

Faith

& International Family Planning



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Foreword

The birth of a baby can be life's most exciting miracle; the death of a mother or child, a chilling tragedy. Ensuring that families have access to reproductive health information and services and can achieve the healthy timing and spacing of pregnancy is an important goal in international health and development.

The United Nations Foundation (UNF), as part of its Universal Access Project, asked the World Faiths Development Dialogue (WFDD) to explore a topic of particular relevance for achieving this goal: the roles of faith-inspired actors. As this report highlights, faith actors have been involved in significant efforts to provide family planning information and services in some of the world's poorest communities. Though many factors other than religion determine people's family planning behavior and religious leaders have been leading players in shaping family planning policy in relatively few countries, when religious actors do play a role in personal or political decisions on family planning, their impact can be powerful.

Across the globe, the vast majority of people say their faith is important to them; religious beliefs are intertwined with many behaviors, cultures and life choices; faith leaders have especially significant influence and credibility; and faith-inspired organizations (FIOs) are responsible for a large share of global health and development work. It is therefore important to understand how faith and family planning interact. Many of the primary target countries for family planning initiatives—those with large populations and high fertility rates—are countries where religion is particularly important and where there is great potential for faith actors to advance the healthy timing and spacing of pregnancy.

Thus, faith voices play vital roles in the conversation on universal access to family planning. We should be wary of allowing debates and differing approaches to obscure the significant efforts of faith actors in this field. Recognizing this, this review aims to document relevant work on policy and operational programs, highlight the ethical and practical issues that arise, and point to lessons for the future.

The report's authors are Lynn Aylward and Nava Friedman, working under my direction. The Universal Access Project team at UNF and their partners provided invaluable feedback at different stages. The report draws on the literature on relationships between religious actors and beliefs with family planning and with government policy, case studies of faith-inspired family planning work, and interviews with reproductive health experts and practitioners.

A clear conclusion that emerged from this review is that family planning is a common goal of many faith-inspired actors. Their work ranges widely in approach, design, and technique. They approach the topic with different theologies and confront different practical issues. The report's findings point to areas where the experiences of these actors might enrich both the understanding of family planning challenges and the design of programs that reach those most in need. Highlighting this work can help balance a conversation that has often mistakenly placed family planning beyond the pale of religion, and thus help us, collectively, to address the challenges faith-inspired actors face in their work.

The next step is to discuss the implications of the review's findings, grounded on the insights that come from experience in the field. The hope is that such dialogue can contribute to better mutual understanding and partnership. We welcome feedback and ideas for further research and action.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AYA	African Youth Alliance
BCC	Behavior Change Communication
BCH	Bwindi Community Hospital
CAFOD	Catholic Agency for Overseas Development
CCIH	Christian Connections for International Health
CHAG	Christian Health Association of Ghana
CHAK	Christian Health Association of Kenya
CHAZ	Christian Health Association of Zambia
CPR	Contraceptive Prevalence Rate
CRS	Catholic Relief Services
DRC	Democratic Republic of Congo
ECC	Eglise du Christ au Congo
EECMY-SCS	Ethiopian Evangelical Church Mekane Yesus-South Central Synod
EOC	Ethiopian Orthodox Church
FIO	Faith-Inspired Organization
FP	Family Planning
FPAP	Family Planning Association of Pakistan
GHI	Global Health Initiative
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IR	Islamic Relief
IUD	Intrauterine Device
LAM	Lactational Amenorrhea Method
MDG	Millennium Development Goals
NFP	Natural Family Planning
PCEA	Presbyterian Church of East Africa
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
RIP	Réseau Islam et Population
SDM	Standard Days Method
SNNP	Southern Nations, Nationalities, and Peoples
STI	Sexually Transmitted Infection
TIAT	Transition into Adulthood Training
UNF	United Nations Foundation
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WFDD	World Faiths Development Dialogue
WHO	World Health Organization
WV	World Vision
YFS	Youth-Friendly Services
ZACH	Zimbabwe Association of Church-Related Hospitals

Case Study Country List

Country	2012 Infant Mortality Rate (per 1,000 live births) ¹	2010 Maternal Mortality Rate (per 100,000 live births) ²	Unmet Need for Family Planning (percentage) ³	Contraceptive Prevalence Rate (percentage) ⁴	Faith-Inspired/Linked Actors Featured in this Report
Afghanistan	71	460	-	21 (2011)	Mullahs
Bangladesh	33	240	13.5 (2011)	61 (2011)	Islamic Relief
Burundi	67	800	32.4 (2011)	22 (2010)	LifeNet International
Cambodia			16.9 (2011)	51 (2010)	Maryknoll
Chile	8	25	-	-	Fundación Cristo Vive
Democratic Republic of Congo	100	540	24.2 (2010)	17 (2010)	Eglise du Christ au Congo
Ethiopia	47	350	26.3 (2011)	29 (2011)	Ethiopian Evangelical Church Mekane-Yesus South Central Synod, Muslim religious leaders
Ghana	49	350	35.7 (2008)	34 (2011)	Christian Health Association of Ghana
India	44	200	20.5 (2008)	-	World Vision
Indonesia	26	220	11.4 (2012)	61 (2010)	Fahmina Institute
Iran	15	21	-	-	High-level religious leaders
Kenya	49	360	25.6 (2009)	46 (2009)	Christian Health Association of Kenya
Liberia	56	770	35.7 (2007)		Ganta United Methodist Hospital
Malawi	46	460	26.1 (2010)	46 (2010)	Namasalima Clinic (Adventist)
Nigeria	78	630	18.9 (2011)	-	Government, Christian Rural and Urban Development Association of Nigeria, Supreme Council for Islamic Affairs
Pakistan	69	260	25.2 (2007)	-	Leading Muslim cleric, Family Planning Association of Pakistan
Philippines	24	99	22.0 (2008)	49 (2011)	
Rwanda	39	340	20.8 (2011)	52 (2010)	The Presbyterian Church of Rwanda
Senegal	45	370	30.1 (2011)	13 (2011)	Réseau Islam et Population
Tanzania	38	460	25.3 (2010)	34 (2010)	Tanzania Interfaith Partnership
Timor-Leste	48	300	31.5 (2010)	22 (2010)	Catholic Relief Services
Uganda	45	310	34.3 (2011)	30 (2011)	Bwindi Community Hospital, Ugandan Muslim Supreme Council
Zambia	56	440	26.6 (2011)	-	Churches Health Association of Zambia
Zimbabwe	56	570	14.6 (2011)	59 (2011)	Zimbabwe Association of Church-Related Hospitals

1 "Mortality rate, infant (per 1,000 live births)." (2012). World Bank: Washington, DC. <http://dataworldbank.org/indicator/SP.DYN.IMRT.IN>.

2 "Maternal mortality ratio (modeled estimate, per 100,000 live births)." (2010). World Bank: Washington, DC. <http://data.worldbank.org/indicator/SH.STA.MMRT>.

3 "2013 Update for the MDG Database: Unmet Need for Family Planning." (2013). United Nations Department of Economic and Social Affairs, Population Division.

4 "Contraceptive Prevalence (% of women ages 15-49)." (2010). World Bank: Washington, DC. <http://data.worldbank.org/indicator/SP.DYN.CONU.ZS>.

Executive Summary

Faith and family planning interact at various levels—personal, community, civil society, and governmental—and in complex ways. Better understanding of these interactions by all stakeholders will allow faith leaders and faith-inspired organizations (FIOs) to better use their considerable influence and track record in global health and development work to advance reproductive health and achieve the Millennium Development Goals (MDGs).

Many faith traditions and denominations, as well as their religious leaders and adherents, support family planning, and essentially all faith traditions support the concept of healthy timing and spacing of pregnancy (HTSP). The term “family planning” is widely acceptable among many faith traditions and FIOs as long as the term is understood to mean voluntary prevention of pregnancy. For some faith groups, it is particularly important that family planning is understood to exclude abortion, and this reflects theology and values, not just semantics.¹ Support from religious traditions, religious leaders, and faith-inspired organizations for family planning can depend on the family planning method employed. A notable example is the Roman Catholic Church’s support for only natural methods of family planning. Many FIOs are engaged in providing reproductive health services around the world in diverse and effective ways.

Sound data across different countries and communities suggest that religious teachings, beliefs, or traditions are usually not the major determinant of individuals’ family planning behavior. Many surveys demonstrate that women and couples commonly ignore religious teachings about family planning when they believe it is their individual and family interest to do so. But it is also demonstrable that religious beliefs and traditions are important parts of most people’s lives, that faith leaders are highly-respected and exercise significant influence, and that faith-inspired organizations are responsible for a large share of global health and development work. Many of the top target countries for family planning initiatives—those with large populations and high fertility rates—are countries where religion is particularly important. Thus there is great potential for faith actors to advance the healthy timing and spacing of pregnancy.

This report draws on the literature on faith and family planning, various sources touching on the interaction of religion and government policy, and interviews with experts and practitioners, but its cornerstone is a set of case studies of faith-inspired family planning work.

¹ Positions of religious groups on abortion vary widely. While some countenance abortion under certain, sometimes highly restricted, conditions, others oppose it in any form.



Photo: Dominic Chavez/The World Bank. Women and their children listen to a nurse explain the benefits of breastfeeding at the Centre De Sante Communautaire De Banconi (ASACOBA) a health clinic in Bamako, Mali on November 4, 2013.

An overarching finding is that faith leaders and FIOs are active in family planning in many areas and ways and have the potential to do more. Several themes underpin this overarching finding:

- **While religious interventions have been a major obstacle or facilitator for government family planning policy in relatively few cases, when they do have an impact, it can be powerful.** The positive potential of faith leaders is powerful and seems to remain underutilized as part of the essential partnerships that offer promise for enhancing reproductive health.
- **Many faith leaders and FIOs support and provide family planning, and are willing to advocate for it.** Essentially all case studies show support for the healthy timing and spacing of pregnancy, though their stance may depend on the family planning method employed.
- **While faith leaders and FIOs have some limitations, they are adaptive and innovative.** They often act pragmatically in the face of religious dogma or resource constraints. People and groups find ways to accommodate religious differences in different stakeholders' policies or stances on family planning where there is commitment to women's and family welfare and good understanding of the facts and issues around family planning. Weaknesses include a tendency among some FIOs to skirt issues around the reproductive health of unmarried youths and gender equality, but headway is being made in these areas.
- **Motivation and integration are important in faith leaders' and FIOs' family planning work.** Faith actors tend to engage in family planning not as an end in itself but instead as just one aspect of physical and spiritual health and an integral part of maternal and child health and survival, poverty reduction, and family well-being and stability. This holistic approach can actually be a strength of FIOs' work in family planning, though it can also be limiting, e.g., when (as noted above) FIOs hesitate to provide family planning to unmarried youths.
- **Faith leaders and FIOs can be especially effective in behavior change communication on reproductive health.** The credibility and trustworthiness of faith leaders and the strong grassroots networks of faith communities make them effective at behavior changes.
- **Faith leaders and FIOs can be effective advocates for family planning.** They are probably the best messengers to clarify to decision-makers and the public that many faith traditions and people of faith favor the healthy timing and spacing of pregnancy as an important component of achieving the Millennium Development Goals and a healthy, stable, equitable world.

Future areas of action for family planning approaches and greater partnership include:

- Working to articulate areas of agreement on family planning between faith and secular actors, such as the integration of family planning into broader health programs and its importance for consensus goals such as maternal and child health as a pillar of the MDGs.
- Explore ways to ensure that data systems include and demarcate family planning services provided by FIOs; this could help in determining ways in which FIOs could better serve as partners in achieving the goals of FP2020.
- Exploring—head-on but in a safe arena separate from the US legislative and policy community—further ways in which areas of difference between the views on family planning of faith-inspired and secular organizations can be accommodated in global health and development work. This exploration should cover areas such as the promotion of contextually appropriate contraceptive methods, how to form partnerships despite differing views on certain issues, and how to deal with adolescents.
- Developing and disseminating better tools illustrating how many faith institutions support family planning and underlining that almost all support the healthy timing and spacing of pregnancy, while clearly acknowledging major differences, such as the Catholic Church hierarchy's support for only natural methods of family planning. These tools should also emphasize the health, development, and economic evidence for family planning. Tools might include sermon guides, theology-based advocacy materials, and religious study guides on family planning.
- Drawing stakeholders' attention and efforts to the fact that—while the relationship of faith and family planning is complex, nuanced, and difficult to disentangle from culture—faith is very important and of great influence in several of the countries that are most critical to the overall success or failure of international family planning efforts, e.g., Nigeria and Pakistan. Thus religious actors and dimensions should be taken explicitly into account.
- Seeking ways to provide greater visibility for faith representatives from low-income countries, so that they can engage decision-makers in the US, European, and other donor countries and the governments of countries that are implementing international family planning programs. One avenue is to ensure appropriate faith actor representation on relevant steering councils, committees, and task forces affecting family planning programs.

Chapter 1

Introduction

This report reviews the family planning work of a selected group of faith leaders and faith-inspired organizations (FIOs). It highlights the diversity of faith-inspired work, practical issues that faith-inspired actors confront, achievements and obstacles, the intersection of faith and governments' policies, and views on priority next steps. The report's aim is to inform dialogue among all stakeholders about the role that faith and FIOs play in international family planning.

