



## Why Evangelical Christians are Supporting International Family Planning: A Response to *Should Evangelical Christian Organizations Support International Family Planning?*

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### Abstract

The article by Monique and Jeffery Wubbenhorst asks the question—*Should Evangelical Christian Organizations Support International Family Planning?*<sup>1</sup> The article's response to this question shows a lack of understanding of the fundamentals of population dynamics in the modern world as well as of the critical role contraceptives play in preventing unintended pregnancies and abortions and promoting maternal and child health. These errors are compounded by selective citation and misrepresentation of the evidence in the scientific literature. This commentary seeks to provide a balanced view of the evidence and correct several unfounded assertions in order to document why evangelical Christians and Christian organizations are, in fact, providing family planning services around the world.

Specific points addressed are as follows: fundamentals of the global demographic transition including how the contraceptive revolution has slowed world population growth; the social, economic, and cultural forces driving couples to choose to control their fertility for the welfare of their families; the critical role of contraceptive practice in preventing unintended pregnancies and abortions as well as directly promoting safe motherhood and child health; the evidence that women and couples in less-developed countries desire to control their fertility as attested by the measurement of unmet need for family planning; and the reason why failing to provide poor women and couples in less-developed countries who want to control their fertility with the information and contraceptive methods of their choice is likely to lead to unintended pregnancies and more abortions.

Christian health professionals and organizations need to be in the world, working with people of all belief systems, since that is a powerful way for the world to be reached with the love of Jesus and the gospel of salvation.

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**Key Words:** Christian, family planning, contraception, abortion, international health, morality, safe motherhood, maternal mortality, public health, demographic transition, unmet need, unintended pregnancy

## Introduction

The article by Monique and Jeffery Wubbenhorst asks the question—*Should Evangelical Christian Organizations Support International Family Planning?*<sup>1</sup> While this could be a relevant question to ask, the commentary seemingly lacks an understanding of the fundamentals of population dynamics in the modern world. Additionally, the contentions are supported with some unfounded assertions about contraception as well as selective citation and misrepresentation of evidence from scientific literature. This paper seeks to provide a balanced view of the evidence. There is a solid rationale for why Christians and Christian organizations from both the more-developed and less-developed countries support international family planning.

## A Christian Definition of Family Planning

As a preface to this critique, there needs to be clarity as to what the international Christian community commonly means by the term “family planning.” Christian Connections for International Health (CCIH), a coalition of 150 national and international Christian organizations (both Protestant and Catholic, and spanning five continents) working in international health and development, has formulated a working definition of family planning, specifically:

Enabling couples to determine the number and timing of pregnancies, including the voluntary use of methods for preventing pregnancy — not including abortion — harmonious with their values and religious beliefs.<sup>2</sup>

It is important to note at the outset that “enabling couples to determine” and “voluntary use” by definition excludes coercive or strongly persuasive fertility control programs of any type. The focus is on “preventing pregnancy,” not “preventing births” since abortion is excluded.

## Biblical Foundations

Let us begin with a brief summary of some of the Biblical foundations for evangelical Christians to support family planning. The first chapter of Genesis includes the narrative of God creating human beings, male and female, in His own image and commanding them to “be fruitful and multiply, fill the earth and govern it” (Genesis 1:28). In the second chapter of Genesis, God established the institution of marriage, a teaching reinforced by Jesus with a condemnation of the ease of divorce (Matthew 19:3-9). God planned for humans to be stewards of His creation, but they failed in their relationship with Him; so we now live in a fallen world. God has a plan for all human life, even before conception (Psalm 139: 13-16). God also created the beauty of sexual relationships as a bond between couples (Song of Solomon). St. Paul, inspired by God, recognized the importance of this relationship in solidifying the marital bond without considering the procreation of offspring (1 Corinthians 7:1-6).

