



International Family Planning: Christian Actions and Attitudes

*A Survey of Christian Connections for
International Health Member Organizations*

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Judith Brown PhD, Richard Brown MD MPH



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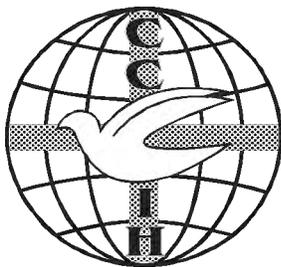
Christian Connections for International Health

www.ccih.org

The mission of Christian Connections for International Health is to promote international health and wholeness from a Christian perspective. CCIH provides field-oriented information resources and a forum for discussion, networking, and fellowship to the spectrum of Christian organizations and individuals working in international health.

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Acronyms

AIDS – acquired immune deficiency syndrome
CCIH – Christian Connections for International Health
FBOs – faith-based organizations
FP – family planning
HIV – human immunodeficiency virus
HTSP – healthy timing and spacing of pregnancies
IRH – Georgetown University Institute for Reproductive Health
IUDs – intrauterine devices
LAM – lactational amenorrhea method
MDGs – Millennium Development Goals
MOH – Ministry of Health
PMTCT – preventing maternal-to-child transmission of HIV
RH – reproductive health
SDM – Standard Days Method
TB – tuberculosis
US – United States
USAID – United States Agency for International Development
WHO – World Health Organization

Statements in the report about the views and practices of CCIH member organizations, as well as the conclusions and recommendations presented, reflect the general findings of the survey but should not be attributed to all CCIH member organizations.

Executive Summary

Christian Connections for International Health (CCIH) is an organization that promotes international health and wholeness from a Christian perspective. Christian health organizations, including CCIH member organizations, have a wide reach in poor countries and have a large potential to provide family planning (FP) information and services. There is little systematic documentation of activities and views for the broad cross-section of Christian faith-based organizations (FBOs) engaged in international health. In order to better understand member organizations' practices and views about FP, the CCIH board approved a study of its 92 member organizations. The expected outcomes of the study were to:

- Increase knowledge of CCIH member actions and views to inform ourselves and the international community
- Strengthen member activities and partnerships for FP/reproductive health (RH) services
- Enable CCIH and its FP/RH Working Group to better serve members
- Understand and respect the diversity within the CCIH membership and identify common ground and aspirations for future FP/RH activities

“Family planning” (FP) in the context of this study means enabling individuals and couples to determine the frequency and timing of pregnancies, including use of methods for voluntary prevention of pregnancy.

Study methods included an internet search of each organization for information on mission, country presence and revenues. An e-mail survey was sent to a key informant in each of the 92 organizations. Additionally, 39 were selected to provide in-depth information through structured phone interviews. Five types of CCIH member organizations were identified for the survey:

- Health service providers
- Health information providers
- National networks of health organizations (e.g., in Africa, Asia)
- International support organizations
- Other CCIH members

All member organizations were included, even though some did not provide direct services or support, since all may have relevant views and recommendations regarding FP/RH in international health.

Sixty-seven of the 92 member organizations responded to the survey, for a response rate of 73 percent – almost three-quarters of the membership. Of the 39 selected for interviews, 27 were successfully contacted for additional information.

Key Findings

The CCIH members responding to the survey had a presence in 151 countries—many countries being served by multiple members. The 27 members providing financial data on their websites—representing almost 30 percent of CCIH members—have combined annual revenues of \$3.4 billion dollars. The study revealed frequent partnerships among CCIH members. Some members are extensive national networks of Christian health facilities, representing virtually all the Christian health facilities in the country.

“Family planning” and “reproductive health” are widely acceptable terms among the Christian international health community, especially if understood to mean *voluntary* prevention of pregnancy, and if they explicitly exclude providing or promoting induced abortion. Slightly over half of the 67 CCIH member respondents provided family planning services or assistance to programs and partners. In terms of FP integration, members are already doing or would consider integrating FP with HIV/AIDS testing and care settings, preventing maternal-to-child transmission of HIV (PMTCT), child health, and as a part of maternal health services for women receiving postpartum and postabortion¹ care.

The majority of respondents reported that they would like to do more in the area of family planning. As one respondent pointed out,

The Church is the one untapped resource that has not been engaged in FP.

The CCIH organizations that did not see themselves doing more in family planning were not necessarily opposed to family planning, and some were unaware of the unmet needs for family planning. In many cases, their scope and focus of work was determined by the organization’s mission or mandate, and they did not see providing family planning services as their niche or strength. None were opposed to family planning

Some respondents said that their staff and donors were “conservative” about FP. The most common concern was about abortion – that “family planning” or “reproductive health” might imply promotion of abortion, or provision of contraceptive methods that acted as abortifacients. There was wide variability in views about FP within organizations, across countries in the same faith community, and between international and US perspectives.

Study results show strong interfaith collaboration and service provision, often with Muslims in Africa and Asia. This interfaith collaboration was a strong and successful element for several programs. CCIH members often partner with other groups to make best use of complementary strengths (e.g., a service-based group partnering with one specializing in drug procurement and logistics). Such partnering included other FBOs as well as secular organizations.

¹ Postabortion care (PAC) is a broadly embraced health intervention to address complications related to miscarriage (spontaneous abortion) and incomplete abortion, including treatment for injuries or illnesses caused by legal or illegal abortions. Voluntary family planning, an integral component of PAC, is widely acknowledged as one of the best ways to prevent subsequent induced abortions.

(<http://www.whitehouse.gov/news/releases/20010123.html>.

http://www.usaid.gov/our_work/global_health/pop/techareas/pac/index.html)

In several FBOs a wide range of FP methods was provided, and the method mix varied considerably across Christian organizations. Pills, condoms, injectables, and IUDs were the most popular methods among organizations providing services. Fertility awareness-based methods were well received in both Catholic and Muslim communities through interfaith services. Some CCIH members were providing innovative services, such as community health workers giving injectable contraceptives.

As for the specific needs expressed by CCIH member organizations, those based in the U.S. or other developed countries often mentioned need for greater buy-in from their own leadership in order to initiate or expand family planning programs. Organizations based in developing countries said they needed training or updates on family planning methods and services, as well as information and service provision for HIV+ women.

The country-wide Christian networks of health facilities (in Africa and Asia) were particularly eloquent about their needs and hopes for expanded family planning activities.

Special areas of interest for expanding family planning services and information included:

- Extending services into rural areas and local communities that are difficult to reach
- Providing FP for HIV-infected persons—particularly for women as a component of PMTCT
- Obtaining a wider range of FP methods, such as implants and injectables and assurance of regular supplies of contraceptives. Lack of supplies was a major problem for several organizations
- Identifying and acquiring FP education & promotional materials, such as user-friendly educational materials for communities.