Voluntary family planning is widely regarded as an important public health advance that improves the health and well-being of individuals and families; empowers women; can support poverty reduction and development; and is cost-effective.¹ Family planning is defined by the World Health Organization as actions which allow "individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births...through use of contraceptive methods and the treatment of involuntary infertility."² Enabling people to make informed decisions about whether and when to have children reduces maternal and newborn deaths and improves the health outlook for mothers, their children, and families overall. With fewer unintended pregnancies, there are fewer abortions (safe or unsafe, legal or illegal) and more opportunities for women to attend school, work outside the home, and otherwise make choices about their lives. USAID estimates that if all women who wanted access to family planning had it, it could prevent up to 30 percent of the more than 287,000 maternal deaths that occur every year by enabling women to delay their first pregnancy and space later pregnancies at the safest intervals. If all babies were born three years apart, the lives of 1.6 million children under the age of five would be saved each year.³

Reproductive health has always raised both personal and political issues. Analysts note different phases in the international family planning movement. It has been grounded on three main rationales—demographics, health, and women's rights. While these rationales are not exclusive, their relative importance has waxed and waned, and they resonate differently with different stakeholders.

Support for family planning was strong and growing from the 1960s to the mid-1990s. During this period, the number of countries with official family planning programs rose from two (in 1960) to 115 (1996), 179 governments signed on to the Program of Action of the 1994 International Conference on Population and Development Conference in Cairo, and

international funding in constant dollars grew from \$168 million (1971) to \$512 million (1985).⁴

But in the mid-1990s, direct support for international family planning declined. Donor support between 1995 and 2007 fell from \$980 million to \$340 million (in constant 2007 dollars) and some major US foundations withdrew support from family planning, even as universal access to reproductive health was added in 2005 as a target under



Photo: US Mission Uganda, 2010. At a large community event for World AIDS day, over 1000 people watch and play a quiz show with the theme "Everybody wins when we know the facts about HIV and AIDS."

Millennium Development Goal 5 to improve maternal health. In the mid-1990s, a Population Council report notes, "The term family planning was largely replaced in the international development discourse by the much broader term, reproductive health and rights."⁵

There were several reasons for the drop in support. Among them, successes of earlier programs, indicated by sharply lowering fertility rates in some countries and regions, fed a misperception that broad family planning goals had been achieved. Women's rights supporters (*inter alia*) reacted strongly against the coercive elements of programs in some Asian countries as well as other aspects of the international family planning agenda that seemed in conflict with women's rights. HIV/AIDS emerged as a global health priority that absorbed billions of dollars in funding. Some newer analyses cast doubts on the links between population growth, family size, development, and poverty reduction. Some religious voices also contributed to a departure from

family planning support, largely related to an increased feeling that contraception must be linked to abortion. By 2001, one commentator observed that “the US joined the Vatican in a determined effort to oppose abortion... that so conflated abortion with sexual and reproductive health issues”⁶ that earlier consensus across both main US political parties about domestic and international family planning faltered and many US legislators and officials, as well as whole governments, were frightened away from reproductive health interventions.⁷

The pronounced importance and sensitivity of terminology on reproductive health and family planning to religious organizations and believers is not just a matter of semantics, but reflects their theology and values. The term family planning is widely acceptable among many faith traditions and FIOs, though, according to a survey by Christian Connections for International Health (CCIH), for many it is essential that the term is understood to mean voluntary prevention of pregnancy and to exclude the provision or promotion of induced abortion.⁸ (It is important to note, however, that not all religious denominations take issue with this, with some even taking arguably pro-choice stances.⁹) The Roman Catholic Church, unequivocally against what it calls artificial methods of family planning, not only allows but promotes natural family planning as a health and anti-poverty tool.¹⁰

Current estimates indicate that 222 million women worldwide have an unmet need for family planning.¹¹ As defined by the World Health Organization, women with an unmet need for family planning “are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child.”¹² In the face of this widespread need, and with more evidence and wider acceptance that (1) family planning programs work, improve health, and benefit development, and (2) many women and families want control over their reproductive health, family planning is being revitalized as an international health and development priority. The Government of the United Kingdom and the Bill & Melinda Gates Foundation, along with the United Nations Population Fund (UNFPA), the United Nations Foundation under its Universal Access Project, and other partners, have launched an initiative called Family Planning 2020 (FP2020).¹³ This initiative aims to achieve the commitments and continue the work of the London Summit on Family Planning in July 2012, where leaders from developing and aid-providing countries, international agencies, civil society, foundations, and the private sector pledged to provide an additional 120 million women and girls in the world’s poorest countries access to voluntary family planning services, information, and supplies by 2020.¹⁴

Because faith can play a significant role in attitudes and approaches to family planning and thus may have a

significant impact on the thinking and decisions of both individuals and government officials and legislators, it makes sense to explore that role and how an engagement with faith dimensions can help with the re-energized campaign to provide voluntary family planning to women and families who wish to access it.

This report focuses on case studies. Chapter 2 presents several country case studies that highlight religious roles at the level of government policy. Chapter 3 is the keystone of the report and explores case studies of faith leaders and faith-inspired organizations at work on family planning. The cases were selected as follows. Following a methodical review of available evidence, a group of examples of faith-inspired work on family planning was selected that covered the breadth and depth of such work. The examples concern Christian and Muslim faith traditions, the most prevalent ones in countries where current internationally supported family planning efforts are focused. They are also the faiths that have more to say related to family planning, compared to faiths such as Hinduism and Buddhism. One important gap in our findings concerns the Ethiopian Orthodox Church (EOC), the faith most widely practiced in Ethiopia, a country with a large population and high fertility rate. The EOC has so far tended not to engage publically with other stakeholders on family planning and no examples of explicitly faith-inspired work by the EOC or with EOC communities were found. Chapter 4 presents conclusions.

The report is also informed by interviews with international family planning experts and a literature review of documents on faith and family planning from the World Faiths Development Dialogue, the Institute for Reproductive Health at Georgetown University, Christian Connections for International Health, UNFPA, Pathfinder International, Islamic Relief, and other organizations.

Overview of Faith and Family Planning

The significant role of faith in family planning, which has been recognized and studied for many years, has several pathways. First, religious belief and practice are intricately related to culture, influencing the way people organize and live their lives, marry, form families and communities, have children, and make choices. Worldwide, across rich and poor countries, surveys identify some 5.8 billion religiously affiliated adults and children, representing 84 percent of the world population.¹⁵ Religiosity is particularly high in low-income countries; a 2009 Gallup Poll reports that in poorer countries, 92 percent of people say religion is an important part of their daily lives, compared to 44 percent in countries where average annual incomes are \$25,000 or more.¹⁶ Faith leaders often emerge as having the highest credibility and influence in polls about trust in leaders¹⁷ and the widespread, strong, grassroots, cross-country networks of faith communities are important in many ways, from providing health care to influencing government policies.

Second, faiths have a lot to say about sex, marriage, families, childbearing, and health and well-being. This includes specific theology and rules on, for example, when sex is permissible (e.g., within a marriage) and on whether and how it is permissible to influence fertility (e.g., the Catholic Church holds that prevention of pregnancy by anything other than natural methods is unacceptable). But faith also involves broader precepts, values, traditions, and practices that are not about sex or childbearing *per se* but can affect these topics, notably, about the roles and rights of women.

Third, faith has a large role in family planning because faith-inspired organizations and communities do a substantial amount of health work in developing countries. The oft-quoted estimate (based in part on 1960s data) that FIOs provide 30 to 70 percent of the health care in developing countries greatly overstates the market share of FIOs in some countries, but FIOs nonetheless are very important providers of and partners in health care, often working in partnership with government.¹⁸ Family planning is one health area where some FIOs eschew or limit participation. There is no reliable estimate of the share of total family planning services that are provided by FIOs or through faith communities. But given the significant involvement of FIOs in health care generally and their heavy involvement in HIV/AIDS—it is said that FIOs provide up to 40 percent of all HIV/AIDS care in Africa¹⁹—and in maternal and newborn health, FIOs are, as the case studies in the next chapter illustrate, important participants in reproductive health services. They are active across the range of family planning-related services, though relatively less active in direct provision of contraceptive supplies and methods.²⁰

The HIV/AIDS epidemic had a major impact on faith and family planning, in addition to absorbing billions of dollars of global health funding. Unprotected sexual intercourse and transmission from mother to child during pregnancy, delivery, or breastfeeding are common pathways for the spread of HIV/AIDS. This centrality of reproductive health issues to HIV/AIDS combined with the heavy involvement of faith-inspired leaders, organizations, and communities and the horrible toll wrought by the epidemic meant that religions and faith-inspired people re-examined their positions on reproductive health. Issues such as the role of condoms in HIV prevention, dealing with discordant couples, and the realities of many women's limited freedom to take steps to protect themselves from HIV led to new ethical and theological debates and understandings about family planning and reproductive health. Some faith leaders and churches took steps such as accepting that while

the ideal choice was abstinence outside of marriage, unmarried people should use condoms if they could or did not remain celibate. Even Pope Benedict XVI weighed in, albeit somewhat vaguely, on the potential relative morality of condom use for disease prevention by male prostitutes who have sex with men.²¹ It was arguably such discussions that helped feed growing acknowledgement of the morality of family planning in the face of poverty, deprivation, and dramatic shortfalls in maternal and child health, as some faith leaders, people of faith, policymakers, academics, and practitioners stated that healthy timing and spacing of pregnancy and limiting fertility could result in better outcomes in terms of health, nutrition, education, social justice, and more. For example, the politically conservative columnist Michael Gerson, a Catholic former speechwriter in the George W. Bush administration who has weighed in against coverage of birth control under the US Affordable Care Act, called family planning a pro-life cause in an August 29, 2011 op-ed article in *The Washington Post*.²²

In addition to being sizable, the role of faith in family planning is complex, varying from country to country or congregation to congregation, even for the same religious tradition. Stakeholders need to understand nuance, fine lines, and seeming or actual inconsistencies to form a textured understanding of what is happening and why.

A major factor in the complexity is not only that different faith traditions have widely different views on family planning, but that what that view is may not always be straightforward. In addition, some faiths or denominations are broadly accepting of family planning but have more nuanced views about or oppose certain methods, notably sterilization and



Photo: Mona Bormet/Christian Connections for International Health. Zambia, 2013. Nurse from Macha Mission Hospital speaking to mothers at an Under 5 Clinic Day about how to take care of their children and prepare for more children.

emergency contraception, as well as the provision of family planning and sex education to young or unmarried people. Some religious denominations or people approve of family planning but are against abortion and/or sterilization. Many faith-inspired organizations or people are highly sensitive about how other actors define family planning.

Mainline Protestant churches, including Episcopalians, Methodists, and Presbyterians, among others, are mostly strongly supportive of family planning.²³ The United Methodist Church is clear on this point in their Resolution on Responsible Parenthood, which states that “each couple has the right and the duty prayerfully and responsibly to control conception according to their circumstances,” and that in order to “support the sacred dimensions of personhood, all possible efforts should be made by parents and the community to ensure that each child enters the world with a healthy body, and is born into an environment conducive to realization of his or her potential.”²⁴

While the stances of evangelical churches vary, the National Association of Evangelicals, which represents more than 45,000 churches in the United States, released a report in 2009 showing that nearly 90 percent of their religious leaders approve of contraception.²⁵ But some Evangelical leaders, churches, and organizations display political solidarity with the US Conference of Catholic Bishops, even if they themselves take a broader view on acceptable methods of family planning. For example, many pastors and evangelical leaders joined the US Conference of Catholic Bishops in opposing the contraception coverage mandate in the Affordable Care Act.²⁶ This may explain why some US policymakers are wary of offending evangelical church actors through funding of international family planning.

Regarding the Mormon Church, LDS.net, an official source of information on the Church of Jesus Christ of Latter-day Saints, states that “we do believe it is important to have children. In fact, we consider it a commandment as God directed Adam and Eve to multiply and replenish the earth.” It goes on to say that “the decision of how many children to have and when is between the couple and the Lord and should be done prayerfully. The health of the mother can certainly be considered as well as her mental health. Those considering making themselves sterile through various procedures should not make this decision lightly.”²⁷

The firm theological position of the Catholic Church is that married couples may influence their child-bearing only through natural family planning (NFP). The US Conference of Catholic Bishops defines NFP as family planning methods based on the observation of the naturally occurring signs and symptoms of the fertile and infertile phases of a woman’s menstrual cycle, with no drugs, devices, or surgical procedures used to avoid pregnancy²⁸ and which include the Standard Days (for which CycleBeads are a tool) (SDM), Lactational Amenorrhea (LAM), Two Day, Billings Ovulation, and Symptothermal Methods.^{29 30} The

Africa Family Life Federation, based in Mauritius, brings together a range of Catholic organizations to support the use of these natural methods (with particular emphasis on the Billings and Symptothermal methods); its formal stance describes international efforts to expand access to artificial contraceptives as “attacks on life and family.”³¹



Photo: Dr. Rahmatuding Bashar Dost/Marie Stopes International Afghanistan. 2012. MSI’s community health worker training program for women in Afghanistan will hopefully inspire and motivate other women in their communities to openly discuss family planning issues and decide the timing, spacing and size of their families.

Many analysts conclude that Islam is generally open to family planning, but with some restrictions, e.g., against sterilization. Only “a small number of Islamic jurists and other Islamic groups oppose family planning and contraceptive use.”³² However, because of Islam’s non-hierarchical manifestation in many contexts, individual local Islamic religious leaders and adherents may have more negative or restrictive views on family planning. Neither Hinduism nor Buddhism proscribes most methods of birth control.