There are a number of references in the Old Testament to God’s people acting on childbearing desires, though in that historical period all the efforts at “family planning” were pronatalist with a strong desire for sons. For example, Sarah gave Abram her servant Hagar to bear a child for her (Genesis 16). Jacob’s two wives, Rachel and Leah, competed with each other to bear children, resulting in the fathers of the twelve tribes of Israel (Genesis 29:31-30:24). Tamar seduced her father-in-law, Judah, to get a son to assure her of her rightful family inheritance. The son was Perez, the ancestor of King David and ultimately Jesus (Genesis 38; Ruth 4:18-22; Matthew 1:3ff). Hannah, one of Elkanah’s two wives, childless for many years, made a vow to give her son to God’s service if He would give her a son. The next year her prayer was answered with the birth of the prophet Samuel (1 Samuel 1:1-28). David “comforted” his wife Bathsheba with another son to replace the child that died, leading to the birth of Solomon (2 Samuel 12:24). Understandably, in those days, the “barren womb” was compared to “the grave” (Proverbs 30: 15-16). However, it is

important to note that women were not only valued for their childbearing abilities. We see in Proverbs 31:10-29 the virtuous and capable wife who was extolled for her industriousness, wisdom, and kindness.

### The Demographic Transition, Contraception, and Low Fertility in the World Today

The article *Should Evangelical Christian Organizations Support International Family Planning?* refers extensively to the negative views towards fertility control by historical secular and Christian figures. But those historical positions, coming from a time period when infant, child, and maternal mortality rates were high, are hardly relevant to the present situation. More relevant is their review of the widely-varying secular and Christian perspectives from the 20<sup>th</sup> century when the world's population transition is well underway. It is in this context that the family planning perspective, articulated by the CCIH and implemented by many Christian organizations working around the world, will be supported in this commentary.

To summarize, until the 18<sup>th</sup> century, human populations were characterized by high birth rates and high infant, child, and maternal mortality rates with life expectancies hardly over the age of 30 years; populations grew very slowly, if at all.<sup>3</sup> Family and tribal survival depended on surviving children (Psalms 127:3-5). No doubt, the Wubbenhorsts' argument that, "Couldn't a large number of children actually help families come out of poverty by having more working members in the family?" would have been relevant at a time when there were no health or educational opportunities and expenses, and children began working at a very early age to support the family. But this is not the situation in the modern world.

With modernization, urbanization, technological advances, and increasing political stability beginning in the 18<sup>th</sup> century and accelerating in the 19<sup>th</sup> and 20<sup>th</sup> centuries, death rates began to decline

so that families had more and more surviving children.<sup>3</sup> In the more developed countries of the Western World, family size declined, and, initially, couples started controlling their fertility with abstinence, condoms, and other barrier methods as well as abortions.<sup>3</sup> However, with families getting larger in the less developed countries because of improved health conditions, world population began to rapidly grow. By the end of World War II there was concern in many quarters about a world population "explosion."<sup>4</sup>

In the 1950s and 1960s, highly effective modern contraceptives were developed, beginning with the IUD and then the contraceptive pill. These, and other new contraceptive methods became widely available, first in developed countries. Then, as governments and international agencies began to provide foreign assistance programs, family planning became a part of the international development package. Over the last 4 decades of the 20<sup>th</sup> century, contraceptives were steadily adopted in the less developed countries, particularly in Latin America, Asia, and North Africa. This initiated the "contraceptive revolution." World contraceptive use rose from less than 5% in the 1960s to about 65% at present, and world fertility fell from over 5 births per woman to the current level of about 2.5 births per woman.<sup>5</sup> Abortion was also a factor in this fertility decline, but this accounted for only about 15% of the reduction in fertility.<sup>6</sup>

Noteworthy, these historical demographic realities contrast with the statement that, "One common motive for 'family planning' is to control population growth. Though this is widely accepted as a present danger, the forecasts of catastrophic overpopulation have not occurred." Why has "catastrophic overpopulation... not occurred"?<sup>1</sup> Precisely *because* of the contraceptive revolution!