Conclusions

From the survey of three-quarters of CCIH member organizations, results indicate that:

- CCIH member organizations have extensive and sustainable presence in 151 countries and provide very substantial assistance. The 30 percent of member organizations with financial information publically available have annual combined revenues of \$3.4 billion dollars.
- “Family planning” and “reproductive health” are acceptable terms among the Christian international health community, particularly if the definitions are understood to mean *voluntary* prevention of pregnancy, and that induced abortion services or promotion are not included.
- CCIH member organizations believe family planning is an important component of international health, including the prevention of mother-to-child transmission of HIV.

- CCIH member organizations, especially those based in developing countries, see large needs in family planning, and are eager to respond to these needs through their own facilities and the networks of health providers they support. They spoke from experience and wisdom; we can learn much from them.

Recommendations to CCIH

1. Bring common understanding about the work and views on FP for CCIH members - “you can’t have a maternal health program without FP”. Use language that recognizes diversity among CCIH members, making clear that “family planning” and “reproductive health” exclude induced abortion services or promotion of abortion.
2. Recognize that some members will provide access only for married couples and may provide only specific methods.
3. Consider educational efforts for US-based CCIH member constituencies regarding the need identified by international Christian networks for increased FP access and their desire to meet these needs on FP needs.
4. Provide connections for CCIH members to link with funding sources & technical input.
5. Help facilitate partnering among CCIH members, especially providers of commodities and drugs.
6. Develop and disseminate a compendium of FP projects, practices and aspirations of CCIH members to inform each other & the international health community.
7. Collaborate with secular international health organizations to achieve wider support of CCIH member activities & strengthen their family planning efforts.

Recommendations to International Organizations for Partnering with CCIH Members and other FBOs

Given the broad consensus among these diverse Christian organizations on the importance of family planning for international health, it is likely these survey results will generally apply to other Christian FBOs working in international health. International organizations wanting to strengthen FBOs to improve FP education, services and supply systems should consider the following factors for partnering with CCIH members:

1. Christian health networks or institutions working in poor countries are frequently eager to respond to a large unmet need for FP information, services and supplies.
2. FBOs will have variable approaches that are consistent with their religious teachings and values.
3. A single FBO may work differently in different countries, and sometimes differently between regions within the same country.
4. Terminology is important, and many FBOs need to be explicit and clear about definitions of “family planning”, “reproductive health” and “contraception”. Whenever possible, implementing FBOs use terminology that is preferred in the host country.

5. Be prepared to address mechanisms of action for various contraceptive methods, particularly the IUD, giving evidence for prevention of fertilization.
6. Some FBOs may request information and training for their own leadership, donors and constituents, about the need for FP as a health measure and a part of comprehensive care that includes child health, postpartum and postabortion services, and HIV/AIDS (prevention, care, testing, and preventing mother-to-child transmission).
7. Several FBOs want to take ownership of FP as a health measure, and want the initiative to be seen as coming from within their organization, rather than being externally driven.

Introduction

Christian-based organizations have been a mainstay of public health initiatives in poor countries for generations. In Sub-Saharan Africa, from 30 to 70% of health care is delivered through FBOs according to a WHO-funded study.² CCIH members are already very active in HIV/AIDS, TB and malaria, particularly in Sub-Saharan Africa, where the unmet need for FP is highest. Their health initiatives often have a strong maternal and child health component, though few have extensively documented their results in reproductive health and family planning.

The role of faith based organizations (FBOs) for international family planning (FP) activities is a topic of increasing interest. There remain major health challenges in most of the countries where CCIH members work that are connected to family planning. Among these are:

- Many women still die from childbirth and pregnancy-related causes (one every minute)
- Unmet demand for family planning is high (every minute 190 women globally face unplanned or unwanted pregnancies); needs are especially great in Africa.
- Birth spacing of 3-5 years is associated with improved maternal and child health outcomes. Compared with children born less than two years after a previous birth, for example, children born three to four years after a previous birth are 2.4 times more likely to survive to age five. Compared with women who give birth between 9 and 14 months following a previous delivery, women who have their babies at intervals from 27 to 32 months are 2.5 times more likely to survive childbirth.³
- Family planning is cost-effective for preventing maternal-to-child transmission of HIV (PMTCT) for women who are HIV+ and do not want to become pregnant, yet family planning services are generally weak or non-existent in PMTCT programs
- Rapid population growth is hampering efforts to reach the Millennium Development Goals (MDGs)—i.e., poverty reduction, reduced maternal and child deaths, improved female illiteracy and controlling the spread of HIV/AIDS. Effective January 2008, the MDGs incorporated “universal access to reproductive health by 2015” as a target under Goal 5, Improve Maternal Health. Contraceptive prevalence rates, adolescent birth rates and unmet need for family planning are several indicators for achieving the target. (<http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>).

Voluntary family planning is widely viewed as one strategy to help address these challenges. However, we know little about how CCIH members view and incorporate family planning in their work. In addition, sometimes sensitive cultural and theological issues impact church and FBO policies and practices.

² Karpf T. Community Realities in Africa Show FBO Partnership Key to Global Scale-Up. AIDSLink, Issue 103, Global Health Council, 1 January 2007; <http://www.arhap.uct.ac.za/publications.php>
Appreciating Assets: The Contribution of Religion to Universal Access in Africa: Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho in Support of Universal Access to HIV/AIDS Treatment, Care and Prevention.

³ <http://www.inforhealth.org/pr/113edsum.shtml>.

The CCIH board approved a survey by CCIH's Family Planning/Reproductive Health (FP/RH) Working Group to examine the issues. The study was funded by the Fertility Awareness-based Method (FAM) Project led by the Institute for Reproductive Health at Georgetown University, a CCIH affiliate.

Anticipated outcomes of the survey are:

- Increasing our knowledge of CCIH members' views and activities related to family planning to guide the CCIH FP/RH working group
- Identifying successful FP/RH approaches to inform ourselves and the wider international health community about the work of CCIH organizational members
- Understanding and appreciating both the diversity and common ground among members on issues related to family planning
- Enabling CCIH members to strengthen activities and partnerships in support of FP/RH services consistent with their values and beliefs

Methodology

One objective was to include as many CCIH member organizations as possible. We used three information sources for the study: 1) internet web pages of member organizations, 2) a Zoomerang e-mail survey, and 3) in-depth telephone interviews, using interview guides, to better understand views on FP/RH and to explore recommendations for CCIH and the wider health community. See Appendix A for a list of survey respondents.

We developed the study plan and original questionnaires in consultation with staff from the Institute for Reproductive Health (IRH), the Executive Director of CCIH and selected outside reviewers. Questionnaires were pretested with these reviewers and with several organizations. (Survey questions and in-depth telephone interview guides available on request.)

The focus of our study was on family planning as "prevention of unintended pregnancy"; in order to clarify that induced abortion and infertility were not included in the purview of our research.

About a week before the data collection began, the Executive Director of CCIH wrote to all 92 organizational members, explaining the purpose of the survey and the methods to be used. We included all member organizations, since all may have relevant views and recommendations regarding FP/RH in international health, even though some do not provide direct services or support.

Website review: We studied the websites of all CCIH organizational members to search for lists of countries in which they currently work, references to reproductive health and family planning, and financial information.

