussion

Kalina (2016) proposed that there is a need for a radical, broad transformation when it comes to human rights in childbirth. We need to guarantee, through explicit and newly created legislation, that it is the birthing woman who always comes first, that her rights over her body. Kamaruzzaman (2013) suggested that a shariah compliant hospital shall have among others a stipulated regulation of requiring all products (foods and medicines) should be halal. All procedures especially nursing procedures (SOP) must shariah compliant. The followings are the suggestions that can be put forward in drafting a special guideline to assist women in giving birth:

1. The hospital that adopts the proposed guideline shall be awarded with special certification that recognized them as having a Muslim friendly hospital.

2. The hospitals which have been awarded with the certification must have guidelines not only for giving birth procedure suitable to Muslim but adopts other Muslim friendly facilities throughout the hospitals. For example, the hospitals which have been awarded with Muslim friendly certification must have trained staffs to advise Muslim patients regarding *ibadah* and *ruksah* and all procedures especially nursing procedures (SOP) must incorporate shariah needs.

3. An appropriate Shariah Compliance System (SCS) must be established that required top-down management.

5. Conclusion

It can be summarized that, being a country with Muslims as the majority of population, Malaysia should adopt a system that could address the thorough needs of Muslims without tolerating the requirements of other religions. Though giving birth can be considered as exclusively women matters, yet it gives an impact on the issue of human right. Above all, it is a serious matter in the context of Islam as preserving aurah and dignity of females is required by the shariah. Hence, the issue of Muslim women giving birth should be categorized as issue that

falls within the sensitivity of the Muslim population that need to be addressed appropriately. Thus having a special guideline to guide the physician, gynecologist and midwife in assisting Muslim women in giving birth would be a good step that brings benefit to both Muslim and non-Muslim women at large.

6. References

Abdallah S. Daar and A. Khittamy. (2001). Bioethics for clinicians: 21. Islamic bioethics. *CMAJ*, 164(1): 60–63.

Abdur Rashid Siddiqui. (2010). *Qur'anic keywords: a reference guide.* UK: The Islamic Foundation, 70-71

Abdullah Yusuf 'Ali . (2007). *The Holy Quran: Text and Translation*. Kuala Lumpur: Islamic Book Trust

Abd Rahman. (2012), Halalkah ubat anda? panduan penting untuk umat Islam. *Selangor: Crescent News K.L) Sdn. Bhd*, 182

Angela Davis (2013) Choice, policy and practice in maternity care since 1948. Policy Papers, retrieved from http://historyand policy.org/policy-papers

Aznan Hasan. (2011). Shariah Principles in Halal Products. *2nd Shariah Law Reports (ShLR),* xxix; B.

Jessie Hill. (2006). The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines. *Scholarly Commons*, Case Western Reserve University.

Jordan & Davis Floyd. (1993). Birth in Four Cultures: A Cross culture Investigation of Childbirth in Yucatan, Holland, United States of America and Sweden. *Eden Press Women Publication Oklahoma*, p.115.

Backes, D.S., Koerich, M. S., & Erdmann, A. L. (2007). Humanizing care through the valuation of the human being: resignification of values and principles by health professionals. Rev Lat Am Enfermagem, 15(1), 34-41

Consumers Association of Penang. (2006). *Halal Haram an Important Book for Muslim Consumers.* (Penang: Consumers Association of Penang). 92

Davis-Floyd R. (2001). The technocratic, humanistic, and holistic paradigms of child birth. International Journal of Gynecology and Obstetrics: the official organ of the International Federation of Gynecology and Obstetrics. Nov; 75Suppl 1:S5-S23.

Davis Floyd. (2004). *Birth as an American Rite of Passage*. California, University of California.

D'oliveira, A.F.P.L.; Diniz, C.S.; Schraiber, L.B. (2002) Violence against women perpetrated within health care institutions: an emerging problem. *Lancet*. n.359. 1681-1685.

Lee YK, Lee PY, Ng CJ. (2012). A Qualitative Study on Healthcare Professionals Perceived Barriers to Insulin Initiation in a Multi-Ethnic Population. *BMC Family Practice.* Vol.13. 28.

Ligia Schiavon, Duarte Umberto, Catarino Pessoto, Raul Borges Guimarães, Eduardo Augusto, Werneck Ribeiro. (2015). Regionalization of Health in Brazil: An Analytical Perspective. Saude e Sociedade 24(2):472-484, Retrievedfrom<http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902015000200472&lng=en&nrm=iso>. access on 29 Nov. 2017. http://dx.doi.org/10.1590/S0104-12902015000200007

Esposito, N. W. (1999). Marginalised women's comparisons of their hospital and freestanding birth center experiences: a contrast of inner-city birthing systems. *Health Care for Women International*. 20 (2), 111-126

Harmy Mod Yusoff et al. (2011). *Fikah Perubatan.* Selangor: PTS Millenia Sdn. Bhd

Healthcare Providers' Handbook in Muslim Patients. (2010) *Queensland Health And Islamic Council of Queensland.* 2nd Edn.

Hasballah Thaib. (2004). *Kapita Selekta Hukum Islam.* Medan; Pustaka Bangsa Press

Ho I, Holroyd E. (2002). Chinese women's perceptions of the effectiveness of antenatal education in the preparation for motherhood. *Journal of Advanced Nursing.* 38(1):74–85.