In the context of concerns about evangelical Christian organizations supporting international family planning, it is relevant to look at the current contraceptive practices of evangelicals and members of other religious groups in the United States. This can give some perspective on their question about

what evangelicals should be doing for the less developed countries. The 2006-2008 National Survey of Family Growth conducted by the Centers for Disease Control and Prevention (CDC) and National Center for Health Statistics (NCHS) provides this information.<sup>7</sup> The data are given in Table 1 below. Noteworthy, in the US where clinical

contraceptive methods (sterilization, hormonal, and IUD) require a physician's consultation and informed consent, the vast majority of women are choosing to use "highly effective methods" with little distinction by religious affiliation. (Note: the data are essentially the same for married and unmarried women.)

*Table 1.* Percent contraceptive use, by method, among sexually-active women who are not pregnant, post-partum or trying to get pregnant, by religious affiliation: USA, 2006-2008.

| Religious affiliation | Highly effective methods* | Natural FP | Other methods | None |
|-----------------------|---------------------------|------------|---------------|------|
| All women             | 68                        | 1          | 5             | 11   |
| Catholic              | 69                        | 2          | 4             | 11   |
| Mainline protestant   | 73                        | 1          | 4             | 10   |
| Evangelical           | 74                        | 1          | 6             | 9    |
| Other                 | 60                        | 1          | 5             | 9    |
| None                  | 62                        | 1          | 7             | 14   |

\*Sterilization, pill and other hormonal methods, IUDs, condoms

What are the messages for Christians in the world today based on these basic demographic realities? First, most of couples around the world desire smaller families for their own family's health and welfare, and the vast majority (approximately 1 billion women) are voluntarily choosing to practice some method of contraception to achieve this. This prevents around 230 million births a year.<sup>8</sup> Still, there are over 50 million induced abortions a year, mostly due to women not having access to a method of contraception to prevent unintended pregnancies, though some do follow contraceptive failure.<sup>6</sup> Indeed, in the past decades some countries themselves initiated family planning programs that were frankly coercive, notably China, in order to slow their population growth. But in the majority of countries, family planning is offered on the basis of an informed, voluntary decision, particularly in programs supported by Christian organizations.<sup>9, 10</sup>

### Is There a "Contraceptive Mentality" that "Leads to More Abortion?"

A critical issue for Christians is being knowledgeable about the relationship between contraceptive practice and abortion. The Wubbenhorst article claims that there is an "explicit

connection between contraception and induced abortion" whereby there is an "inevitable progression of the contraceptive mentality, from preventing pregnancies with contraception to limiting or preventing births with abortion." However, this reasoning leads to a false conclusion that "... more contraception tends to establish a 'contraceptive state of mind' which leads to **absolving responsibility for children conceived which, in turn, leads to more abortion.**" (emphasis added)

What is the actual situation? In 1956, Kingsley Davis and Judith Blake developed a framework that was very informative in the study of human reproduction.<sup>11</sup> Basically, reproduction depends on a few fundamental "biosocial mechanisms" (behaviors that directly affect the likelihood of conception and the production of a live birth); in terms of human choices and actions, these may be grouped into four broad categories:

- Entering into and maintaining a sexual union (which may or may not be formalized by marriage)
- Practicing contraception to prevent a pregnancy (by any method, traditional or modern, including voluntary sterilization)

- Procuring an induced abortion to terminate an unwanted pregnancy
- Practicing breastfeeding following a live birth (that biologically temporarily inhibits ovulation and can delay the next pregnancy for a period of time)

There are other biological factors generally beyond the conscious control of couples like genetic infertility and disease processes that may inhibit conception or lead to spontaneous abortions. But the main point of Davis-Blake framework is to make it clear that it is various combinations of these four major practices that result in the level of fertility observed in a population. The *underlying* determinants of these practices are the very powerful social, economic, and cultural factors that influence how many children couples desire, when they desire to have them, and which of these practices they will use to control their fertility.