Questionnaires: Since CCIH has various types of organizational members, original questionnaires were developed (and tested) for each of four categories:

- Groups that directly provide health and medical services (P) – 11 CCIH members
- Groups that directly provide health information (I) – 17 members
- National or international networks of Christian health organizations (all but one located in Africa and Asia) (N) – 10 members
- Organizations that support the above health actors – with funds, supplies, staffing, etc. (S) – 46 members; and those for whom FP is not related to their work (N) (8) – 54 members total

On April 24, 2008, the research team sent an E-mail to every organizational member, providing more specifics about the survey and the electronic link to one of the four online questionnaires. Those who did not reply within a week were contacted by E-mail and/or telephone and were asked to respond in one of three ways -- online, through an attached MS-Word document, or by a telephone call with one of the researchers.

In-depth phone interviews: The researchers selected 39 of the member organizations in advance for a follow-up phone call, to discuss key questions in depth. These organizations were selected because they were likely to be supporting or could potentially support family planning services or information. Respondents were initially identified as the lead contact that CCIH had in its data base. In several instances the person referred us to other colleagues who could better answer the questions.

The phone interviews began about a week after the online questionnaire was sent. In some cases the respondent had completed the e-mail questionnaire, which was used as the basis for further exploration. The interview approach was guided not only by the outline, but also by the conversation that developed, sometimes exploring values and views of the organization and their faith community that were not official, yet were important to their approach to FP/RH.

Data Analysis: Data collection ended on May 20, 2008. Quantitative results from the Zoomerang e-mail survey plus supplemental information from member websites were entered into Zoomerang when available. The quantitative data was analyzed using Microsoft Excel.

Qualitative information was summarized and discussed among the team members, based on responses that were the most common, as well as identifying some uncommon responses that were of special importance. Not all questions were asked in every telephone conversation, and some e-mail responses were incomplete, resulting in variable denominators in the “findings” tables.

Representative quotations were identified which reflected the general views of many. All respondents had been assured that, in the survey report, no statements would be attributed to them as individuals or to their organizations. This helped ensure that respondents were comfortable giving their understanding of the organizational activities, policies and use of terminology, even though they may not have had complete information.

Statements and quotes in the report were given codes designated by the categories above (P, I, N, S, or O) and organizational number from our internal records (e.g., “I-15”). The codes are provided to give a sense of the diversity of organizational views in the report.

Findings

CCIH member profile

A total of 67 member organizations participated in the survey—a response rate of 73 percent. Of the 39 selected for interviews, 27 were successfully contacted for additional information.

At the time the survey started, CCIH had 92 member organizations, all of them Christian faith-based organizations. A search of their websites showed that these member organizations were present in 151 countries, including almost all poor countries of the world. “Presence” included having field offices, implementing programs, and/or shipping medicines and supplies to the country. Several organizations had an in-country presence for more than 100 years. In many countries, multiple CCIH members were active.

CCIH member organizations provide very substantial resources for health and development, and many have had a long-term sustainable presence. For the 27 organizations that posted financial data on the internet—representing 30 percent of CCIH member organizations—their combined annual revenue was \$3.4 billion dollars. These were generally larger member organizations.

CCIH member organizations form partnerships frequently. Some members are extensive national networks of Christian health facilities, representing virtually all the Christian health facilities in the country and providing 30-70% of all health care in several countries.

Interfaith collaboration and service provision is common among CCIH member organizations. For example, many serve and work with Muslims in Africa and Asia. Here are statements from two of the CCIH members:

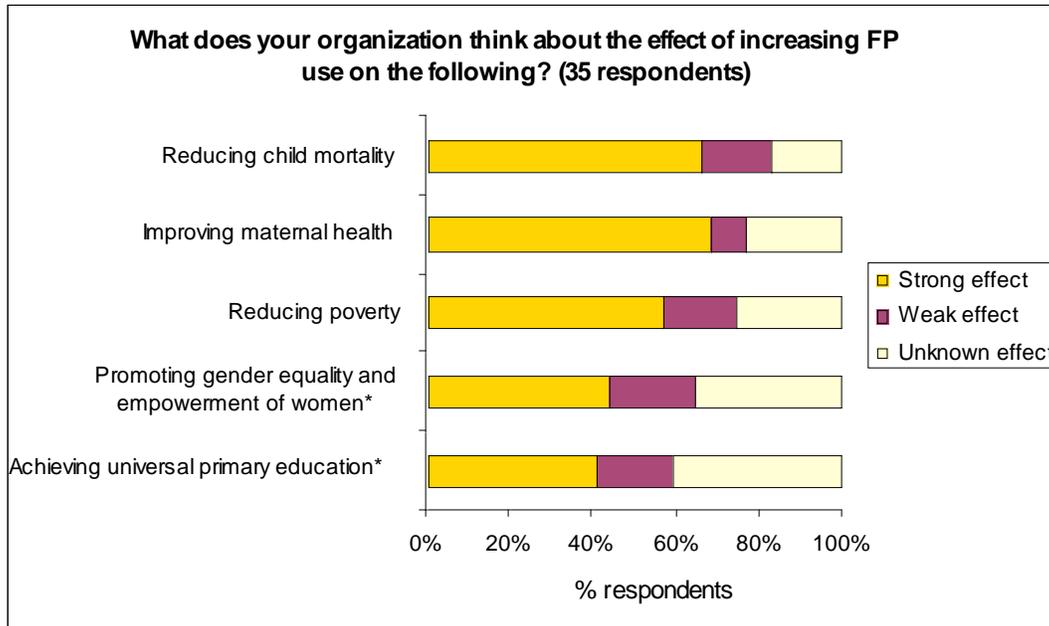
In some of our Christian hospitals, 50% of the doctors are Muslim, and they work in complete harmony with the Christian doctors. (N-02)

The churches are significant providers of health care in our country. They are especially active in the Muslim areas. One Christian hospital has been working in a predominantly Muslim setting for 100+ years; they are experts in such community relations and how to keep them positive. In some Muslim families, three generations have been born in the local Christian hospital. (N-03)

Family planning and its effects

More than half of the respondents felt that increased use of family planning would have a strong positive effect on achieving several of the Millennium Development Goals (MDGs) (Figure 1).