Speaking on religions’ views, Dr. Pauline Muchina, a theologian who has worked at UNAIDS, observed at the Faith and Family Planning panel at the 2013 Women Deliver conference, “Almost everybody believes in family planning but what we argue about is the method.”³³ Similarly, Christian Connections for International Health, an alliance of Christian organizations and individuals working on health, reports that the vast majority of its members support family planning. Such consensus views are a positive development, but may gloss over areas where beliefs, opinions, understandings, and terminology significantly diverge. A survey by Christian Connections for International Health and the research undertaken for this report found nuance in faith actors’ support for family planning even when the relevant faith tradition supports family planning; for example, some respondents said that comfort with offering family planning services varied between an organization and its board members, between home and field offices, and even between more and less conservative staff members of a given FIO.³⁴

Another factor in the complexity of the interaction of faith and family planning is that, as noted above, there are traditions and broader precepts that exist separate from theology and can be mixed up with traditions, cultures, and political issues. While, as previously mentioned, the Mormon faith is liberal on birth control, Mormons celebrate large families. A Population Reference Bureau policy brief observes, “It is not uncommon for family planning programs to become politicized in Muslim societies...opposition groups have rejected their governments’ organized family planning program as a political move, invoking Islam in support of their position.”³⁵ Aspects of gender inequality in some Christian and Islamic cultures translate into women having a limited amount of control over their reproductive health that is not because of theology *per se*. For example, Pathfinder International found, when working with Christian and Muslim communities in rural Egypt, that both men and women believe that it is a man’s right to control his wife.³⁶ In many cases, women do not use family planning because their husband has either forbidden it or expressed negative views on it. Careful analysis has shown that in many cases, differences in attitudes or practices about contraception that appear correlated with religion disappear when demographic and socio-economic characteristics such as education and income are controlled for.³⁷

Furthermore, notwithstanding that religion is important to many people and an important part of their lives and cultures, the impact of religion on people’s attitudes and behaviors about family planning is complicated. Most humans do not follow every rule or value they believe in or ascribe to all the time. Notwithstanding the credibility and influence of religious leaders, research indicates that religion is, for example, a good indicator of attitudes toward sex, but a poor one of sexual behavior. A study reported that while 74 percent of US evangelical adolescents believe in abstaining from sex before marriage, a much higher share than for certain other religious groups, they are also more sexually active than those other groups.³⁸ During controversy over the provision of the US 2010 federal healthcare law requiring employers to provide health insurance that covers birth control, it was reported that based on data from an official government health statistics survey, the National Survey of Family Growth, 98 percent of US Catholic women have used contraceptives at some point in their lives. Despite their religions’ theological openness to family planning, a study of Muslim and Hindu women in Southern India found that 99 percent of the Muslim women believed their religion forbade contraceptive use—but most of the women said they did not necessarily agree with their religion’s position on contraception.³⁹ Some studies have found that being a member of a church, even one that is strongly against artificial methods of family planning, is associated with higher rates of contraception use, if a congregation provides a socio-culturally diverse and inclusive environment favorable to the spread and legitimization of information on contraception.⁴⁰ Both men’s



Photo: Gates Foundation. Benin, 2011. A family planning poster in Benin.

and women’s concerns about the possible personal health side effects of contraceptive methods such as the pill, IUDs, and injectables represent on average a more important deterrent to using contraception than do religious beliefs.

Turning from personal reproductive health behavior, the ways in which institutional religious positions on family planning work out in practice vary. As the case studies in this report illustrate, there are individual Catholic sisters who sanction the use of artificial methods of birth control or of condoms by HIV/AIDS-discordant couples. Catholic FIOs may find acceptable ways to partner with organizations such as CARE that support artificial as well as natural family planning methods, though the FIOs themselves do not distribute or advocate for artificial methods.⁴¹ And while the official Catholic position on family planning is clear, firm, and not affected by individuals’ deviations from the rules, the Church itself varies in the fervor of its active opposition to government policies that support or include artificial family planning; as reported in Chapter 2, the Church has been a strong, active, and vocal opponent of such government policies in some countries, such as Guatemala, the Philippines, and the US, but not in others, such as Chile or Kenya. Similarly, the nature and strength of Islamic objections to government policies on reproductive health have varied from one country or period to another, sometimes reflecting, as noted above, politics more than theology.

Chapter 2

How Faith Interacts with Government Policy on Family Planning

This chapter assesses how religious institutions have responded to and affected government policies and programs on family planning. Governments in developing countries often play an instrumental role in family planning. While other organizations are also heavily involved, such as external development partners and private organizations, when and how government puts family planning on the national agenda is important. While two-thirds of countries have national programs, programs vary in terms of their strength. The Family Planning Effort Index, which measures this strength in about 80 countries covering 90 percent of the world population, put the 2009 global average index at 57 percent (i.e., of maximum effort), indicating that there is much room for improvement.⁴² Moreover, there are large regional disparities—many countries in Sub-Saharan Africa have low scores—and some high-population, high-fertility rate countries, such as Pakistan, Nigeria, and Ethiopia, score lower than the average.

Religious institutional impact on government family planning policy, just like its impact on individual behavior, is complex and varied. In the majority of countries, faith leaders and religious institutions more broadly have not had a major impact in supporting or opposing the launch of government programs. In many cases, this occurred because government programs were instituted in a period (the 1960s or 1970s) when novel birth control methods such as the pill and IUD were relatively new and religious organizations were still digesting the implications. In some countries, religious leaders spoke out against family planning programs, but not in an organized, concerted fashion that influenced policy. However, there are country cases where religious institutions have either actively opposed or supported reproductive health policy, with clear discernible impact. These complex faith roles have been varied and uneven by place, denomination, and time. Faith leaders have supported public family planning measures in some cases, especially where governments have sought them out as partners (though they have rarely led efforts to expand access to family planning information and services). In contrast, faith actors have in some instances been early instigators against government family planning programs, blocking or delaying them from getting off the ground.

Indonesia and Iran are prominent examples where the government courted and co-opted religious leaders to gain approval and support for public family planning initiatives. Guatemala, the Philippines, and the US provide country

examples where a faith tradition—in all three cases, the Catholic Church—has actively opposed government policies on family planning or contraception. The level of active, public opposition that the Catholic Church has mounted has varied from one country to another, even when taking into account the extent or predominance of Catholicism in the country. Dr. W. Henry Mosley, Professor Emeritus of Johns Hopkins University's Bloomberg School of Public Health, suggested in an interview for this report that the fact that Chile's family planning program was motivated by very high rates of illegal abortion at the time may have quieted Catholic opposition.⁴³ A review of Kenya's family planning program cites a 1972 paper that stated that the Catholic Church offered little opposition to Kenya's program and that Catholic mission hospitals were offering family planning services to non-Catholics who requested them.⁴⁴ Recently, however, it was reported that the Kenyan Catholic Bishops penned a public objection to the Kenyan government's participation in the London Summit on Family Planning, saying that global contraceptive policies could "lead to destruction of the human society and by extension the human race."⁴⁵

Nigeria: The President Raises the Role of Religion Upfront

Until recently, international aid agencies rather than the government took a lead in family planning programs in Nigeria. Although the government had had numerous population polices since the 1960s and had run education and communication campaigns on reproductive health, it had spent "little to nothing on contraception procurements,"⁴⁶ and family planning was not a priority. However, beginning in 2010, the government began a series of steps to raise the profile of family planning, an effort largely credited to President Goodluck Jonathan.⁴⁷ Nigeria committed \$3 million for family planning commodities for fiscal year 2011 and the same amount for the next year. It announced the Primary Health Care Free Maternal Health Package, which includes family planning services and commodities, and the National Health Insurance Scheme extended coverage to contraception.⁴⁸ The Ministry of Health hosted its first ever National Conference on Family Planning in 2010, with a second held in 2012. In July 2012, addressing family planning policy, President Jonathan acknowledged upfront that the issue of birth control was a sensitive one, saying: "We are extremely religious people... It is a very sensitive thing. Both Christians and Muslims, and even traditionalist

and all the other religions, believe that children are God's gifts to man. So it is difficult for you to tell any Nigerian to number their children because...it is not expected to reject God's gifts."⁴⁹

The interaction of religion with the new programs in Nigeria will probably reflect the complex issues covered in Chapter 1. Empirical studies on Nigeria find that while concerns about personal health side effects and husbands' approval of contraception are leading determinants of women's contraceptive behavior, religion is still a factor.⁵⁰ ⁵¹ And, notwithstanding the findings of these studies that religion is a relatively minor determinant of contraceptive use, many religious leaders in Nigeria have not been receptive to family planning.⁵² Moreover, the overlapping and non-transparent combined impact of religion, culture, and politics on reproductive health outcomes could be particularly important. In Nigeria, there is polarization between the North of the country, with a large Muslim population and more poverty, and the South, with a higher share of Christians and less poverty. This polarization has already given rise to the well-known religion-mediated health controversy about polio vaccination in northern Nigeria, where Muslim religious leaders were first obstacles to and then catalysts for immunization, even though the root problem was not Islamic theological objections to immunization.⁵³

Faith leaders may play a supportive role in Nigeria's new family planning initiatives. The 2012 National Family Planning Conference addressed the role of religion, and in January 2013, a Nigerian faith-based nonprofit organization, the Christian Rural and Urban Development Association of Nigeria (CRUDAN) South-west Zone, issued a position paper urging the government to formulate and enact laws to support a family planning/childbirth spacing policy, create budget lines, and provide funding for it.⁵⁴ The Nigerian Urban Reproductive Health Initiative, a project funded by the Bill and Melinda Gates Foundation and a partner in the government's family planning and maternal and child health programs, has formed Interfaith Forums, groups of religious leaders who meet each year to discuss family planning and are trained in positive aspects of family planning.⁵⁵

Bangladesh and Pakistan: Study in Contrasts

Bangladesh and Pakistan are often compared with respect to the relative success of government family planning efforts.^{56 57 58} Both are large, poor, religiously conservative countries with majority Muslim populations, and they were for several decades the same country (Bangladesh became independent in 1971). But Bangladesh is a family planning success story, while Pakistan still faces high fertility rates and low CPRs. The role of faith leaders and the behavior of faith communities are among the factors explaining the difference.

Relatively little progress was achieved by the Family Planning Association of Bangladesh (FPAB) from the 1950s until the 1980s, when FPAB staff realized that despite good service delivery efforts, interpersonal communication at the community level, and a range of contraceptive choices, program success was impeded by religious leader opposition. Faith leaders' claims that family planning was against Islam reinforced male opposition to contraception. In an effort to win the support of religious leaders, the FPAB established an Islamic Research Cell in 1984 and launched targeted advocacy and orientation programs. Faith leaders were taught that Islam directly or indirectly promotes family welfare from the viewpoint of the health and economic needs of the family.⁵⁹ There are reasons other than achieving religious support that help explain the success of Bangladesh's family planning programs relative to Pakistan's efforts. These include an abundance of non-governmental organizations active in health service provision that the government lets operate relatively freely, and the fact that the programs brought about ideational changes around small families and modern contraceptives.⁶⁰ While these two factors are not directly related to religion, there were numerous indirect links (i.e., many NGOs are faith-inspired and faith leaders and communities can be effective at behavior change communication).



Photo: Mark Garten/UN Photo. Bangladesh, 2011. A mother and child at the Mobarakpur Community Clinic in Kulaura Upazila, northeastern Bangladesh where Secretary-General Ban Ki-Moon highlighted the importance of ensuring access to women's health care in rural areas.

While Pakistan has also had a long-standing government commitment to family planning, the results indicate much less success than in Bangladesh. One factor which may explain this is that many local Muslim leaders continue to preach that family planning is wrong under Islam. A National Public Radio story in 2011 quoted an important local religious leader stating that family planning is a Western convention that offends Islam.⁶¹ A young woman interviewed for the story said that while she never went to school and cannot read the Qur'an, she listens to clerics' sermons carried over loudspeakers that equate birth control with sin. Among women in Pakistan who wish to space or limit their births but are not using contraception, fear of personal health side effects of contraception and disapproval from spouses or mothers-in-law are major factors (that may overlap with religion), as is the belief that family planning is against God's will.⁶² A study by the Pakistan National Institute of Population Studies found that women in communities where ulema (Muslim religious leaders) gave permission to use birth spacing methods were 1.7 times more likely to use contraceptives than women in communities where ulema actively opposed family planning programs.⁶³ As the case studies in the next chapter report, numerous Pakistani religious leaders have spoken out in favor of family planning; high-level and widespread Islamic support could help increase the success of the Pakistani government's family planning efforts.

The Philippines: The Catholic Church and the Reproductive Health Law

The Catholic Church is currently running in the Philippines what is arguably the most active and prolonged campaign against government family planning policy in its history.

The Philippines' Responsible Parenthood and Reproductive Health Act of 2012 (the RH Law) provides for universal access to contraception via free or subsidized provision of family planning methods and placement of government family planning officers in remote parts of the country, sexual education, and maternal and child health care. Lawmakers passed the RH Law in December 2012, after similar measures were reportedly introduced in every new Congress for 13 years but never came to a vote due in large part to opposition by the Church. And Church opposition is considered a major factor in why the RH law is currently on hold after the Supreme Court delayed implementation in March 2013.⁶⁴

Reproductive health has a controversial history in the Philippines. The country's family planning program in the 1980s was so pro-active as to be regarded as coercive by some and subsequent administrations backed off the policy. At present, contraceptives are available in the Philippines, but not subsidized or promoted by the government. From 2000 to 2009, an order by the mayor of Manila effectively banned contraceptives in public health facilities, creating



Photo: William A. Ryan/UNFPA, The Philippines, 2009. Reproductive health supporters and volunteers.

reported hardship for women and families seeking family planning—plus a natural experiment that researchers have analyzed, finding that the ban led to a significant increase in family size and a sizable, negative impact on child education.⁶⁴

Drawing conclusions about the current public debate on the RH Law is sensitive. While in other countries, open public debate on family planning policies has contributed to the creation of workable public consensus, so far, the discourse in the Philippines has not led to less polarization. Some polls indicate that in the Philippines—where 80 percent of the population identifies as Catholic, the birthrate is relatively high for Southeast Asia, and half of pregnancies are unintended—nearly 70 percent of people believe the government should fund all means of family planning,⁶⁶ and many Filipino people and civil society organizations have helped keep the RH Bill alive and advancing.⁶⁷ Some 200 faculty members at Ateneo de Manila University, a Catholic institution, publicly declared support for the law; the university president countered by declaring the school's official opposition to the bill.⁶⁸ There is a general perception that the strength of the Church's institutional position does not reflect the majority view of the people, though at the same time, Catholics have turned up in the thousands for prayer rallies against the law despite severe weather conditions and are mobilizing to defeat politicians who support it.⁶⁹

Interfaith Advocacy for Family Planning in Kenya

The Faith to Action Network was established in 2011 in conjunction with the “Interfaith Declaration to Improve Family Health and Well-Being” signed in Nairobi in June 2011 by several hundred faith leaders and FIOs representing the world’s major religions.⁷⁰ The Faith to Action Network is composed of Christian, Muslim, Hindu, and Buddhist religious leaders and organizations and its stated purpose is to serve as a multi-faith platform for family planning and reproductive health advocacy at global, regional, national, and local levels.⁷¹ The network may provide a new and effective channel through which faith actors can support government family planning policy and programs and perhaps even function as “first movers” to advance public sector reproductive health activity.