Critical to the actions that may be taken by couples to achieve childbearing desires are not only their socio-economic circumstances and beliefs and values, but also their knowledge of the fertility control options and their access to the methods of their choice. Here the overwhelming empirical evidence is that in the absence of knowledge or availability of effective contraceptive methods to prevent a pregnancy, individuals and couples may often resort to induced abortions to terminate an unintended pregnancy.<sup>12</sup> Tragically, in too many cases in less developed countries, these are unsafe abortions, resulting in a very high risk of maternal deaths.<sup>13</sup> Correspondingly, the most effective way to prevent the practice of abortion as a means of birth control is to provide a wide range of easily accessible contraceptive methods that can satisfy a couple's personal choices. (In the case where women have already had an induced abortion, post-abortion contraception should always be made available to prevent another unintended pregnancy and abortion.)

The empirical evidence for contraception reducing abortions and saving lives is overwhelm-

ing.<sup>13</sup> Only a few national examples from the literature will be given here.

As far back as the 1960s, Chile began experiencing an "epidemic" of unsafe abortions as couples were seeking to control their fertility and contraceptives were mostly unavailable except to wealthy couples.<sup>14</sup> 20% of hospital beds were occupied by women with complications from unsafe abortions; unsafe abortions were the leading cause of maternal mortality, accounting for about 40% of maternal deaths. In 1964, Benjamin Viel began providing contraceptives (IUDs and orals) to women from an area in Santiago who were visiting two hospitals - for delivery care or post-abortion complications.<sup>15</sup> Over a span of 3 years he provided contraception to almost 21,000 women and documented a sharp decline in fertility and an estimated 33% drop in the number of women arriving due to complications from abortions. Finally, in 1965, the government made contraceptives available nationally as well as strengthened other public health services to combat the epidemic of induced abortions; by 1990, about 50% of women were using modern contraception.<sup>16</sup> In the 15 years from 1965 - 1980, the fertility rate fell 46% (from 4.5 to 2.6 births per woman), the abortion mortality ratio declined 78% (from 90 to 20 per 100,000 live births), and the maternal mortality rate declined 88% (from 400 to 46 per 100,000 women of fertile age).<sup>17</sup>

In 2003, Marston and Cleland provided a comprehensive review of the empirical evidence from 13 countries demonstrating that the increasing practice of using modern contraception reduced the practice of abortion. As they note in their summary:

In seven countries—Kazakhstan, Kyrgyz Republic, Uzbekistan, Bulgaria, Turkey, Tunisia, Switzerland—abortion incidence declined as prevalence of modern

contraceptive rose. In six others—Cuba, Denmark, Netherlands, the United States, Singapore and the Republic of Korea—levels of abortion and contraceptive use rose simultaneously. In all six of these countries, however, overall levels of fertility were falling during the period studied. After fertility levels stabilized in several of the countries that had shown simultaneous rise in contraception and abortion, contraceptive use continued to increase and abortion rates fell. The most clear-cut example is the trend in the Republic of Korea.<sup>12</sup>

They conclude:

**Rising contraceptive use results in reduced abortion incidence in settings where fertility is constant. The parallel rise in abortion and contraception in some countries occurred because increased contraceptive use alone was unable to meet the growing need for fertility regulation in situations where fertility was falling rapidly.**<sup>12</sup> (emphasis added)

Marston and Cleland's article is particularly relevant to the reference in Wubbenhorst's article that refers to the article by Nguyen and Budiharsana documenting the "paradoxical" concurrent high rates of contraception and abortion in Vietnam.<sup>18</sup> This is misattributed to a "contraceptive mentality" that "cannot help but lead couples to turn to abortion when contraception fails."<sup>1</sup> Indeed, as documented in Chile and reinforced by the Marston and Cleland study, the Vietnamese are resorting to abortion to achieve their desired family size, but this is not due to a "contraceptive mentality." The study authors' own interpretation of the reason for this seemingly paradoxical observation is because of a lack of knowledge and access to effective contraception. To quote the authors:

... [T]hese findings imply that women in general are still receiving poorly performed family planning counseling and inadequate

information/communication about their method of choice, not to mention facing limited contraceptive access/availability.<sup>18</sup>

Consequently, the study authors recommend:

Policy-wise, increasing the availability of modern contraceptive methods other than IUDs, as well as providing quality information, **will increase the use of effective modern family planning methods and decrease the use of traditional methods, leading to change the paradoxical situation of high use of contraceptives and high abortion in Vietnam.**<sup>18</sup> (emphasis added.)