Figure 1

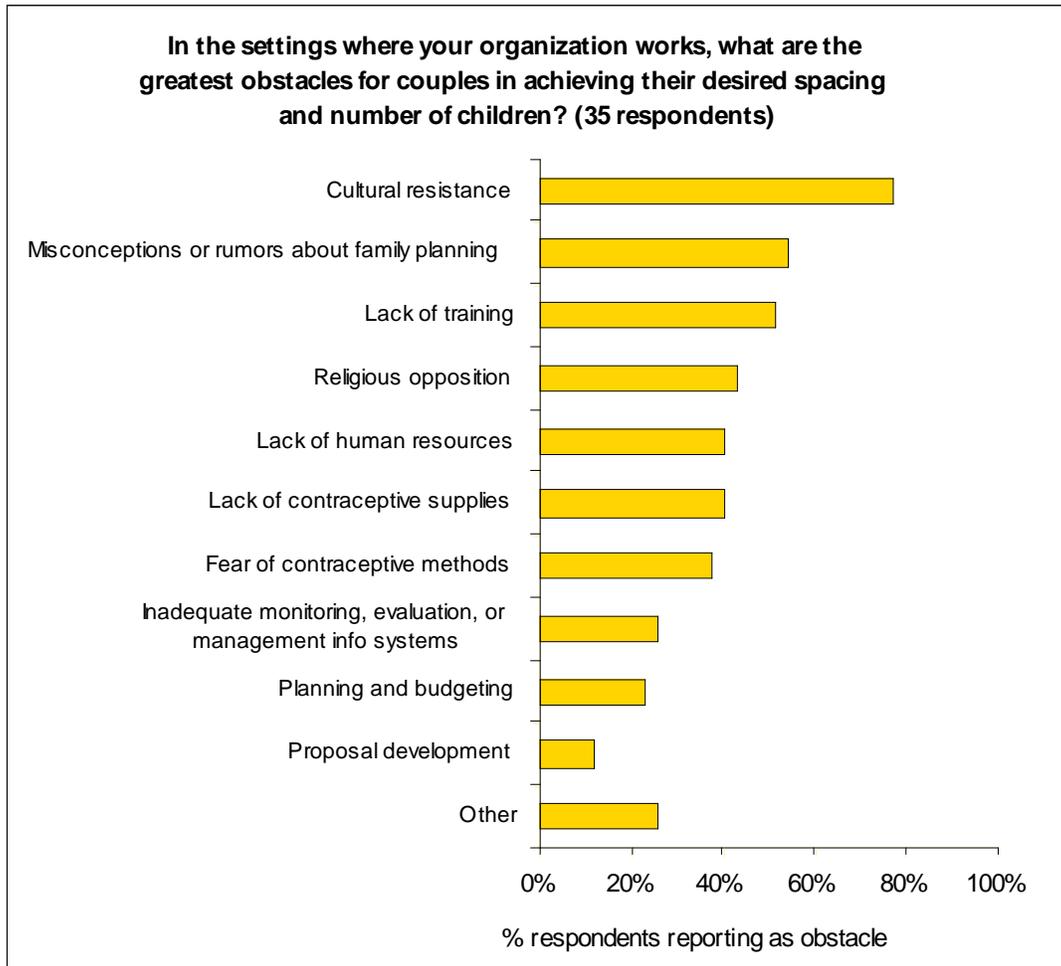


All interviewed CCIH members favored FP as a component of international health. All favored voluntary FP as a component of preventing maternal-to-child transmission of HIV (PMTCT), except one who was neutral. Some respondents emphasized that FP for PMTCT was acceptable if this was the desire of the woman, reflecting a concern that a woman with HIV/AIDS might be pushed into using FP.

Obstacles for couples in achieving desired number and spacing of children

CCIH member organizations said that in the settings where they work, many different obstacles prevent couples from achieving their desired spacing and number of children (Figure 2).

Figure 2



Most often mentioned was cultural resistance. Only a few organizations feel they have overcome most obstacles to family planning. Below are some of their comments:

In most parts of Africa, there is some degree of opposition due to cultural and religious reasons. (S-03)

Cultural issues – the idea that using contraceptives would make people weak. (P-11)

There is tendency for people just to accept all pregnancies. (S-22)

People have other priorities such as food & survival. (S-07)

As we have been working in this area for many years, most people accept family planning, and there are no fears or misconceptions. Spacing is sometimes a problem, as some women get pregnant within the first year or two of giving birth to a child without using contraceptives – this is more due to negligence and relying too much on lactational amenorrhea. (P-07)

In the countries where we work, we see five main problems:

#1 Cultural resistance – children are highly valued, and the number of children is an indicator of the well-being of the marriage. Couples are expected to get as many children as God provides.

#2 Fear of contraceptive methods – especially that they may cause sterility.

#3 Access to good counseling for couples, so they can make decisions together, and access to contraceptive methods.

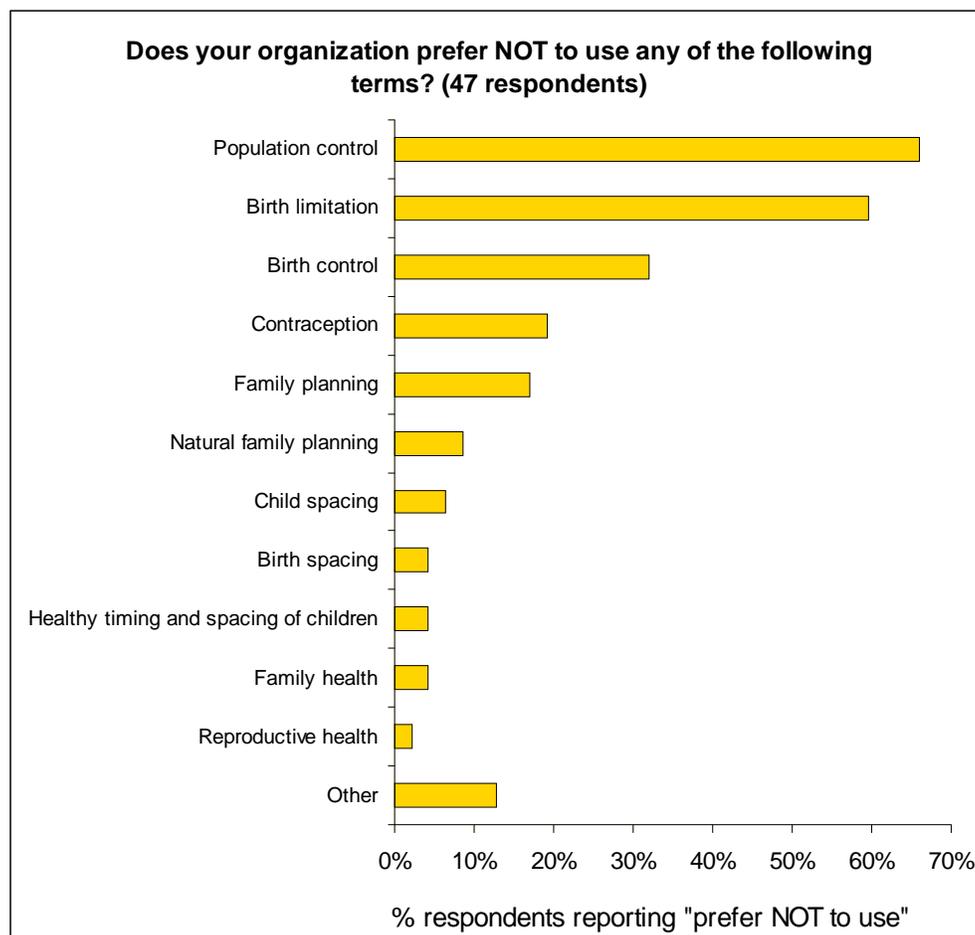
#4 Religious opposition – Much of our work is in Muslim cultures, and FP is considered tampering with what Allah has ordained. That's especially true of tubal ligation and permanent methods.