Analysis of the Interaction of Faith and Government Policy

The various country examples illustrate cases where religious denominations, faith leaders, and FIOs have influenced new reproductive health laws, policies, or plans. Also relevant is how FIOs interact with established government policies and programs, or modifications in them. The government of Burundi requires all clinics to provide at least family planning counseling. Catholic clinics there offer counseling, but do not offer anything other than natural methods. Monica Slinkard, medical director of an organization operating in Burundi, observes that people are aware of the Catholic stance and choose other types of clinics when seeking family planning services; Burundi is sufficiently densely settled that this appears not to deter many of those who wish to do so from securing services.⁷² The government of Rwanda also mandates family planning service provision; since Catholic facilities supply much of the health care in Rwanda, the government establishes secondary health posts in those areas where the Catholic clinic would otherwise be the only source of health care (often placing them right next to these facilities, to ensure that a range of options are visibly available).⁷³ While Catholic institutions provide counseling for natural family planning methods, the presence of such a family planning clinic, which provides the full range of methods, allows for full service provision without ignoring the concerns of Catholic leadership.⁷⁴ All of the members of the Churches Health Association of Zambia (CHAZ) provide artificial methods of family planning except its Catholic member institutions (which provide NFP); for areas that would otherwise not have access to other providers, CHAZ arranges with Zambia’s Ministry of Health to provide family planning services through the District Health Management Teams. Chapter 3 also provides information on how some of these situations have been worked out.

While there are many examples of actors successfully working with differences in views on family planning, rare counter-examples must be acknowledged to avoid glossing over challenging realities. Conservative Catholic organizations



Photo: Gates Foundation. Nairobi, Kenya, 2009. Esther Njeri originally didn’t want to hear about family planning, but changed her mind and decided to seek information on the occasion of a visit to the Makadara district hospital planned for 6 months after she gave birth.

carefully scrutinize Catholic Relief Services’ operations for any perception of tolerance for so-called artificial methods of family planning, and when Catholic Relief Services (CRS) worked with CARE and the government of Madagascar on a USAID-funded mother and child health program that also included family planning, a Catholic pro-life organization charged that “CRS is using funding from American Catholics to distribute contraceptive and abortifacient drugs and devices.” In the end, CRS issued a detailed statement countering the claims and explaining its involvement in the grant was specific to a water and sanitation program.⁷⁵

The research on faith and government policy found that religion has not played a direct role in the evolution of most low-income countries’ family planning policies. While faith leaders and FIOs have been supportive when engaged actively as partners by government in some countries, they have not been pro-active in supporting efforts to expand access to information and services, though they have been eager opponents in some cases. This suggests there may be significant untapped potential for faith actors to advocate for government laws, policies, and funding for reproductive health. Religious belief is not the core determinant for most people’s family planning behavior in developed or developing countries, and in many countries, religious leaders or organizations have not been main players in government family planning policy. But when religion does play a role in personal or political decisions on family planning, it can be very powerful. Many of the countries critical for international family planning efforts—countries

such as Nigeria and Pakistan, with large populations, high fertility rates, and serious international development challenges—carry particularly strong ties to religion. They are countries where religion is particularly important to the culture, where faith leaders and communities have great influence, and where there is a track record of religion or religious actors impacting or being perceived as impacting health-related behavior or programs.

While the cases above have mostly focused on low-income countries implementing family planning programs, advocacy is also critical in aid-providing countries. It is mainly or perhaps only in the US, among the traditional large donor countries, where religion is important in political decisions on foreign assistance for family planning. As noted in Chapter 1, some US legislators take strong positions against government support for family planning, both domestic and international. Katey Zeh, a Project Director with the United Methodist Church General Board of Church and Society, which is a partner of the United Nations Foundation's Universal Access Project, coordinates an advocacy training program for lay community members. She observes that the sound bite which reaches Congress on faith and family planning is that religion is against family planning. This leads to a challenging advocacy situation wherein people of faith speak out for family planning because, for example, it saves mothers' lives, while legislators process this nonetheless as a secular message. In other words, because many assume support for family planning is a non-religious value or belief, when advocates from a faith constituency support family planning, legislators hear a secular message and overlook the faith constituency messenger. Certainly, the faith-based message from Chapter 1 that "almost everybody believes in family planning though we argue about the method" is nuanced, and nuance is hard to capture in a sound bite.

Chapter 3

Case Studies of Faith Work on Family Planning

This chapter is the core of this report. It presents 30 case studies (24 shorter and six longer) that highlight how faith-inspired leaders and organizations work with people on family planning. By way of analysis, it draws out eight themes that emerge. The discussion of themes is interspersed with text boxes that contain the case studies, which are organized loosely by theme, though many themes can apply to a given case and vice versa. The longer case studies are presented in the second half of the section for presentational ease, though they also relate to the eight themes.

1. Faith-inspired work on family planning reflects the complexities of the interactions of religion and family

The case studies reflect a central finding presented in Chapter 1, that the relationships between religion and family planning are not straightforward. They confirm that despite the broad conclusion that all mainline Protestant traditions, most Evangelical institutions, and Islamic leaders do not have strong, clear theological positions opposing family planning, misconceptions suggesting otherwise persist among many believers and religious leaders in low- and middle-income countries. Clearing up theological apprehensions thus has obvious importance. But the reasons for reticence about family planning go well beyond religious beliefs or teachings. Chapter 1 cites evidence that, in addition to pronatalism, one reason families of faith do not use birth control is concerns about health side effects. For example, the negative feelings about family planning of mullahs who became involved in the Accelerating Contraceptive Use Project in Afghanistan were mainly related to health concerns about contraceptive methods. Thus, responding to their constituents' health concerns can be a point of entry of religious leaders as supporters (or opponents) of family planning. The fact that most of the service delivery case studies involved a range of birth control methods confirms what interviewees said: that theological concerns related to specific methods, e.g., that pills or IUDs do not act as abortifacients, can be important to faith actors operating at the government policy level, but may be less important to women and families who are actually seeking family planning services.

CHILE*

8: Infant mortality rate
25: Maternal mortality rate



Catholic Nun in Chile Sees Past Dogma to Provide Family Planning Services to Those in Need

Sister Karoline Meyer, a German nun who has been living and working in Santiago, Chile since 1968, left her order to dedicate herself to the city's poor. The foundation she created in 1977, *Fundación Cristo Vive*, has benefited tens of thousands of Chileans. The foundation is funded by a combination of public financing through government agencies, contributions from foreign governments, institutions, and individuals, and donations from Chilean institutions and individuals.⁷⁶ Among the many social service organizations that Sister Karoline's foundation supports are two renowned clinics that are known for their emphasis on preventative medicine and have served as models for the government and medical schools. These clinics provide the full range of family planning services, excluding abortion services. Sister Karoline sees family planning as necessary health care, though her support caused significant tension between her and her parish priest. She reports that after several attempts to consult with her cardinal about her stance on contraception, she concluded that he may have been avoiding passing judgment (thus tacitly allowing Sister Karoline to continue her work).⁷⁷

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

Catholic Relief Services Turns Focus to Birth Spacing in Timor-Leste

Timor-Leste has one of the lowest contraceptive prevalence rates in the world—only 22 percent of married women use any form of contraception, with an even lower number using modern methods.⁷⁸ Recognizing this need, Catholic Relief Services (CRS) embarked on their first program that focused specifically on family planning services. Working with the Ministry of Health and local Catholic service providers in partnership with the Institute for Reproductive Health at Georgetown University,⁷⁹ CRS implemented “Planning for Responsible Parenthood,” through which they provide modern natural family planning services to poor Timorese. Methods taught include the Standard Days Method (SDM) and Lactational Ammenhorea Method (LAM), both of which have been scientifically tested by the Institute for Reproductive Health. They run educational programs, do demonstrations, and train midwives and volunteers who can reach the most remote areas, equipping them with calendars and CycleBeads (used in conjunction with SDM). The program has reached hundreds of couples (580 at the time of CRS’s most recent tally). In the heavily Catholic country of Timor-Leste, natural family planning methods are an important mechanism for addressing a significant unmet need for contraception.⁸⁰

Nigerian Religious Leadership Issues Document in Support of Contraception: Reproductive Health Issues in Nigeria: The Islamic Perspectives

In 2004, Nigeria’s Supreme Council for Islamic Affairs conducted an exhaustive search of Islamic source material to determine how Nigerian Muslims can best improve their reproductive health while adhering to religious doctrine. Supported by Pathfinder International and the Policy Project and funded by USAID and the Packard Foundation, the Council explored a broad array of issues—including HIV, STIs, harmful practices, and family planning—and determined, in contrast with popular opinion, that most forms of contraception were allowable under Islamic law. Furthermore, while they determined that explicit “population control” was not acceptable, spacing births was an important practice to protect family well-being. For example, the Qur’an states that mothers should breastfeed for two years, indicating that a mother should wait at least that period to bear another child.⁸¹

World Vision Gains Ground in Family Planning, Though Challenges Remain, Say WV’s Leading Reproductive Health Experts

Adrienne Allison, the Technical Specialist in Family Planning and Reproductive Health at World Vision, described in an interview how the organization has become increasingly active with family planning in recent years, overcoming earlier discomfort with the issue connected to its common rhetorical linkage to abortion. Coming from a religious perspective, World Vision has been particularly sensitive in its approach in a variety of religious communities, as seen in the Pragati case described later in this paper and in the organization’s embrace of “Healthy Timing and Spacing of Pregnancy” (HTSP) marketing. HTSP emphasizes family planning’s role as a preventive health intervention and is defined by USAID as “an intervention to help women and families delay or space their pregnancies, to achieve the healthiest outcomes for women, newborns, infants and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.”⁸² This, Ms. Allison notes, has vastly enhanced the openness of religious communities to family planning. This work caught the eye of the Gates Foundation, which recently awarded World Vision a grant to increase their family planning advocacy. Even with these advances, sensitivities remain: World Vision cannot partner with organizations which openly support abortion in addition to family planning services, blocking alliances with preeminent reproductive health organizations such as Marie Stopes International and Pathfinder International. However, World Vision has strong partnerships with governments.⁸³ Dennis Cherian, World Vision’s Deputy Director of Health and HIV, suggested in an interview that it is not only sensitivities but funding

TIMOR-LESTE*



48: Infant mortality rate
300: Maternal mortality rate
31.5% Unmet need for family planning
22% Contraceptive prevalence rate



NIGERIA*

78: Infant mortality rate
630: Maternal mortality rate
18.9% Unmet need for family planning



TANZANIA*

- 38: Infant mortality rate
- 460: Maternal mortality rate
- 25.3% Unmet need for family planning
- 34% Contraceptive prevalence rate

that is the central challenge, for World Vision as well as other (usually smaller) FIOs. FIOs, in part because many are quite new to the field and because of the hesitations of some private donors, are not attracting grants that are large enough to make full use of their organizational strengths and to allow their work and approaches to be integrated well into the “grander strategy” of family planning efforts.⁸⁴

Religious Leaders in Tanzania Join to Dispel Misconceptions and Promote Family Planning

In Tanzania, many Christian and Muslim leaders and believers hold the view that contraception is a sin against God. To combat these views, which contribute to particularly high fertility rates on the island of Zanzibar, religious scholars have worked jointly with medical professionals under the banner of the Tanzania Interfaith Partnership (TIP). This partnership includes the Christian Council of Tanzania, the National Muslim Council of Tanzania, the office of the Chief Mufti of Zanzibar, and the Tanzania Episcopal Conference. Religious leaders examine their texts and relay the results of their exegesis to their large community networks through written documents and sermons, conveying lessons on family planning that are health-based and rooted in religious values. TIP has contributed to the increased contraceptive use in Tanzania, which has gone from 9 to 13 percent since the partnership began.⁸⁵



RWANDA*

- 39: Infant mortality rate
- 340: Maternal mortality rate
- 20.8% Unmet need for family planning
- 52% Contraceptive prevalence rate

Rwandan Religious Leaders Pledge to Join Forces to Promote Family Planning

Fertility rates have been declining rapidly in Rwanda due to concerted government efforts to encourage birth spacing and provide family planning services (contraceptive prevalence went from 17 to 52 percent between 2005 and 2010). However, some religious institutions have resisted providing family planning in faith-linked clinics. Therefore, the government has established secondary health posts to supply family planning services near faith-inspired centers (mostly Catholic) where artificial contraceptives are not available.⁸⁶ The Presbyterian Church of Rwanda has organized family planning workshops in collaboration with the Ministry of Finance, in order to strengthen the role of religious leaders as family planning advocates. One such workshop, held in October 2010, ran under the banner “What the Bible says about the procreation of humans.” It fostered productive discussion about the need to rally faith actors around family planning. Recognizing the negative role religious leaders have sometimes played in family planning advocacy in the country, where 40 percent of healthcare institutions are faith-inspired (60 percent of which do not offer artificial contraception), the leaders who gathered were urged by Pastor Emmanuel Muhozi of the Rwanda Presbyterian Church and Ministry of Finance representative Innocent Gihana to lead efforts in family planning promotion. They discussed the shared values which family planning and religious text claimed, despite assertions of contradiction. Participants pledged to “join hands to control birth rates.”⁸⁷