As a final note on this, I want to briefly point to my own experience in Bangladesh. In the late 1970s, I initiated a series of studies with my Indian and Bangladeshi colleagues to develop a client-centered family planning strategy offering a wide range of contraceptives along with surgical sterilizations to help couples achieve their fertility desires.<sup>19</sup> In less than 2 years, over 30% of couples adopted a contraceptive method and fertility fell by 25%. This approach was adopted nationally in the 1980s, and to make a long story short, currently over 55% of women in Bangladesh are using modern contraceptive, and fertility has declined from 6 births per woman to just over 2 births per woman.<sup>20</sup>

Critically relevant in this context, there is direct empirical evidence from Bangladesh that this family planning strategy not only reduced unintended pregnancies, but more significantly, reduced the practice of abortion among married couples. (Note: Early abortion is legal in Bangladesh and is provided by the government but not by any of the research projects.) The evidence comes from a study by Rahman, Davanzo, and Razzaque who compared two geographic areas in the 1980s and 1990s, one (MCH-FP area) with the high quality comprehensive family planning program and the other (comparison area) with a substantially lower level of government-provided family planning services.<sup>21</sup> In both areas, couples had a strong desire to limit childbearing and a high unmet need for

family planning. Over time, the MCH-FP area had a much higher level of contraceptive practice, resulting in a greater decline in fertility and correspondingly in unmet need for family planning leading to fewer unintended pregnancies and a much lower level of abortion. From a national perspective, the authors concluded:

The remarkable fertility declines that have occurred throughout Bangladesh have been achieved with much less abortion than other countries with similar fertility declines. The political priority that the Bangladesh government has placed on fertility reduction and family planning services has helped to accomplish this.<sup>21</sup>

The evidence is clear, contraception prevents abortion. Given the opportunity to make a choice, couples would prefer to prevent unintended pregnancies rather than resort to induced abortions. Furthermore, couples around the world practice contraception because they want to invest more in the children they have or will have, and are well aware that too many children limit the resources they may have to provide the nurturing, health care, and education they want for each child. Additionally, most are well aware of the facts that birth spacing with contraception can improve the health and welfare of the mother and her young children.<sup>22</sup>

### How is Contraception Related to Maternal Mortality?

In a section in the Wubbenhorst article entitled “Saving Lives?”, only select literature is reviewed which leads to some erroneous conclusions. The discussion is confounded by the failure to distinguish between the maternal mortality **rate** and the maternal mortality **ratio**. Both measures count the number of deaths to women due to complications of pregnancy and childbirth, but the **rate** uses the total number of women of reproductive age in the denominator, while the **ratio** only uses the number of women having live births in the same period in the

denominator. This critically important distinction is clarified below.

The maternal mortality **rate** is measured as the risk of maternal death **among all reproductive age women**. From a population perspective, maternal deaths can occur only if the women have pregnancies. Put simply, without pregnancies, the maternal mortality **rate** will obviously be zero; correspondingly, the more pregnancies women have in their lifetime, the higher will be the risks of death for individuals, and the higher the maternal mortality **rate** will be. It should be intuitively obvious that contraception, by preventing unintended pregnancies, will directly reduce a woman’s risk of maternal mortality. This, in fact, is part of what happened in Chile in the case study cited earlier. In terms of the global impact of contraception on preventing maternal deaths, Saifuddin Ahmed and colleagues have estimated that among the approximately 1 billion women using contraception in 2008, about 230 million pregnancies were prevented, resulting in the estimated prevention of about 270,000 maternal deaths.<sup>23</sup>