#5 High infant and child mortality. Parents want to have many children, because they are not sure how many will survive. When they have only one or two, losing a child is like starting all over. (S-37)

Family planning language

Many CCIH member organizations are careful about words they use for various aspects of family planning and reproductive health (Figure 3).

Figure 3



A large proportion prefer not to use the terms “population control”, “birth limitation”, and “birth control”.

The terms “population control”, “birth control”, “family planning” and “contraception” trigger negative responses and prevent further conversations to continue. (S-22)

We generally avoid terms such as “population control” or “birth limitation”, since those words imply power dynamics. We prefer more empowering word usage, rather than “control” language. We strive to be culturally sensitive. Terms that have the widest acceptance are: “reproductive health”, “family health”, “healthy timing and spacing of children”, and “birth spacing”. The terms “family planning” and “contraception” are accepted by most organizations, but others found that key people (including their donors) equate these terms with induced abortion. (S-31)

We in the (headquarters) office are okay with all the terms listed, but there may be concerns among some board members regarding using the following terms – birth control, population control, contraception. (S-18)

The comfort level with terms reflected the perceptions of what these may mean. For example, “family planning” was acceptable when it was clear the term was not “drifting into abortion”, a concern shared by several informants. Therefore, the 20% who indicated they preferred not to use “family planning” were favorable if the meaning of the term was made explicitly clear – that it did not include abortion.

For some respondents and the communities they serve, there was concern that some contraceptives may function as abortifacients. This concern was considered an important area for public education of the organization’s constituents in the US, as well as in developing countries.

One strong personality in our organization was concerned about the term “contraception”. His perception was that the term could “drift toward abortion” in its meaning. (I-15)

We have found that talking about family planning in terms of “healthy timing and spacing of children” is best, because it is terminology that our donor and supporter constituents are most comfortable with, across the ideological spectrum. (S-45)

Some organizations were not opposed to using any particular terms. Instead, they let the local people who run the programs and know the local culture decide which terms to use.

We at the denominational level do not initiate programs overseas, but support initiatives proposed by our partner churches. We encourage program planners to be sensitive to the folkways and mores of the society in which they work, while at the same time challenging behaviors which have negative consequences on health. (S-31)

A number of survey respondents emphasized that certain terms should be used only in the right contexts. For instance, some organizations would not use the term “family planning” in their youth programs, although they have no problem using it in other contexts.

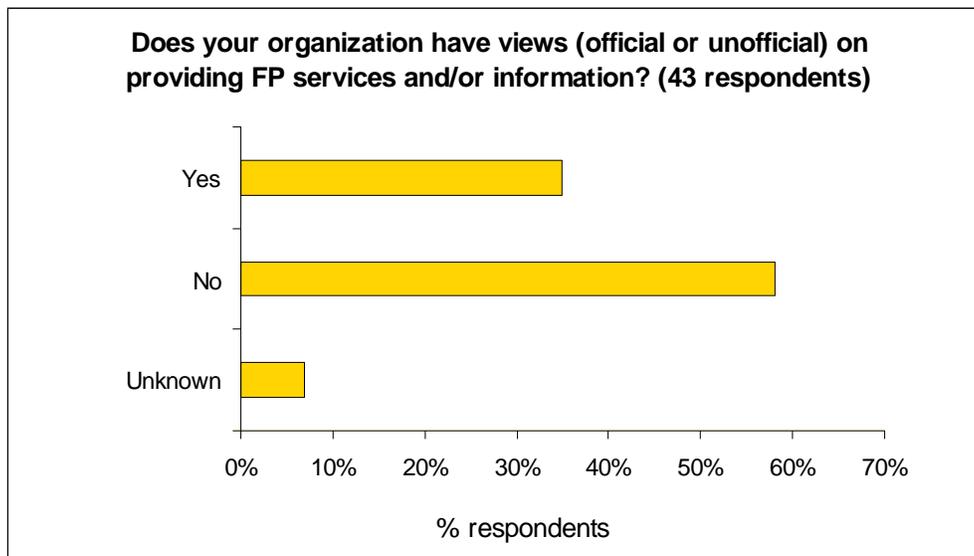
Finally, it was clear that many CCIH organizations have considerable experience and skill in choosing appropriate terms acceptable to various groups in different countries.

Policies, views and concerns within member organizations

A general question about possible opposition to FP or to particular FP methods revealed no concern among 44% of the 54 respondents. However, 43% indicated some concerns within the organization or the supporting faith community, though this did not mean that they were opposed to family planning in international health services.

The telephone interviews generally reflected greater “conservatism” about family planning among US-based offices (and staff) than for their international partners or the international networks of Christian organizations. Several respondents pointed to a need for education of their US constituencies. Only about one-third of the responding organizations said they have policies (written or understood) about family planning (Figure 4).

Figure 4



Organizations without policies often refer to guidelines from other groups.

We use the Ministry of Health national policy. (P-08)

In our organization, the program offices address FP issues in their context. No organization-wide policies or guidelines. (S-25)

Nationals in the field say only, "We conform to our country's law." They don't say much about FP to us in the US office. (S-41)

Within the same organization, family planning may be viewed differently by administrative and medical staff. Differences occur also between US & international branches, but they can differ in either direction:

Yes, there is opposition in some partner organizations overseas, but not in our US organization. (S-25)

The issues are more in the US than overseas. Our US branch is issue-sensitive [about family planning]. (S-35)

Within some organizations, views on family planning differ from country to country. Moreover, within a single country, different organizations may have different views on family planning, or may be heavily influenced by regional religious leaders.

In our country, it all depends on the how, and which group is being dealt with. So the approach differs according to the people--religion, economy, social status, etc.. (P-09)

In our country, a few denominations in our national network have problems with FP, but their health people do not. Abortion, and maybe emergency contraception, is a problem for some. (N-03)

CCIH member organizations varied considerably in their preferences for serving (or not serving) different subgroups. In some cases this was based on values and culture, and in others it was to promote services that were felt to have the greatest health impact.

We are okay with information about FP, but not promotion of FP for youth. The churches we work with are usually against it, so we opt for a more conservative approach focused on what we believe will bring about the greatest good, an AB approach (abstinence for unmarried and be faithful for married). As an organization, we do not take a stand one way or another on FP issues for adults. (I-10)

Life is sacred. Parents are responsible. FP helps parents ensure children's welfare. (I-12)

Our Christian community supports Healthy Timing and Spacing of Pregnancies. We value lives of mothers and children. We ensure health, so that mother's body recovers, and the baby has access to undivided attention for three years. (S-46)

Once again, respondents often brought up the subject of abortion.