Preeminent Population Expert Looks to Life’s Work for Lessons in Religion’s Effect on Family Planning

Dr. W. Henry Mosley, Professor Emeritus at Johns Hopkins Bloomberg School of Public Health, has spent 50 years in the field of reproductive health, helping to establish both the Hopkins Population Center and the Bill and Melinda Gates Institute for Population and Reproductive Health. He was a board member for Christian Connections for International Health and serves on their family planning working group. Dr. Mosley argues that it is not usually religion itself but the culture and politics that surround religion that present barriers to family planning uptake. He points to the challenge of Nigeria, where the heavily Islamic North has retained a high level of fertility, which he sees as rooted in local Islamic cultural values and their effects on women’s roles rather than in Islam itself. In terms of best practices regarding family planning in the context of faith, Dr. Mosley sees dialogue and communication to be key; he points to the case of Iran, where a societal dialogue among members of different knowledge communities

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

(economics, policy, religion) allowed for an eventual uptake of extensive family planning activities that was supported by each community. Expanding knowledge, Dr. Mosley stresses, is also a key factor in reaching groups that can be particularly neglected by faith-inspired actors, such as adolescents. Some religious leaders worry that educating youth about family planning and contraception leads to increased sexual activity (as is clear in the case study of Christian Health Association of Ghana, cited later in this report). Mosley stresses that this is actually the opposite of the truth; in fact, teaching adolescents about contraception delays their sexual activity, a finding he has relayed to religious groups. Lastly, Dr. Mosley observes that the manner in which knowledge is disseminated in religious communities must be carefully planned if faith is to have a positive impact in spreading family planning. He describes a high-level meeting involving religious leaders on family planning in Pakistan, which, despite fostering open discussions about family planning among attendees, was not successful in spreading its findings through the community because it did not build on the knowledge and authority of local religious leaders.⁸⁸

The case studies indicate that faith leaders and FIOs have been active in family planning for many years. For example, hospitals, clinics, and other health providers that are members of the Christian Health Associations of Kenya and Zimbabwe have been providing family planning services since the 1980s.

Faith leaders and FIOs deliver a wide range of family planning services, including direct provision of services and supplies, education, behavior change communication, capacity building, and advocacy. Although the IRH study found that FIOs are less likely to be providers of direct services than of support services such as education and health worker training, where they are involved in direct provision of family planning methods and supplies, they (except for most Catholic ones) provide a variety of methods, e.g., pills, IUDs, and injectables. Moreover, in several cases (e.g. Bwindi Community Hospital in Uganda, the Ethiopian Evangelical Church Mekane-Yesus South Central Synod in Ethiopia), FIOs are the major or sole provider of reproductive health services in the region, offering a full range of contraceptive methods. The African Christian Health Associations Platform, which represents the Christian Health Associations and Church Health Networks of Sub-Saharan Africa, is on record that its many members want to do more in family planning.⁸⁹

30 Years of Faith-Inspired Family Planning Promotion: The Zimbabwe Association of Church Related-Hospitals

The Zimbabwe Association of Church-Related Hospitals (ZACH) includes both Protestant and Catholic institutions, with 60 member hospitals and 66 smaller healthcare institutions. Many of the church-related health centers of which ZACH is comprised have been providing family planning services since 1982, including a range of contraceptive methods (such as injection, pill, implant and barrier methods). These family planning programs, mostly funded through the Ministry of Health and Child Welfare (MOHCW), with ZACH filling in gaps where necessary, have continued to expand. They now provide a full array of reproductive health and HIV services as part of a national reproductive health strategy. In 2009 alone, ZACH hospitals had over 40,000 first visits for family planning, over 100,000 repeat visits and over 4,000 referrals.⁹⁰

2. Many faith leaders and FIOs support and provide family planning.



ZIMBABWE*

56: Infant mortality rate

570: Maternal mortality rate

14.6% Unmet need for family planning

59% Contraceptive prevalence rate



KENYA*

- 49: Infant mortality rate
- 360: Maternal mortality rate
- 25.6% Unmet need for family planning
- 46% Contraceptive prevalence rate

Christian Health Association of Kenya Works with Religious Leaders to Spread Family Planning

The Christian Health Association of Kenya (CHAK) and other faith-inspired organizations provide around 30 percent of health care in Kenya, including family planning services. Joseph Oyongo, who is a Health Services Technical Officer with CHAK, sees family planning as essential to decreasing illness, child and maternal death, and related social factors such as poverty, lack of education, and malnutrition. In 2010, with funding from the World Bank, CHAK launched a project that utilized community health workers (CHWs) to provide contraceptive options to people in remote areas of Kenya’s Eastern Province. Beneficiaries were provided with client-controlled methods (including modern artificial and natural methods, such as pills, condoms, and CycleBeads) and were referred to health centers if they desired surgical/injectable methods. CHAK trained 72 pastors from 32 churches on information that would allow them to incorporate family planning messages into their sermons.⁹¹ Follow-up surveys showed that the combined efforts of this religious and CHW outreach correlated with significantly higher uptake of contraceptive methods.⁹² The project reached over 6,000 people, and increases in contraceptive use were detected in the target communities, including a 275 percent increase in pills used.⁹³



UGANDA*

- 45: Infant mortality rate
- 310: Maternal mortality rate
- 34.3% Unmet need for family planning
- 30% Contraceptive prevalence rate

Bwindi Community Hospital Spreads Family Planning Services and Discussion to Remote Area of Uganda

Bwindi Community Hospital (BCH), a private not-for-profit Church of Uganda Hospital under the Diocese of Kinkiizi, serves a remote community. One of very few facilities in this remote region of Uganda, it sends outreach teams to surrounding communities seven days a week. BCH sees the direct consequences of Uganda’s high fertility rate. It has therefore trained 40 health workers to distribute contraceptive pills and injections, allowing more than 500 women a month to access these methods. While contraceptive devices are provided by the Ugandan government, BCH relies on donations from a variety of individuals and organizations (most prominently the Kellerman Foundation) to cover salaries, transport, and training for staff. BCH integrates family planning into its HIV and postnatal clinics, and the hospital runs “Family Planning Camps” where those who desire them can receive implantable contraceptives (which last up to five years). Beyond service provision, BCH workers engage in debates on the radio and in person in many of the surrounding communities concerning the importance of family planning, taking particular interest in male perspectives. Contraceptive prevalence in the Bwindi area has already gone up to 28 percent—BCH hopes to reach at least 40 percent in the near future.⁹⁴

Ugandan Muslim Supreme Council Takes on Family Planning Research and Advocacy

The Ugandan Muslim Supreme Council, with the funding and support of the United Nations Population Fund (UNFPA), undertook a project whose aim was to determine why Uganda’s Muslim community was not taking advantage of the reproductive health services and activities that Uganda’s population policy provides. They convened workshops to explore the issue, and determined that major barriers to Muslim uptake of family planning resources included the low priority reproductive health held in various programs that were addressed to religious leaders, and their uncertainties in trying to reconcile reproductive health issues with their understandings of Islamic precepts. The Council and UNFPA then embarked on a three-pronged project, involving advocacy, behavior change communication, and an improvement of the available health services. Workshops that focused on respecting local Muslim customs were first targeted at men, who then encouraged their wives to attend. Turnout was high. Under Mufti Sheikh Shaban Mubajje’s guidance, religious leaders studied reproductive health messages and their relationships to Qur’anic texts. This allowed them to determine which messages

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

were in accordance with Islamic text, and could thus be promoted in their communities. Reproductive health is no longer a taboo subject in the community, and health services have become more widely available to those who need them most, resulting in important health improvements in the community.⁹⁵

Réseau Islam et Population (RIP) Promotes Religious Discourse on Family Planning and Reproductive Health in Senegal

Réseau Islam et Population brings together religious leaders, academics, and prominent Senegalese marabouts (as Muslim leaders are known there). RIP works to promote research, discussion, and action around reproductive health and family planning. Specifically geared toward religious leaders and their followers, with funding from UNFPA, USAID, and the Senegalese government, the organization's activities aim to combat mistaken notions that family planning is "un-Islamic" and a tool of "the West" whose true objective is population control. In order to advance their goals, RIP organizes workshops run by religious leaders and publishes articles addressing misconceptions about family planning's relationship to Islam and clarifying its importance.⁹⁶

Social Anthropologist Tracks a Career of Faith-Inspired Family Planning Work and Negotiation

Judith Brown, a social anthropologist and development consultant, has worked extensively in family planning services since the 1970s. Serving as a medical missionary of the Presbyterian Church with her husband, a medical doctor, in the Democratic Republic of the Congo (then Zaire), Brown offers a complex but adaptive picture of the issues surrounding family planning there. Working in a rural area of the DRC, where contraceptives had very rarely been available, Brown (who undertook cultural negotiation and evaluation work during the project) and her medical colleagues saw contraceptive prevalence go from 1-2 percent to 17 percent during her first placement from 1973-1976. Catholic workers who were also operating in the area were not pleased with the project, according to Brown, but did not voice any objections loudly. During a later assignment (in 1987) to the Congolese region of Kananga, Brown and her colleagues worked with both church and government clinics to implement family planning services and AIDS education programs. There, Catholic entities in the area were once again approached. While they did not agree to provide artificial contraception, the Catholic maternal and child health center opened their doors to family planning teachers, on certain days, where they could describe all methods and counsel and refer patients to other clinics on an individual basis.⁹⁷ Brown's later work on a Bible-based family planning guide in Kinshasa is described in another case study. Her experiences in these early family planning efforts reveal the extent and complexity of faith-inspired family planning work. They also speak to the power of negotiation around faith-related differences regarding family planning on the local level, where these differences and their challenges can (in some cases) be open to compromise.

Leading Pakistani Islamic Cleric Speaks out in Support of Birth Spacing

Hafiz Muhammad Tahir Mehmood Ashrafi, Chairman of the Pakistan Ulema Council, has voiced explicit support of birth spacing as it can protect the life of both mother and newborn, and give mothers the opportunity to care for their existing children. Dismissing perceptions that Islam is against family planning, Ashrafi stated that "it is not correct to believe that birth prevention is completely forbidden in Islam and Sharia...only a healthy baby and a healthy mother can build a nation."⁹⁸

SENEGAL*



45: Infant mortality rate
370: Maternal mortality rate
30.1% Unmet need for family planning
13% Contraceptive prevalence rate



DRC*

100: Infant mortality rate
540: Maternal mortality rate
24.2% Unmet need for family planning
17% Contraceptive prevalence rate



PAKISTAN*

69: Infant mortality rate
260: Maternal mortality rate
25.2% Unmet need for family planning

3. Faith leaders and FIOs are adaptive and resourceful.

Faith leaders and FIOs often take open or pragmatic approaches inspired and influenced by the links they see between their religious beliefs and the human needs of the people they serve. Humanitarian Marguerite Barankitse, a devout Catholic, provides family planning at the hospital that she runs, based on the moral imperative to help women avoid having more children than they can feed. The Churches Health Association of Zambia regards family planning services as a key part of its member facilities' work, yet it also respects the views of members who oppose artificial methods of family planning and helps ensure that government family planning services are available in the areas these members serve. The Family Planning Association of Pakistan is a secular NGO, but it holds workshops for clerics who wish to use Islamic texts as a foundation for advocacy of family planning. The Rwandan government, which since 2007 has made family planning a stated development priority, establishes secondary health posts in areas where Catholic faith-based health providers, who provide up to 60 percent of health services in Rwanda, do not supply family planning services other than natural methods.⁹⁹ Catholic providers have agreed to refer those clients interested in artificial methods to such facilities.¹⁰⁰

The Maryknoll Prevention of Mother to Child Transmission (PMTCT) program (with funding from Catholic Relief Services) in Cambodia is a highly-effective program that services a significant share of HIV-positive mothers. When the Maryknoll staff counsels patients on voluntary family planning, it provides them with "full and free information" about their options for preventing unintended pregnancies and refers them to the appropriate clinics for services they cannot provide.

The partnership between the Ethiopian Evangelical Church and Muslim elders illustrates another dimension of pragmatism in creative use of partners. Countering fears that the partisan nature of religion hinders effectiveness, the family planning education work of this partnership of faiths has resulted in its region, Alaba, having one of the highest contraceptive prevalence rates in the country.