The maternal mortality **ratio** is a measure of the risk of death **among women experiencing pregnancy**. This is due to many factors, including the health of women, their social and economic conditions, the availability and use of high quality childbirth care, and the practice of unsafe abortion for unintended pregnancies. Again, as documented in Chile, contraception can reduce the maternal mortality ratio to the degree that it can prevent unintended pregnancies that otherwise might be aborted under unsafe conditions. Also, there may be additional benefits as in the case of women choosing to use contraception because of their poor health or a rapid succession of pregnancies. But the major reductions in the risks of death with pregnancy will primarily come about with improved maternal health conditions and the availability of high quality maternity care. This, of course, is in agreement with the Wubbenhorsts’ on the need for quality maternity care.

The Wubbenhorst article fails to clarify this critical distinction between the maternal mortality rate and the maternal mortality ratio. This results in their wholly erroneous conclusion that:

. . . statistically speaking, reducing the number of pregnancies and live births does not decrease the maternal mortality **rate**; since in the absence of good maternity care the **ratio** of deaths remains the same even though the number of births (the denominator of the MMR) may be decreased.”<sup>1</sup> (emphasis added)

As explained above, the numbers of maternal deaths, therefore the **rate**, is definitely reduced by the use of contraception since it reduces the number of (unintended) pregnancies.<sup>23</sup> Indeed, the **ratio** could remain relatively unchanged without other health interventions. This being the case, of course, maternity care is also essential for a comprehensive and safe motherhood program.

The Wubbenhorst article goes on to conclude, “Thus, the goal of reducing maternal mortality cannot be achieved through contraception alone: birth limiting—through abortion—is also required.”<sup>1</sup> As already shown above, this statement is simply not true; contraception alone has had a profound effect in reducing maternal mortality. This is the reason that family planning has been recognized by the international community as the first of the “four pillars of safe motherhood,” the others being antenatal care, safe delivery, and the availability of essential obstetric care.<sup>24</sup>

### Is International Family Planning Being Imposed on Developing Countries by the West?

Christian public health professionals are working in international spaces to serve the preventive health needs of the people. Family planning is one of these preventive needs since it is one of the “pillars of safe motherhood” as well as having other health and welfare benefits for families. In this context, the article asks the rhetorical question

“... **have the women in developing countries been asked whether they want contraception?**” (emphasis added) and answers: “‘Unmet need’ assumes, without considering women’s desires or wishes, that they need Western people to tell them how to control their fertility.”<sup>1</sup> Following this, they refer to international family planning as “sexual imperialism” and “sexual colonialism.” Unfortunately, this characterization of “unmet need” totally misrepresents the measurement of this sociological indicator. Further, it shows a clear lack of understanding of its utility by family planning program managers in countries throughout the world.

Basically, “unmet need” is measured by asking married women capable of having a pregnancy and not using any method of contraception if they ever want to have another child, or, for spacing, the question is, do they want to delay their next pregnancy by more than 2 years.<sup>25</sup> If these respondents do not want to have another child or want to space their children out, conceptually they are considered to have an “unmet need” for family planning. While it has been well established by social scientists that not all individual women who report that they want to space births or stop childbearing will actually consider accepting contraception, this measure is useful in assessing the overall level of “potential demand” for contraception in a population as well as in evaluating how well a family planning program is meeting that demand. Typically, as more and more couples desire fewer children, the measure of unmet need will increase if they are not able to freely access contraceptives. Correspondingly, a country with a high unmet need will ordinarily have a higher level of unintended pregnancies and more abortions; furthermore, the unmet need will decline along with unintended pregnancies and abortions as women gain more access to contraceptives. The Bangladesh case study cited above documents these relationships.<sup>21</sup> As expressed by Casterline and Sinding:

In making the reduction of unmet need a primary goal, population policies are



insisting that **helping individuals achieve their personal aspirations** is a primary objective of public policy.<sup>25</sup> (emphasis added)

## Is Contraception a Gateway to Immoral Behavior?

In the section titled “Avoiding the Contraceptive Mentality,” the Wubbenhorst article, after opening with their earlier premise that “We have seen that the contraceptive mentality has been associated with increased likelihood of acceptance of abortion” infers that “a further case can be made that the acceptance of contraception leads to other things that the Christian church has traditionally denounced.” Here, they mention such behaviors as mutual masturbation, sodomy, anal intercourse, etc., even though all of these behaviors have existed since ancient times, far preceding the age of contraception. The implication of this line of thinking seems to be that the practice of non-procreative sexual relations, even among married couples, leads to “abortions and other moral problems.”