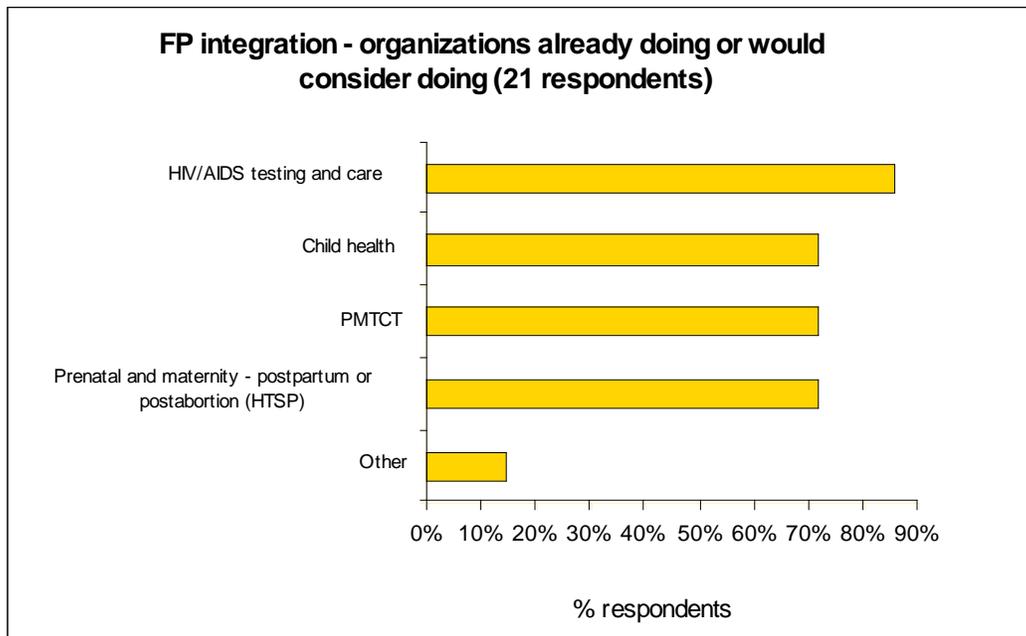
Our conservative Christian donor base reportedly still equates FP with abortion. I would like the highest levels of our organization to support FP because it saves the lives of mothers and children. In our office, top international people support birth spacing in a general way, but not enough to take it to higher levels (for policy change). (S-46)

Most members of our church would generally oppose a procedure that results in an abortion. However, there is a wide diversity of opinions on the matter, depending upon the nature of the pregnancy (rape or incest, for example), the age and health of the mother, and the stage of pregnancy. (S-31)

Provision and integration of family planning services

About half (34 of 65 organizations responding) currently provide family planning methods, information, or assistance. At least 21 organizations are already integrating FP into other services or would consider it (Figure 5). The most common interests in integration of FP was to combine with HIV/AIDS testing and care, PMTCT, child health services, and postpartum and postabortion care for healthy timing and spacing of pregnancies (HTSP).

Figure 5



CCIH members' work with Muslims

Men are a part of the program, as well as imams and religious leaders of other faiths in several countries. In Nepal, we own and operate a clinic and 2 mobile clinics, including no-scalpel vasectomy and tubal ligation. In Guinea, we developed a Koran-based family planning training curriculum for working with religious leaders in their project area. The curriculum was developed with the support of the Guinea Islamic League and in collaboration with the District Ministry of Health (DPS) as the main partners. In Yemen, safe motherhood includes FP/RH. In Afghanistan, west of Kabul, we are implementing the Basic Package of Health Services (which includes integrated FP services). (S-01)

Catholic-Protestant modes of cooperating

Our network members are Protestant hospitals and health facilities. Catholics have a separate health organization. Our office operates a large primary health project, in several dozen health zones around the country. That project includes family planning. (N-08)

Many of the project health zones have health facilities and programs operated by both Catholic and Protestant groups. When we offer FP training courses for a particular health zone, the personnel from all facilities (Catholic and Protestant) are trained in all FP methods. But not all facilities offer all methods. Catholics offer only natural methods of FP—the necklace [CycleBeads used with the Standard Days Method], LAM, cervical mucus, temperature, fertility regulation. They do not promote the other methods. However, if a client chooses a FP method not offered in that particular facility, she is referred to a place that does offer it. (N-08)

Our network includes both Catholic and Protestant hospitals. Our country is using modern methods. Our family planning programs are very active and are implemented at all our hospitals except the Catholic institutions. However, these institutions do not deny access but refer patients to other institutions. They give health education to patients on preventive methods like rhythm, ovulation method, etc. (N-10)

Our organization supports the entire range of family planning options. However, if we are working with a local partner that has reservations with some of the methods, we respect that position and will find ways to work with that partner, while at the same time making sure that the community gets the services it needs and should have. (S-21)

In working with Catholic partners, we have found that it is helpful to engage in family discussion even though the partner was only interested in promoting 'natural' methods. We were able to emphasize the importance of birth spacing/family planning and with the clients who would have not received this education otherwise and may not have thought about birth spacing. Once they are aware of the importance, the likelihood of their seeking methods appropriate to them increases. (S-21)

We work hand in hand with our church partners (both Protestant and Catholic). (S-22)

Providing family planning methods

Of the 67 survey respondents, 12 organizations could give information on the most popular methods. Many could not answer, particularly those US based, as they did not have enough information about specific methods provided in programs they supported internationally—or there were many different programs, which made the question not applicable. When asked to identify the three most popular FP methods in their setting, eight named condoms, oral contraceptives, injectables and seven identified intrauterine devices (IUDs). Voluntary female sterilization was mentioned by two, and the Standard Days Method (SDM) (also known by the term “the necklace” or CycleBeads), calendar rhythm and implants were each mentioned by one.

However, the fertility awareness methods were often mentioned by network organizations representing diverse Christian organizations at the country levels (see “Catholic-Protestant modes of cooperating” above). Catholic organizations particularly specialized in SDM and other “natural methods” and Muslim populations were particularly favorable to fertility awareness methods provided through Christian facilities. This was especially the case in one predominantly Muslim South-Central Asian country. In a number of instances it was noted that where fertility awareness methods were the primary focus for direct service delivery, that counseling and referral for other methods was common. In one country the districts served by Catholic facilities reported higher all-method contraceptive use rates than districts served by protestant facilities,

The lactational amenorrhea method (LAM) was seldom identified as a method. Some respondents indicated they thought women were relying too much on breastfeeding for contraception and having unintended early pregnancies as a result.

CCIH member organizations differ widely in their views of various family planning methods. Some endorse a wide range of methods and let local programs and individuals decide which to use. Some provide only “natural” family planning methods (fertility awareness methods). In other organizations, a limited number of methods are approved by the organization or the religious leadership.