ZAMBIA*

56: Infant mortality rate
440: Maternal mortality rate
26.6% Unmet need for family planning

Churches Health Association of Zambia Ensures Family Planning Access While Respecting Views of Members

The Churches Health Association of Zambia (CHAZ) represents health facilities and training schools. In addition to providing structure and support to the country's network of church-affiliated healthcare providers, CHAZ acts as a principle recipient of grants from a variety of international aid organizations which it sub-grants to its member institutions.¹⁰¹ All of CHAZ's member healthcare facilities provide a range of family planning methods except for its Catholic health facilities, which provide natural family planning (NFP). However, in these cases, CHAZ arranges with the Ministry of Health to provide additional family planning services through the District Health Management Teams, in order to ensure that no single religious institution is determining which services each community can receive.¹⁰² Catholic facilities will also refer clients to government hospitals should they desire to access other methods of family planning.¹⁰³



PAKISTAN*

69: Infant mortality rate
260: Maternal mortality rate
25.2% Unmet need for family planning

Family Planning Association of Pakistan Engages Supportive Clerics in Advocacy Work

The Family Planning Association of Pakistan (FPAP) conducts workshops for clerics who are interested in advocating for family planning on religious terms, in addition to devising health promotion manuals citing Islamic jurists and texts, and creating thoughtful refutations to fatwās which oppose family planning. They are primarily supported by the International Planned Parenthood Federation, with additional funds from an array of foreign and multilateral donors.¹⁰⁴ FPAP carefully advocates those methods which can be accepted by Muslim practitioners in the area in which they are working—for instance, largely excluding permanent methods in favor of temporary ones to be used for "birth

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

spacing,” such as pills and condoms—in order to spread a method of family-focused FP that is in line with local religious and cultural sentiments. While religious leaders, community leaders, and healthcare providers are the main targets for publication dissemination, medical anthropologist Emma Varley found that women in her research area had been able to attain some access to these documents themselves, and that these documents encouraged their choices to practice family planning, particularly in younger (18-35 years) women.¹⁰⁵

Church Programs in Ethiopia Reach 8.5 Million People with Family Planning Services, Form Partnerships with Muslim Leaders to Spread FP

The Ethiopian Evangelical Church Mekane Yesus-South Central Synod (EECMY-SCS) and the Ethiopian Kale-Hiwot Church Development Program have provided the bulk of reproductive health and family planning services to the people of the Southern Nations, Nationalities and People (SNNP) region of Ethiopia. These efforts have been funded by USAID through Pathfinder International. The church programs work in 49 of the region’s 104 districts, providing services in one of Africa’s most densely populated areas. These Protestant organizations have a strong history of service provision to people of the Muslim faith, particularly in the district of Alaba. There, two influential Muslim elders formed a partnership with the EECMY-SCS to deliver family planning services to a community that had previously looked down on contraception as against Islam. Through the engagement of religious leaders in discussion around family planning and its positive relationship with Islamic doctrine—and the essential service provision of EECMY-SCS—Alaba has achieved one of the highest rates of family planning use in the region.¹⁰⁶

Catholic Hospital Founder in Burundi Sees Family Planning to be as Central to Health as Preventing Disease

Maggie Barankitse is a renowned humanitarian who transformed a tragic experience of violence during Burundi’s genocide into a lifesaving program, serving thousands through the creation of Maison Shalom. Maison Shalom is a community which includes housing, a school, a farm, three banks, and a hospital, as well as other facilities and small businesses that are run and attended by children raised there. Their programs are funded by a variety of foreign development, charity, and faith-inspired organizations.¹⁰⁷ Ms. Barankitse makes a point of providing family planning services to patients of her hospital. She argues that the importance of human life outweighs dogmatism in her quest to better her society and embrace her religious obligations. Ms. Barankitse equates family planning to vaccination. She sees these services as a way to allow women to create families they can truly provide for, without fearing malnutrition due to an overabundance of mouths to feed.¹⁰⁸

Catholic AIDS Program Educates Patrons about Range of Contraceptive Options in Cambodia

The Maryknoll Prevention of Mother to Child Transmission (PMTCT) program in Cambodia, funded through Catholic Relief Services with money from USAID, the Catholic Agency for Overseas Development (CAFOD), and CRS private funds, has proven to be one of the most effective such programs in the nation. In 2008, the program was providing services to almost one quarter of all HIV-positive Cambodia mothers who give birth in PMTCT facilities. As part of this program, Maryknoll (despite its Catholic affiliation) counsels its patients in family planning, providing them with “full and free information” about their options for preventing further pregnancies and referring them to clinics for service. They encourage decisions with respect to family planning founded not only on HIV status, but also on socio-economic circumstances, while retaining respect and acceptance for the reproductive choices of mothers.¹⁰⁹



ETHIOPIA*

47: Infant mortality rate
350: Maternal mortality rate
26.3% Unmet need for family planning
29% Contraceptive prevalence rate



BURUNDI*

67: Infant mortality rate
800: Maternal mortality rate
32.4% Unmet need for family planning
22% Contraceptive prevalence rate



CAMBODIA*

16.9% Unmet need for family planning
51% Contraceptive prevalence rate



AFGHANISTAN*

- 71: Infant mortality rate
- 460: Maternal mortality rate
- 21% Contraceptive prevalence rate

Afghan Mullahs Promote Birth Spacing: Lessons from the Accelerating Contraceptive Use Project

Mullahs (Islamic teachers) in Afghanistan, where contraceptive prevalence is still very low (21 percent in 2011¹¹⁰) and the rate of maternal mortality is among the highest in the world, have in some cases served as key links in disseminating positive knowledge about family planning. The *Accelerating Contraceptive Use Project*, funded by the William and Flora Hewlett Foundation, has served as a vehicle for this dissemination. In interviews with 37 mullahs, program administrators realized that mullah disapproval came primarily from health safety concerns rather than religious disapproval. Once provided with accurate information, these mullahs were supportive of birth spacing and instrumental in creating pamphlets about family planning with Koranic verses.¹¹¹ A mullah even appeared on a national television program with persuasive information about the positive aspects of family planning within Islam. The feedback was so positive that further airtime was granted to the program for extended programming on contraception, and about 70 percent of television viewers in Afghanistan are recorded as having watched.¹¹² Afghanistan’s nearly universal and strongly conservative Islamic religion and culture is understandably understood as a barrier to reproductive health in the country. This case shows that Islamic leaders can serve as important advocates for family planning once convinced of its health benefits.

4. Faith leaders and FIOs are innovative.

A range of interviewees underscored that the limited resources, greater autonomy from government, and religious motivation that often characterize FIOs can turn them into mothers of innovation in the demanding environments where they operate. This is evident where groups operate in isolation and when they work in partnership with the government, external partners, and NGOs. The case study on the dogged work of the Adventist health clinics in Malawi provides an example: nurses go to great lengths to obtain contraceptive supplies, but when there are gaps at central supply points, they provide training in natural methods to their clients and remind women to return when the clinic has fresh supplies of contraceptives.¹¹³ Since they often operate in remote and underserved areas, FIOs have been active in the wider global health initiative to train community health workers to provide services traditionally provided only by doctors or nurses, when they believe that such approaches can work well. Another example of FIO innovation is World Vision’s combined service provision and behavior change communication (BCC) family planning program, Pragati, in Uttar Pradesh, which used the “timed and targeted approach” it developed. In addition to the programmatic innovation, World Vision, a leading Christian global aid organization, underwent an internal evaluation to re-examine, define, and strengthen its work on family planning. Importantly, the organization embraced “healthy timing and spacing of pregnancy” (HTSP), a term and rationale that resonates with religiously diverse communities, as the basis for its family planning work.

A Leading FIO Engages in Innovative Methods of Family Planning Promotion in India



INDIA*

- 44: Infant mortality rate
- 200: Maternal mortality rate
- 20.5% Unmet need for family planning

Uttar Pradesh, in north-central India, lags behind the rest of the country in many health indicators, particularly when it comes to fertility rates. According to the 2005 National Family Health Survey, 44 percent of Uttar Pradesh women were using contraception, while nationally the rate of use was 56 percent. To address this gap, World Vision implemented the Pragati program, funded by USAID, in order to boost child survival and family planning use in the region. Pragati (Hindi for “acceleration” or “momentum”) is the name used by World Vision for their Uttar Pradesh-based maternal and reproductive health program which focused on behavior change communication (BCC) and was specifically geared toward providing information to women when they needed it, not when it was convenient to the providers’ work schedules or when the calendar was approaching a specific month. This included interactions at calculated

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

moments during pregnancy, infant age and/or fertility desires of a couple—a “timed and targeted” approach. Most visits and BCC were undertaken by trained workers of the *anganwadi* (“shelters”), centers for childhood development (and by extension women’s and children’s health) established by the Indian government, who were already familiar with the communities and the types of information being conveyed. Over four years, the rate of contraceptive use more than doubled for postpartum women in the project zone (in one district nearly quadrupling), and other NGOs as well as the Indian government have looked to replicate World Vision’s method.¹¹⁴

Adventist Health Clinics in Malawi Struggle with Supply Dearth to Provide Isolated Women with Contraceptives

Only four in ten women in Malawi have access to contraception (according to UNFPA data), but Adventist clinics have been attempting to overcome this unmet need. While supplying contraceptives in small villages has proved to be challenging, health practitioners at the Adventist Namasalima Clinic in southern Malawi have gone to great lengths to provide contraception to 400 women per month (as of June 2010). Activities at the clinic and at other Adventist health outposts are funded by an array of individuals, organizations, corporations, and churches.¹¹⁵ Nurses at the clinic need to travel 20 miles to the nearest hospital to collect contraceptive supplies when their clinic runs out. When these supplies are depleted, nurses educate women in a natural method and ask them to return later, once the clinic has been able to obtain their next batch. While supply issues remain a challenge that calls for wider systemic attention, the clinic has strived continually to meet contraceptive needs where no other source is available to local women.¹¹⁶

Bible Studies Help Encourage Family Planning in the Democratic Republic of the Congo

The Eglise du Christ au Congo (ECC) is a union of 62 Protestant denominations which represent 20 percent of the DRC’s population. While working with the ECC, medical missionaries Judith and Richard Brown noticed that though access to family planning in Kinshasa was increasing after a spike in services in the 1990s, a lack of available knowledge was giving rise to opposition toward family planning among pastors and church members. To help alleviate these misconceptions, the Browns designed and implemented Bible study sessions focused on understanding the Biblical underpinnings of a positive attitude toward family planning and contraception.¹¹⁷ Judith Brown described in an interview how they solicited passages deemed problematic for family planning from community members, basing discussions on these passages. The passages and discussions evolved into a study guide that is currently being used by the Christian Health Association of Kenya, among others.¹¹⁸ The Browns’ position at a faith-inspired organization as well as their direct engagement with religious practitioners and texts allowed participants to have an open discussion about family planning and its relationship to religious practice. They saw an increased desire by participants for technical information on modern contraceptive options during and after these discussions, which they (as medical practitioners) were able to provide.¹¹⁹

Islamic Relief Trains Sexual Health Peer Educators in Bangladesh

Islamic Relief (IR) nurses conducted trainings for young women in Bujruk Kumurpur, Bangladesh on topics relating to sexual health, including HIV and family planning. IR’s Bangladesh activities are supported by a number of international development organizations, including UNDP, DFID, and Christian Aid.¹²⁰ These sessions were born from IR’s insight that youth feel more comfortable discussing these issues among their peers. In creating peer educator groups, IR was very careful to obtain the permission of girls’ parents and to gain the consent of the community. After their training, peer educators told their trainers how significant their knowledge increases were, as well as how they

MALAWI*



- 46: Infant mortality rate
- 460: Maternal mortality rate
- 26.1% Unmet need for family planning
- 46% Contraceptive prevalence rate

DRC*



- 100: Infant mortality rate
- 540: Maternal mortality rate
- 24.2% Unmet need for family planning
- 17% Contraceptive prevalence rate

BANGLADESH*



- 33: Infant mortality rate
- 240: Maternal mortality rate
- 13.5% Unmet need for family planning
- 61% Contraceptive prevalence rate

were able to share their knowledge with friends and family. Girls who went through the program noted that other girls would frequently ask them about the lessons they had learned. Facilitators particularly noticed that the program encouraged the girls to think more broadly about the issues affecting their lives and the ways in which family planning could alleviate problems such as poor nutrition, limited education, and limited access to health care. Islamic Relief has done a thorough study of the relationship between Islamic doctrine on family planning and its interpretation by Muslim religious leaders, wherein they present this case study of their work.¹²¹

5. There are limitations and challenges in faith work on family planning.

There are areas in reproductive health where faith actors do not get involved because they conflict directly with their values. Working with adolescents and unmarried young adults is an example. But as the case studies show, some FIOs find a basis to work in this area. Islamic Relief nurses conducted trainings for young women in Bangladesh, since younger women relate well to peer educators; Islamic Relief was careful to respect sensitivities about young women receiving reproductive health information. The Christian Health Association of Ghana created an environment such that members who felt called to do so could participate in the Window of Hope Project, providing youth-friendly reproductive health services. The Presbyterian Church of East Africa provides opportunities for youth as well as couples to discuss family planning before it becomes a point of contention, including through the youth-focused Transition into Adulthood Training that deals with issues such as relationships and teen pregnancy.



GHANA*

- 49: Infant mortality rate
- 350: Maternal mortality rate
- 35.7% Unmet need for family planning
- 34% Contraceptive prevalence rate

Religious Sensitivities and Youth-Friendly Services: Ghana's Christian Health Association

Between 1988 and 2003, fertility rates in Ghana dropped from an average of 5.8 children per woman to 4.5 children per woman.¹²² Yet the Ghana Demographic and Health Survey 2003 showed that only 17 percent of the sexually active population was using family planning. Low prevalence among youth was particularly troubling: 57 percent of those 15-19 and 41 percent of those 20-24 had an unmet need for family planning. Outreach to young people proved to be a central challenge, and one that raised issues for Ghana's significant religious health care providers and religious institutions more generally.

To reach this group, Pathfinder International and their African Youth Alliance (AYA) initiative launched the Window of Hope Project in 2002, aimed at providing youth-friendly services (YFS), in collaboration with the Christian Health Association of Ghana. The project was funded by the Bill and Melinda Gates Foundation. YFS involves services that are attractive to young people, respond to their needs, and encourage them to commit to long-term reproductive health care. Contraceptives, which many young people seek, were an integral program component.

The successes and difficulties of Window of Hope offer a range of lessons. CHAG members include some 152 health institutions from around Ghana, with different faith links and ethos. These and other religious institutions provide an estimated 35 percent of Ghana's healthcare services. Pathfinder, through the African Youth Alliance (AYA) program, was able to work with CHAG to bring a package of youth-focused services to health institutions run by six different Christian denominations. The project reached almost 450,000 youth and included the dissemination of 118,000 condoms by the time it concluded in 2005. Because the program required that contraceptives be made available, some CHAG members were reluctant to take part. Some religious leaders and

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

community members felt that encouraging contraceptive use by youth was a negation of Christian beliefs and condoned sexual intimacy before marriage, which is frowned upon by many Christian denominations. Nevertheless, members of the CHAG secretariat found the program intriguing, and began a frank but sensitive dialogue between its members and AYA/Pathfinder in order to explore the possibilities for YFS among CHAG facilities.