Actually, in this context, essentially all evangelical Christians, Catholic and Protestant, approve of the Fertility Awareness Method (FAM) as a means of achieving non-procreative sexual relations.<sup>26</sup> Thus, one relevant question is, if FAM is acceptable as a means of having non-procreative sexual relations, why not other contraceptive methods without any abortifacient properties? In fact, such methods are approved and provided by many Christian organizations working in international health.<sup>27</sup> More relevant, if non-procreative sex intrinsically leads to abortion and other morally unacceptable behaviors, why is the practice of FAM any less consequential? After all, since contraceptive failures occur with FAM as with other methods—what is the evidence that couples with FAM failures are less likely to choose to abort an unintended pregnancy than couples with any other method failure?

On the positive side, God created the beauty of sexual relationships as a bond between couples (Song of Solomon). St. Paul, inspired by God, recognized the importance of this relationship in solidifying the marital bond without considering the procreation of offspring (1 Cor. 7:1-6). As summarized by Barranco and Soler, even Catholic teaching recognizes the legitimacy of non-procreative sexual relationships as important for the marital bond.<sup>26</sup>

## A Christian Rationale for Participating in International Family Planning Programs

In the lead to this commentary, I cited the definition of family planning as formulated by CCIH. The Wubbenhorst article extensively critiques this statement, much of which has been covered above. But their concluding point needs to be addressed since it would seem to essentially preclude Christians from being engaged in providing family planning services, except to fellow Christians. They state, “The vague mention of couples’ ‘values and beliefs’... means that a couple could have beliefs that might not be Christian or could even be anti-Christian. Should Christians support such values and beliefs as some have done?”<sup>1</sup>

Jesus’ life and ministry provides the example of how Christians are to live and serve others. Jesus had a healing ministry serving all who came to him (Mark 1: 32-34) as well as giving special attention to the care of children (Matt. 19: 13-15). The parable of the sheep and the goats clearly shows how Christians are to serve people in need (Matt. 25:31-46). Most relevant in this regard is Jesus regularly reaching out to the outcasts and “sinners” in society. Noteworthy, Jesus responded to the religious critics of His practice with the observation, “Healthy people do not need a doctor, sick people do. For I have come to call not those who think they are righteous, but those who know they are sinners.” (Mark 2: 15-17, Living Bible) Finally, Jesus did not ask the Father that His

followers be taken from the world, but that, “Just as you sent me into the world, I am sending them into the world.” (John 17:15-18, Living Bible)

What is the message for Christian public health professionals going out into the world, particularly where most people are not Christians, as I did in Bangladesh? Simply put, we are not going out to “support such values and beliefs” but to show the love of Jesus by modeling His life of service and healing. This can be done these days with many powerful, lifesaving technologies, not the least of which is contraception, since this is such a fundamental public health intervention that can have a powerful influence on the health and welfare of couples and their children as well as on the roles and status of women. Obviously, people being served should be fully informed about the risks and benefits of all interventions including the primary mode of action for all methods, but they should have the opportunity to choose or reject any intervention based on their own beliefs and values.<sup>28</sup> This does not preclude Christians seeking to encourage couples to choose effective contraceptive methods least likely to result in a fetal loss, but, as discussed earlier, failure to make available the method of their choice can result in unintended pregnancies and not infrequently unsafe induced abortions and even the loss of the mothers’ lives.

Christian health professionals and organizations need to be in the world, working with people of all belief systems, since that is a powerful way for the world to be reached with the love of Jesus and the gospel of salvation.

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