We talk freely about condoms, but with caution. We are against offering condoms to all. (P-02)

No abortion or condoms for promoting promiscuity of youth. Anything short of those is OK. (S-21)

Among some communities, we see resistance against talking about condoms or using them. (S-44)

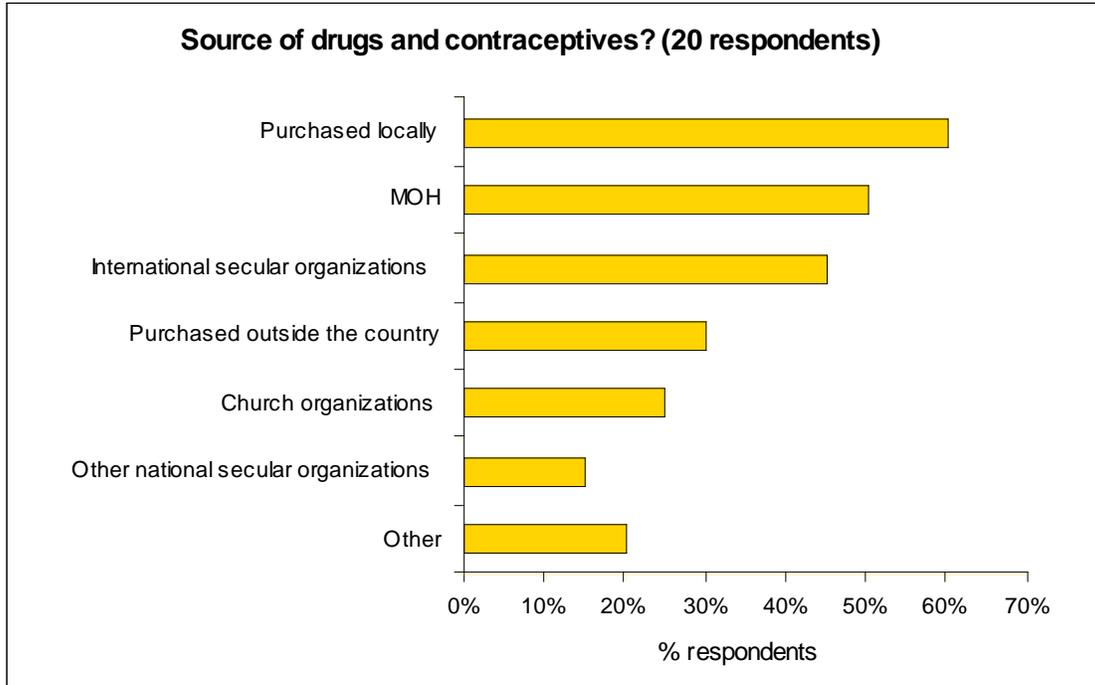
Our organization is against abortion or anything that is thought to be an abortifacient. Some of our people were concerned about IUDs. A knowledgeable doctor informed those concerned that the 380A IUD is specially made and does not function as an abortifacient. (S-46)

There is general agreement that family planning is important. Hormonal methods (Norplant, Depo, pills) are well-accepted. But there is not uniform agreement about the Copper-T IUD, and some feel it is an abortifacient. Each doctor decides. (S-37)

Source of family planning supplies

CCIH member organizations get their contraceptive supplies from varied sources (Figure 6).

Figure 6



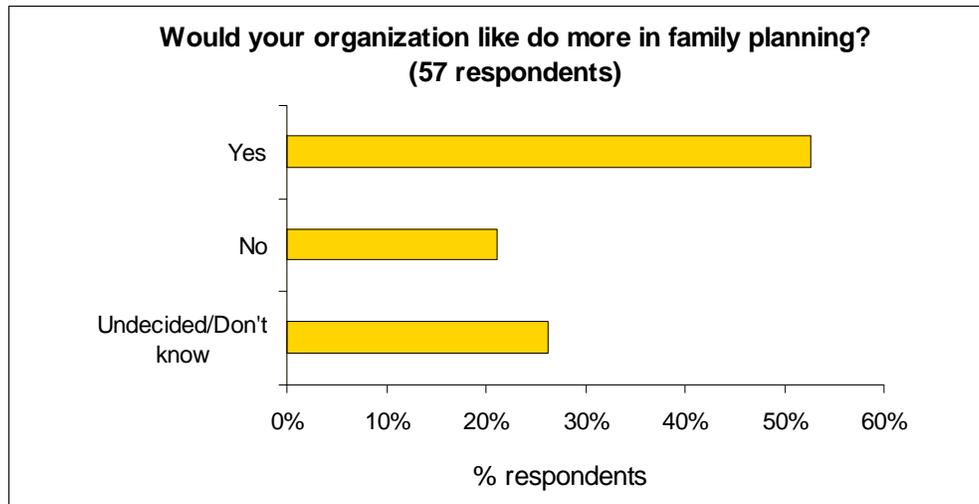
Many organizations do not provide contraceptives, since they know or believe other organizations are doing it. For those that do provide contraceptives, stock-outs are often an urgent problem. For those that provide only family planning information, steady supplies for the people they teach are sometimes a matter of concern

CCIH members want to do more in FP and have varied needs

More than half of the 57 organizations responding said they would like to do more in family planning, defined as voluntary prevention of unwanted pregnancies (Figure 7). The second largest group was undecided or did not know what their organization's view might be.

The CCIH organizations that would rather not do more in family planning were not necessarily opposed to family planning or unaware of the unmet needs for it. In many cases, their scope and focus of work is determined by the organization's mission or mandate, and they do not see providing family planning services as their niche or strength.

Figure 7



As for the specific needs expressed by CCIH member organizations, those based in the U.S. or other developed countries often mentioned greater buy-in from their own leadership, in order to initiate or expand family planning programs. Organizations based in developing countries said they need training or updates on family planning methods and services, as well as information and service provision for HIV+ women.

The country-wide Christian networks of health facilities (in Africa & Asia) were particularly eloquent about their needs and hopes for expanded family planning activities:

Currently we have no special program on FP, as we do for malaria, maternal and new-born child health. We would like to have a small group to work on this—others could then learn from us and assess their needs. Would like to find someone to work with us more closely, help negotiate with partners.... The need is there. It is a big need. We hope to do more because the people really need this. (N-04)

There is a need for information-sharing, also access to tools & communication for FP. Many misconceptions persist. For example, the perception that FP is externally driven -- we need to change that. (N-05)

We have had family planning programs for many years. We don't need expensive training courses that take our nurses and doctors off the job for two weeks. Condensed updates are sufficient. (N-08)

Above all, we need regular sources of contraceptives. It is very discouraging to educate people so that they want family planning, then not be able to supply them regularly with the methods they choose. (N-08)

We need functioning FP clinics in ALL our institutions, equipped with visual aids and contraceptive methods. (P-02)

Educating our caregivers would be of first priority. (S-37)

Facilitate FP through existing structures. We're cautious about programs that require new structures. (S-44)

We would love to train various gatherings of doctors, including allopathic and homeopathic doctors. (N-02)

The issue is not money, but commitment and will, since we're a network organization. (N-06)