CHAG's executive secretary worked within the limits of its constitution to allow those members who wished to take part in the program to do so, while respecting those who did not. Leaders of member facilities of the Methodist, Presbyterian, Salvation Army, Pentecost, Church of Christ, and Seventh Day Adventist denominations decided to implement the project, citing a religious need to respond to the health realities of modern Ghanaian youth. The medical director of Pentecost-affiliated Alpha Medical Centre (now called Pentecost Hospital) was particularly keen on the program and its ability to reach church members and others alike: "All along we were only talking and teaching but now we are also providing the services. We opted for it in order to provide better and holistic service not only to church members but also to young people in the community."

The successful integration of YFS into the institutions' service delivery was evident when the participating denominations sought to expand the services to their other institutions; the Methodist, Salvation Army and Pentecostal Churches all sought funding after the project's official completion to expand the program. The flagship health facilities were able to sustain their programs with the assistance of CHAG and other funding sources.

When Window of Hope ended, YFS had reached hundreds of thousands of Ghanaian youth. However, there are challenges. The partnership itself had reached 10 of 152 CHAG health facilities, leaving a sizeable number without YFS. And the question of integration of YFS into the Catholic Health Directorate and other dissenting health directorates remained open. Yet the Window of Hope Project displayed the value of partnership, dialogue and respectful decision-making in expanding sexual and reproductive health services to people of varying religious backgrounds and the possibility these tools hold for overcoming the unmet need for contraception among Ghanaian youth.¹²³

6. Motivation and integration are important to faith actors.

Integration of family planning in a broader family context has special importance for faith leaders and FIOs. Incorporating statements of motivation and vision into care and engaging faith leaders in exploring issues around family planning can improve program success. Many of the case studies confirm other research findings that suggest that the motivation for reproductive health work and its integration with broader health and well-being objectives are important for faith actors. They tend to engage in family planning as “not necessarily...an end unto itself, but rather one aspect of a larger effort to improve physical and spiritual health for the whole person and for the family.”¹²⁴ Faith actors are motivated to support or provide family planning because it is part of maternal and child health and survival, poverty reduction, and family well-being and stability, rather than because reproductive health is seen as a human or women’s right. Some FIOs, such as the Fahmina Institute in Cirebon, Indonesia, combine a religious stance—in this case, support for Islamic values—with a rights-based and social justice stance. However, “healthy timing and spacing of pregnancy” and the concept that families should be able to feed, educate, and care for their children without it straining the health and well-being of the family as a unit or of its members are ideas embraced by many faith leaders and FIOs, rather than ideas or indicators such as limiting overall population, women’s rights, and contraceptive prevalence rates. For example, the Reverend Elias Otieno Agola of the Presbyterian Church of East Africa sees family planning methods as just one piece of the messages he spreads to his congregation on the benefits of family planning. The case studies also show that when religious people act in ways that are not in accordance with their faith’s official stance on family planning, they explain it in moral terms, having to do with maternal health, poverty, or the need to protect people from the further spread of HIV/AIDS. Related to this motivation, FIOs tend to integrate the family planning services they provide with other services, as indicated by several of the case studies, e.g., Maryknoll’s PMCT program, Ganta Hospital’s child survival project, and the ChemiChemi Baptist clinic in Kibera. Faith leaders’ and FIOs’ motivation to serve the whole person and their integration of family planning efforts with maternal and child health and broader health programs are both approaches that are endorsed by global health organizations as being efficient and effective.

Family Planning in a Post-Conflict Situation: Liberia’s Ganta Methodist Hospital

LIBERIA*

56: Infant mortality rate

770: Maternal mortality rate

35.7% Unmet need for family planning



Nimba County, Liberia’s second most populous country (over 450,000 people), was devastated by the two civil wars that engulfed the country between 1989 and 2003. Many inhabitants fled and infrastructure was left in ruins.¹²⁵ Today Nimba is slowly coming to life. The Ganta United Methodist Hospital is part of this revitalization effort.

Ganta Hospital is one of Liberia’s oldest modern health institutions. Begun in 1926 as a health post, it today provides community-based primary health care, including dental, ocular, diabetes, maternity, and post-natal services. Ganta emphasizes preventative measures and has a group of professionally trained community health volunteers who travel the region to educate local communities on how to stay healthy.¹²⁶

In 2011, Ganta added a significant family planning program, in partnership with sustainable health NGO Curamericas Global and funded by USAID and World Learning (a US-based NGO). It is organized in the context of a child survival project called Nehnwaa, begun in 2009, and is jointly administered by Ganta and Curamericas. The project is geared toward improving maternal and child health and reducing maternal mortality. Through the family planning component, volunteers teach community members about the importance of spacing their children, and offer birth control pills and condoms.¹²⁷

Still newly emerging from civil war with limited infrastructure and access to health care of any kind, Liberia has the seventh-highest maternal mortality rate in the world (770 maternal deaths per 100,000 live births¹²⁸) and limited contraceptive prevalence is one of the main causes. The unmet need for family planning in Liberia was last recorded to

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

be 36 percent.¹²⁹ Ganta launched the family planning program because surveys showed that in addition to limited access to health facilities and family planning supplies, cultural resistance and a lack of knowledge about family planning were strong barriers to service uptake in the region.¹³⁰ Thus, community health workers are a key part of the project, conducting educational seminars and meeting with community members to discuss the benefits and importance of family planning, in addition to dispensing contraception.¹³¹

Kormassah Malbah, a community health volunteer with Ganta, encountered some resistance to her family planning work, particularly from men and those who felt that contraception works against God's plans. She was able to move past this resistance with many in the community. Her success has been borne out in the results: a midterm survey, conducted by Curamericas, found that the unmet need for family planning in the project area had declined by 12 percent since the family planning component began.¹³²

The Methodist denomination globally encourages family planning, and this meant that Ganta faced no theological issues in embarking on the program. The United Methodist Book of Discipline, which serves as the denomination's code of conduct, points to family planning as an important aspect of "The Right to Healthcare:" "the right of men and women to have access to comprehensive reproductive health/family planning information and services that will serve as a means to prevent unplanned pregnancies, reduce abortions, and prevent the spread of HIV/AIDS."¹³³

The Curamericas partnership ends in September 2013, but Ganta plans to continue the project, albeit on a smaller scale.¹³⁴ Through the Nehnwaa Project, Ganta has acted on the Methodist belief in the right to family planning, and has allowed Nimba County's women the chance to create stronger and healthier families.

A Baptist Clinic Deals with Women's Health Needs in a Diverse Slum Community

Kibera is reputed to be Africa's largest contiguous slum. A bustling, densely settled community, it has no government schools or clinics, and most rudimentary services are provided privately. Kibera's residents come from many of Kenya's ethnic and religious groups and the slum was the site of considerable violence during the 2008 post-election troubles. Insecurity is a vital and daily concern.

Patience Otieno is the administrator of the small ChemiChemi Ya Uzima clinic, not far from an entrance to Kibera. ChemiChemi Ya Uzima means "spring of life" in Swahili. She reports that the Nairobi Baptist Church wanted to do something for people in Kibera, "to share God's love", and in 1999, initially with some UK partners, started to build a small clinic. Since 2004, the Nairobi church has been the sole support for the clinic.

Working in Kibera is never easy and the program has had to overcome many obstacles. From the start, the aim of the clinic has been to serve "anyone and everyone", but the community (which is majority Muslim) was initially suspicious. Each morning, for months, construction progress from the previous day would simply disappear. The Church leaders met with the community leaders (who were ethnic Nubians) and learned that the community believed the Church came to convert. After apologizing for going about the founding of the clinic in an inappropriate and insensitive way by failing to consult properly, the Church engaged a committee of elders from the community in the effort. The construction continued and the clinic opened.

Patience used the word "holistic" repeatedly to discuss the clinic's work; the Baptist community wants to help the whole human being. So, besides clinical services (with around 50 patients each day), they support a group of 35 children who need special help (many have AIDS), do home-based visits to people who are bedridden, and give advice on proper nutrition and sanitation. One of the community social workers, Zam Obed, runs a radio program that highlights messages on health including sanitation. The clinic staff started a Bible study class for those who wished to join; there was enough



KENYA*

- 49: Infant mortality rate
- 360: Maternal mortality rate
- 25.6% Unmet need for family planning
- 46% Contraceptive prevalence rate

interest that a new church was established near the clinic.

Family planning is an integral part of the clinic's services. They provide a range of advice and contraceptive devices (including pills, injections, and condoms). Patience describes their services in matter-of-fact terms; their approach is highly pragmatic. She reports that men seldom come and are "shy," so condoms are kept apart, where men can collect them privately. Some women also come privately; they report that their husbands would beat them if they knew that they were taking a pill. Family size tends to be large, and families' decisions are mostly "cultural." For example, a woman is expected to keep having babies at least until a boy is born. But raising children is hard and expensive. The deep religious convictions of the clinic's founders and operators are at the core of their work but so is their deep understanding of the community, its realities, and its cultural norms.

The Kibera community is served by a large number of small clinics like ChemiChemi, most of them run by faith-linked groups. There are also private operators (unregulated in this environment), with male circumcision and other services advertised on rough billboards. The quality of drugs and services from these sources is questionable and potentially dangerous. In this grueling environment, clinics like ChemiChemi do noble work with scant resources.¹³⁵

7. Faith leaders and FIOs have secured big wins in family planning, especially in behavior change communication.

The case studies demonstrate that faith leaders and FIOs have contributed to some highly effective family planning projects. They are especially effective in BCC, thanks to the credibility and trustworthiness of faith leaders and the strong grassroots networks of faith communities. Examples include the work of the World Vision Pragati program, where the rate of contraceptive use more than doubled among postpartum women in the project zone, inspiring interest in program replication from the Indian government and other NGOs. A CHAK program in Kenya reached 6,000 people, with a 275 percent increase in the number of oral contraceptives used in the program area. 70 percent of television viewers in Afghanistan watched a program on contraception that included mullahs speaking favorably about family planning. And the historical successes of the family planning programs in Indonesia and Iran would not have been possible without religious leaders' support.

A Religious Group Fills Gaps in a National Policy: Fahmina and Family Planning



INDONESIA*

26: Infant mortality rate

220: Maternal mortality rate

11.4% Unmet need for family planning

61% Contraceptive prevalence rate

Indonesia is particularly renowned for two facets of its family planning programs. First, strong political support underpinned one of the world's most ambitious and successful family planning programs in the 1970s and 1980s. Second, the two large Indonesian Muslim popular and political movements, Nural Islam (NU) and Muhammadiyah¹³⁶, provided active support. Indonesia's story is told as a success based on cooperation involving religious groups that was grounded both in theology and practical, operational program activism. The results were remarkable: birth rates came down and women and families benefitted.

Suharto, who led Indonesia for 31 years before resigning in 1998, first instituted a family planning program in 1968. This program, meant to address Indonesia's rapid population growth, is generally seen as a successful (and heavily enforced) effort in national family planning.¹³⁷ Yet recent developments in Indonesia, in the post-Suharto era, have presented new challenges. Family planning is still part of the government's agenda but its priority is lower than it was. Most important, alongside most other public services, family planning is now decentralized. District governments (there are 441 for the national population of about 250 million) are responsible for health care, which includes running clinics, providing personnel (midwives are the most pertinent for family planning), and supplies including drugs and contraceptives. The reality is thus that services are less coherent and consistent, and once local politics gets involved, the priority for services like family planning has tended to decline. There is evidence that

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

the unmet demand for contraceptives is rising as are birth rates.

The issue is complicated by a backlash against women's rights in many areas of the country, associated with a rise in radical Islamic thinking and political activism. Local politicians are reluctant to challenge those who question women's rights. New regulations about dress and behavior and strict interpretations of sharia law are appearing in many of Indonesia's districts. There is evidence that certain kinds of female genital cutting, which was deemed legal by the Indonesian government in 2010, are on the rise, alongside acid throwing at unveiled women and pressures for restrictions on women's movements and access to jobs.

All told, Indonesian women, especially those who are poor and live away from the major urban centers, face significant challenges, including limited access to knowledge about family planning.

The Fahmina Institute in Cirebon (a metropolitan area of about 2 million, three hours by train from Jakarta, the capital) combines a religious role that supports the teaching of Islam and Islamic values, an intellectual role as a leader in theological studies and interpretation, and an activist role supporting poor communities in their efforts to improve their lives. Thus this unusual NGO engages in academic teaching, spiritual activities like prayer and preaching, and community organizing. Its programs in support of women's equality are especially lively and the organization is tied to Southeast Asian women's networks whose mission is to "recapture" Islam from radical interpretations that are counter to women's full and equal rights.

One section of the Fahmina Institute supports reproductive health. It is a small unit, with seven full time staff (whose support consists of travel allowances) and volunteers, largely students. The team focuses on information, which they see as lacking and critical. Sex education is minimal in Indonesia but in the Islamic schools, where Fahmina has extensive contacts, the topic is taboo. Furthermore, Fahmina is combating a bureaucratic culture that looks down on the poor, refuses to answer their questions, and will not acknowledge mistakes; in Indonesia, midwives typically dispense contraceptives, but they offer women no choice and if a problem (like bleeding) arises they simply say that the situation is normal and send the woman away.