Idris Ahmad S.H. (2000). *Fiqh Shafii.* Vol.2. Kuala Lumpur: Pustaka Antara Sdn. Bhd

Jabatan Mufti Kerajaan Brunei. (2007). *Fatwa Mufti Kerajaan: Isu-Isu Produk Halal*. Selangor: Al-Hidayah House of Publishers Sdn. Bhd

Juka Vareliues. (2006). The Value of Autonomy in Medical Ethics. *Medicine, Health Care and Philosophy.* Vol.9

Kalina Christoff. (2016) Is respect and dignity during childbirth only for royals?, <http://www.humanizebirth.org/blog/is-respect-and-dignity-during-childbirth-only-for-royals> accessed 20 August

Kamaruzzaman, WS .(2013). Ideal Islamic concept of IIUM hospital. *Paper presented at a Seminar on Islamization of Medical curriculum and Practice*, IIUM Kuantan.

Kuo, S. C. (2005). [Humanized childbirth]. Hu li za zhi, 52(3), 21-28

Lazarus, E. (1994). What do women want: Issues of choice. Control and class in pregnancy and childbirth?. *Medical Anthropology Quarterly*. 8(1). 25-46.

Locicero, A.K (1993). Explaining excessive rates of cesareans and other childbirth interventions: Contributions from contemporary theories of gender and psychosocial development. *Soc. Sci. Med.*, n.37, 1261-69.

Mansour Z. Al-Mutairi. (1997). *Necessity in Islamic Law*. Unpublished PhD Thesis. UK: University of Edinburg.

Moura, F. M. d.J.S.P. Crizostomo, C., Nery, I., Mendonca, R.D.C.M., De Arajo, O., & Da Rocha, S. (2007). Humanization and nursing assistance to normal childbirth. *Revista brasileira de enfermagem*. 60(4). 452-455

Omprakash V. Nandimath. (2009). Consent and Medical Treatment: The Legal Paradigm in India. *Indian Journal of Urology.* Vol.25.

Page, L. (2000). Human resources for maternity care: the present system in Brazil, Japon, North America, Western Europe and New Zealand. *International Journal of Gynecology & Obstetrics*. 75. 81-88

Pope, R,. & Graham, L. (2001). Women-centered care. *International Journal of Nursing Studies*. 38. 227-238

Raphaeal J. Leo. (1999). Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Case Physicians. *The Journal of Clinical Psychiatry.* Vol. 5

Rattner, Daphne. (2009). Humanizing childbirth care: brief theoretical framework. Interface - Comunicação, Saúde, Educação, 13 (Suppl. 1), 595-602. https://dx.doi.org/10.1590/S1414-32832009000500011

Roxana Behruzi, Marie Hatem, William Fraser, Lise Goulet, Masako Li & Chizuru Misago. (2010) Facilitator's and barriers in the humanization of childbirth practice in Japan. *BMC Pregnancy and Childbirth*. doi: 10.1186/1471-2393-10-25

Roxana Behruzi, Marie Hatem, William Fraser & Chizuru Misago. (2013). Understanding childbirth practices as an organizational cultural phenomenon: a conceptual framework. *BMC Pregnancy and Childbirth.* doi:10.1186/1471-2393-13-205

Saim Kayadibi. (2010) *Istihsan*: the doctrine of juristic preference in Islamic law. Kuala Lumpur: Islamic Book Trust

The New Arab (26 May 2016). Saudi Man Shoots A Male Doctor Delivering His Baby. https://www.alaraby.co.uk/english/news/2016/5/26/saudi-man-shoots-male-doctor-for-delivering-his-baby

Sayyid Abu A'la Mawdudi. (2011). *Towards understanding the Quran: A Bridged Version of Tafhim Al Quran* (trans) by Zafar Ishaq Ansari. UK: The Islamic Foundation

Securities Commission Malaysia. (2009). *Islamic Commercial Law (Fiqh Al-Muamalat)*. Selangor: LexisNexis Malaysia Sdn Bhd

Suleiman Zubair, Abubakar Sadik Mustafa, Ahmad Ali Badri, Ali Reza Lari, Mohammadreza Daroonparvar & Fauzi Hussin. (2013). A Revisit Of Assisted Reproduction Technology And The Humanization Paradigm. *Perintis E–Journal.* Vol.3, No.1

Shaykh Muhammad Saalih al-Munajjid (2016) Islam Question and Answer. Retrieved in August 30, 2016. https://islamqa.info/en/82994

Umenai, T., & Wagner, M. (2001). Conference agreement on the definition of humanization and humanized care. *International Journal of Gynecology & Obstetrics*. 75. 3-4.

Yasmin Hanani. (2010). *Necessity (darura) in Islamic law: a study with special reference to harm reduction programme in Malaysia.* Unpublished PhD Thesis. UK University of Exeter

Yusuf al Qaradawi .(2001). *The lawful and the prohibited in Islam*. Egypt: Al Falah Printing and Publication

Yusuf al Qaradawi. (2003). *Principles of Halal and Haram* in the book by Riza Mohammed and Dilwar Hussain. *Islam the way Of Revival*. UK: Revival Publication

Yusuf al Qaradawi. (2011). *Halal Haram Dalam Islam* (trans.) by Wahid Ahmadi, Jariman, Khosin Abu Faqih, Kamal Fauzi. Solo: PT Era Adicitra Intermedia