The Fahmina team travels from village to village, meeting groups of women and opening discussions to any topic around reproductive health. For example, in *pesantrens* (Islamic boarding schools) the volunteers discuss menstruation, which the girls do not understand. They open the topic of domestic violence, making it clear that it is not sanctioned by any Islamic text. Likewise they explain the facts of different contraceptive methods and problems that arise. They talk about the negative consequences that come with female genital cutting. They advise women planning to migrate to other cities or countries (normally as domestic workers) on how they can protect themselves from sexual harassment and violence. The group operates on the principle that any subject is open for discussion and they report that women respond to this openness with a thirst for knowledge and honest discussion. In addition to their traveling volunteers, Fahmina has a network of experts nationally who are called on when there are questions and problems and who conduct periodic training for the volunteers.

This effort is a drop in a large bucket but it highlights the importance and benefits of setting women's reproductive health and issues of rights in a religious context for the many Indonesian women for whom their faith is a central guide to their values and lifestyle. It builds on Indonesian Islam's longstanding traditions of pragmatism and openness. It illustrates that information, whether in the form of school, community education, or community services that reach out to women can provide a critical role in the lonely challenges many women face in regard to their sexuality and reproductive health. Fahmina's interventions are an important entry point for its broader work on women's rights within the faith of Islam.¹³⁸

BURUNDI*

67: Infant mortality rate

800: Maternal mortality rate

32.4% Unmet need for family planning

22% Contraceptive Prevalence rate



LifeNet International Approaches Family Planning Across Denominations in Burundi

Burundi, a small central African country of nearly 11 million, has endured much hardship since it gained independence in 1962. A history of ethnic tension and genocide has led to over 200,000 deaths and the displacement of 188,000 Burundians. These years of unrest have resulted in limited health infrastructure and troubling reproductive health statistics, including an unmet need for family planning of 32 percent.¹³⁹

LifeNet International, a young NGO operating in Burundi, works to expand health care by improving the performance of Burundi's church-linked clinics.¹⁴⁰ They are supported by funds from (largely Christian) individuals and family foundations.¹⁴¹ LifeNet decided to partner with church-linked clinics in 2011 after noticing that they "vastly outperformed" other local healthcare providers. These clinics represent 14 percent of those in Burundi. The organization has begun collaborations with 41 such institutions thus far, with a goal of reaching 50 by the end of 2013.¹⁴² As most of Burundi's health care is provided by nurses (Burundi has only 300 doctors), LifeNet focuses much of its work on nurse training. One third of this training is centered on reproductive health, with a significant family planning component. Monica Slinkard, the organization's medical director, notes that providing accurate knowledge about family planning has been a core focus of the project, with an eye toward allaying prevalent fears about contraception and ensuring that women use using their method of choice properly. Thus, LifeNet's family planning training is twofold: they provide information about contraceptive medication via a case study method while also teaching modern natural family planning methods.

While LifeNet wants to support women's decisions regarding contraception, "women often do not really have a choice because of cultural norms." Religious and cultural issues are at play in Burundians' use of family planning, and this is reflected in Burundi's contraceptive uptake: according to a 2011 survey, 70 percent of all clinics in Burundi provide contraceptive methods, but only 22 percent of families utilize these methods. Further exacerbating this non-use is the availability of free health services for mothers and children up to five, which delays (but does not eliminate) the cost of having many children.

LifeNet works with both Catholic and Protestant clinics in their family planning training programs, and has learned to work with a variety of attitudes toward contraception. While all clinics are required by the government to provide at least family planning counseling, Catholic clinics—representing the majority of faith-linked clinics—rarely go beyond this. Though they are able to offer natural methods such as the Two Day Method and Standard Days Method, people are aware of the Catholic stance on family planning and rarely go to a Catholic clinic seeking such services. Pentecostal clinics in Burundi have also adopted a limiting position on family planning wherein they do not provide contraceptive medications or longer-term methods, such as sterilization. Other Protestant clinics vary, though few are directly opposed to contraception.

LifeNet's experience with church-linked clinics of varying backgrounds suggests important insights. For instance, language (in line with existing studies) is key in working with many church-linked clinics and faith practitioners, with discussion of "birth spacing" far more acceptable than "birth limiting." The nuns who run some Catholic clinics are not necessarily providing contraception, but international experience has made them sensitive to family planning policies and issues, a characteristic which locally-focused Pentecostal nurses tend to lack. Such observations are likely to multiply as LifeNet continues its family planning work.¹⁴³

LifeNet's partnership model has already resulted in a 72 percent improvement in quality of care overall.¹⁴⁴ With a mission and strategy that remain ever cognizant of the challenging religious and cultural landscape and a swiftly growing group of partner clinics, LifeNet's model may become a paradigm for locally tailored family planning work.

*Full dataset page 5. Infant rate per 1,000 live births. Maternal rate per 100,000 live births.

The case studies indicate that faith leaders can be effective spokespeople, clarifying to the public that their faith tradition is not against family planning and lobbying governments and donors to make family planning a funded priority. When the UNFPA realized that Uganda’s Muslim community was not taking advantage of reproductive health services, it worked with the Ugandan Muslim Supreme Council. The partners engaged in advocacy as well as BCC and an improvement of health services. Senegal’s Réseau Islam et Population (RIP) brings together religious leaders, academics and other thought leaders to promote research, discussion and action around reproductive health and combats notions of family planning as “un-Islamic” and a Western tool to limit the Senegalese population. The existence of RIP may have contributed to the key role for religious leaders to advocate for family planning in the government’s new reproductive health initiative.

8. Faith leaders are often willing to advocate for family planning.

Communication as a Core of Family Planning: The Presbyterian Church of East Africa Takes a Holistic Approach

The Presbyterian Church of East Africa (PCEA) has hospitals and clinics throughout Kenya which provide a range of family planning services. Yet while these services are vital for the Kenyans who come seeking such services, Rev. Elias Otieno Agola, a PCEA minister, sees medical provisions as only a small piece of spreading the benefits of family planning to his congregants.

Communication, says Rev. Agola, is a key component to successful family planning. As a pastor, he has taken particular notice of the damage resistance to family planning—even where contraceptives are available and encouraged by the church—can cause in a family. With many women pursuing family planning on their own, men will often become enraged when they find out that contraceptives are being used behind their back. Disagreements about family planning use, says Rev. Agola, have broken up families and have increased the suffering of those children a family already has.

To address these social barriers to family planning uptake, PCEA provides opportunities for couples and youth to discuss the importance and proper utilization of family planning before it becomes a point of contention. Pre-marital counseling seminars in the church include significant attention to family planning. Pastors encourage couples to space their children, utilizing Biblical insights to show congregants how they are not religiously required to procreate indefinitely (on Genesis: “it is filling the earth, not filling the house”).

While they focus on couples about to be married, those who are already married but have not attended previously are also encouraged to attend and the church serves as an ideal network for bringing in community members. And for those who are too young to marry, PCEA provides the Transition into Adulthood Training (TIAT) program, which focuses on issues particular to youth. This program deals with relationships and teenage pregnancy, in addition to other issues related to “rites of passage.”

Rev. Agola says that in his church, family planning does not refer only to child spacing, but rather the general planning of the family: saving to take care of your children and retirement, investing in children’s education and ensuring optimal parenting. Seeing child spacing as an aspect of family planning allows people to see the importance of having the number of children for which a family can actually provide. To demonstrate the benefits of family planning, Rev. Agola has incorporated testimonials from community members with smaller families, allowing them to show for themselves the health and education benefits they have achieved.

Creating communication around family planning, notes Rev. Agola, is central to ensuring that all community members are aware of its importance and open to its use.¹⁴⁵



KENYA*

- 49: Infant mortality rate
- 360: Maternal mortality rate
- 25.6% Unmet need for family planning
- 46% Contraceptive prevalence rate

Chapter 4

Recommendations

Faith interacts with family planning at the personal, civil society, and governmental levels in complex ways. Credible studies indicate that religion is not a central determinant of people's family planning behavior, that perceived religiosity may be obscuring actual determinants such as level of education or income, and/or that cultural mores such as inequality for women are miscast or exaggerated as religious obstacles to family planning. This can be important information for decision-makers who worry that supporting family planning will offend religious stakeholders. But it is equally true that religious beliefs and institutions are important determinants of how people live, and faith leaders and FIOs have significant potential to influence the health and well-being of citizens in many world regions through their views, work, and communications touching on reproductive health. Faith institutions, leaders, and beliefs have strong and important roles in many countries with large populations and high fertility rates, maternal mortality, and unmet need for family planning, such as Ethiopia, Nigeria, the Philippines, and Pakistan. They can determine the success or failure of the international priority accorded to family planning.

Faith leaders and FIOs have strong credibility, grassroots networks, and other assets that are vital for health work, and they have long actively provided family planning services, education, and capacity building. Most, especially those who are closest to communities, believe in family planning and the healthy timing and spacing of pregnancy. This reality is often obscured in exaggerated rhetoric of false preconceptions. It is important that the positive support be better appreciated, together with faith leaders' and FIOs' flexibility, innovation, and special efficacy in behavior change communication. Many faith leaders and FIOs have not yet translated their work in the field on family planning into advocating to governments and aid-providing organizations for expanded support of international family planning. Groups like Christian Connections for International Health and the multi-faith Faith to Action Network can help provide advocacy opportunities for faith actors who want to do more.

Six broad approaches emerge from this review as important potential avenues for action:

- 1 Working to build areas of agreement on family planning**, such as the integration of family planning into broader health programs and its importance for consensus goals such as maternal and child health and the MDGs.
- 2 Exploring ways to ensure that data systems include and demarcate family planning services provided by FIOs**; this could help in determining ways in which FIOs could better serve as partners in achieving the goals of FP2020.
- 3 Probing—head-on but in a safe arena separate from the US legislative and policy community—further ways in which areas of difference between the views on family planning of faith-inspired and secular organizations can be accommodated in global health and development work.** This exploration should cover areas such as the promotion of contextually appropriate contraceptive methods, how to form partnerships despite differing views on certain issues, and how to deal with adolescents.
- 4 Developing and disseminating better tools illustrating how many faith institutions support family planning and underlining that almost all support the healthy timing and spacing of pregnancy**, while clearly acknowledging major differences, such as the Catholic Church hierarchy's support for only natural methods of family planning. These tools should also emphasize the health, development, and economic evidence for family planning. Tools might include sermon guides, theology-based advocacy materials, and religious study guides on family planning.
- 5 Drawing stakeholders' attention and efforts to the fact that while the relationship of faith and family planning is complex and nuanced and difficult to disentangle from culture, faith is very important and of great influence in several of the countries that are most critical to the overall success or failure of international family planning efforts**, e.g., Nigeria and Pakistan. Thus religious actors and dimensions should be taken explicitly into account.
- 6 Seeking greater visibility for faith representatives from low-income countries**, so that they can engage decision-makers in the US, Europe, and other donor countries, and the governments of countries that are implementing international family planning programs. To fully engage and integrate the potential of FIOs, it is important that they have appropriate representation on relevant steering councils, committees and task forces where policies and resource allocation decisions are made affecting the expansion and strengthening of family planning programs.

Endnotes

1. There is an extensive literature by respected international organizations such as the World Health Organization and in peer-reviewed journals, in addition to studies by reproductive health organizations such as UNFPA, the Population Reference Bureau, and the Guttmacher Institute, that provides evidence on the benefits of access to family planning and the healthy timing and spacing of births. A series in *The Lancet* on family planning, published in July 2012, summarizes current views on the health, economic, and other implications of lack of access to family planning. See: "Family Planning." (10 July 2012). *The Lancet*. <http://www.thelancet.com/series/family-planning>.
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Interviewees

Rev. Elias Otieno Agola, Minister at the Presbyterian Church of East Africa

Adrienne Allison, Reproductive Health Technical Advisor at World Vision

Marguerite (Maggy) Barankitse, Founder of Maison Shalom

Judith Brown, Former Presbyterian Medical Missionary and current Senior Technical Advisor for Family Planning/Reproductive Health at Christian Connections for International Health

Dennis Cherian, Senior Director of Health, HIV and AIDS at World Vision

Lily Gomes, Program Manager for Community Health and Natural Family Planning at Caritas Bangladesh

Douglas Huber, Physician and Reproductive Health Expert, Co-Chair of Christian Connections for International Health Family Planning/Reproductive Health & Maternal Health Working Group

Hahna Kimbrough, US Director at LifeNet International

W. Henry Mosley, Professor Emeritus at Johns Hopkins Center for Global Health

Patience Otieno, Administrator at ChemiChemi ya Uzima Clinic

Karen Sichinga, Executive Director at Churches Health Association of Zambia

Monica Slinkard, Medical Director at LifeNet International

Nancy Warren, Liberia Program Manager, Curamericas Global, Inc.

Allen Zomonway, Project Manager, Nehnwaa Child Survival Project, Ganta Hospital Primary Hea



WORLD FAITHS
DEVELOPMENT
DIALOGUE

The World Faiths Development Dialogue is a not-for-profit organization, housed at Georgetown University, working to advance poverty-focused development work by bringing to bear knowledge and insights from religious ideas and institutions. WFDD works to build partnerships and encourage dialogue among faith-inspired organizations and other development actors through research, consultations, and public events. The aim of this work is twofold: to reinforce and publicize the common purposes of religious and other development institutions working to end poverty; and to explore with care and respect contentious issues around development with a view to increasing mutual understanding and opening doors to stronger partnerships.



The Universal Access Project (UAP) works to achieve universal, voluntary access to reproductive health care and international family planning, Millennium Development Goal 5b and the International Conference on Population and Development Programme of Action, which leads to healthier women, stronger families, and more stable, prosperous communities. UAP focuses on strategy development, advocacy, and tactical re-granting to U.S.-based civil society organizations to strengthen U.S. leadership on international reproductive health and family planning (IRH/FP). Since the launch of the project, UAP and partners have successfully increased the U.S. financial contribution to IRH/FP including support for UNFPA and improved U.S. policy on IRH/FP quality, services and information.

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