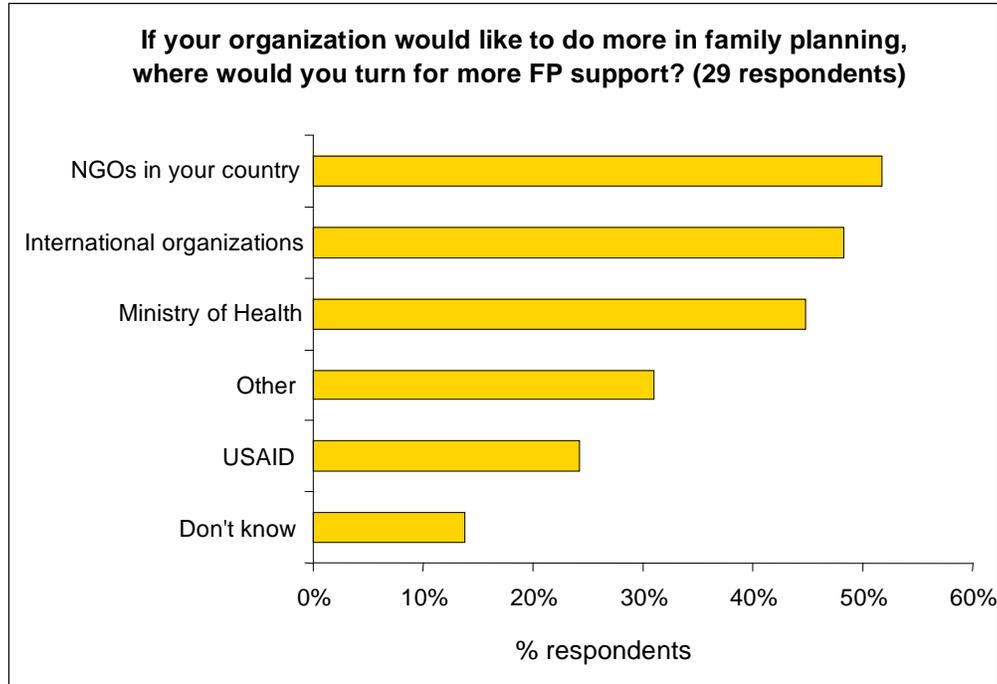
Special areas of interest for expanding family planning services and information included:

- Extending services into rural areas and local communities that are difficult to reach
- Providing FP for HIV-infected persons—particularly for women as a component of PMTCT
- Obtaining a wider range of FP methods, such as implants and injectables and assurance of regular supplies of contraceptives. Lack of supplies was a major problem for several organizations
- Identifying and acquiring FP education & promotional materials, such as user-friendly educational materials for communities.

If we moved into more FP-related programming, it would most likely fit within the realm of health education in the community and not provision of services, because our health work is focused at the community level and not the health facility level. (S-45)

CCIH members identify several potential sources for support of with family planning work. However, they do not necessarily have ready access. They mentioned various sources to which they could turn for support (Figure 8).

Figure 8



For example, one US-based organization said this:

Our office does not actually provide contraceptive information or supplies. Each country makes its own decisions and gets its own supplies. If they ask us for help, we search U.S. and European suppliers. We have not had any requests for FP supplies. If we did, we would ask our usual sources of drugs and supplies in the US or Europe. (S-37)

Involving churches and religious leadership in family planning

Several organizations spontaneously mentioned their desire to extend family planning into the life of their churches and to engage church leaders. This seems consistent with comments that several FBOs want to take greater ownership of family planning within the context of their own faith communities.

We'd like to work with churches and other organizations. The government is not able to take care of all the needs for FP due to limited human resources. We need church involvement. Churches need to do a lot in educating members about FP & birth control. There's a need to train church leaders. (I-12)

We need religious leaders who will be educated in FP. Intentionality is needed to bring FP teachings into the Church. One influential woman is a fierce champion for maternal health. She

is clergy, and people have a lot of respect. The church is the one untapped resource that has not been engaged in FP. (I-15)

We are a body of Protestants and Catholics, and we can support FP without offending those that do not offer a full range (of contraceptive methods). Church leaders can take this avenue and talk about FP in churches as well as in their health facilities. FP services cover a good portion of the country, potentially, through churches and mosques. We have an interfaith group that works with Muslim groups for FP information and the importance of spacing. We could also address misinformation on contraceptives. (N-04)

Conclusions

- CCIH member organizations have extensive and sustainable presence in 151 countries and provide very substantial assistance—annual combined revenues more than \$3.4 billion.
- CCIH member organizations uniformly believe family planning is an important component of international health, including the prevention of mother-to-child transmission of HIV. They believe family planning should be provided as a part of comprehensive health services, rather as a stand-alone service. Many want to do more to provide services and information, not only through health facilities, but also through churches. Family planning methods and specific groups to be served vary among the members.
- CCIH members, especially those based in developing countries, see large needs in family planning, and would welcome broader dialogue and partnerships. Several are eager to respond to these needs through their own facilities and the networks of health providers they support.
- “Family planning” and “reproductive health” are acceptable terms among the Christian international health community, and with their US constituencies, particularly if the definitions are understood to mean *voluntary* prevention of pregnancy, and that services for or promotion of induced abortion are not included.
- There is considerable scope for increasing access to and use of family planning in low resource countries through CCIH member organizations. Given the broad consensus among these diverse CCIH members on the importance of family planning for international health, it is likely that our survey results will generally apply to other Christian FBOs working in international health.
- We, the authors, were struck by the wisdom of the Network and Support respondents who work with Catholic and Protestant hospitals or groups. They talked knowledgably and easily about all methods. They explained how they all get along, respecting each others' opinions, and accepting each others' decisions about what FP methods to teach or provide. At times, they seemed to agree to disagree, and some even referred patients or clients to each other. They spoke from experience and we can learn a lot from them.

Recommendations to CCIH

Based on the study results, the authors recommend that the CCIH Board and the FP/RH Working Group:

1. Bring clarity about common values and perspectives on the role of FP in international health for CCIH members. Though differences exist about which methods each organization may provide, there is broad acceptance of family planning as an important health measure for women and children. As one respondent said,

You can't have a safe motherhood program without helping women avoid unintended pregnancies (with family planning). (I-15)

2. Provide connections for CCIH members to link with funding sources & technical input

We are very pleased CCIH is doing this survey & wanting to help Christian organizations provide family planning. (N-02)

3. Help facilitate partnering among CCIH members, especially providers of information, commodities and drugs.
4. Consider educational efforts for US constituents of member organizations regarding the need identified by international Christian networks for increased family planning access and their desire to meet these needs
5. Use language that recognizes diversity among CCIH members, making clear that “family planning” and “reproductive health” exclude induced abortion services or promotion of abortion. Encourage international health organizations working with FBOs to be aware of appropriate language and the explicit definitions needed to improve working relationships.
6. Continue discussions within CCIH on the diversity of views on family planning, with a special focus on terminology that is acceptable and clear. Acknowledge that some members will provide FP information and services only for married couples. Some will directly provide only specific methods.
7. Develop a compendium of FP projects, practices & aspirations of CCIH members, to inform each other & the international health community
8. Collaborate with secular health organizations to achieve wider support of CCIH member activities & strengthen their family planning efforts

Recommendations to International Organizations for Partnering with CCIH Members and other FBOs

Given the broad consensus among these diverse Christian organizations on the importance of family planning for international health, it is likely these survey results will generally apply to other Christian FBOs working in international health. International organizations wanting to strengthen FBOs to improve FP education, services and supply systems should consider the following factors for partnering with CCIH members:

1. CCIH member networks or institutions working in poor countries are frequently eager to respond to a large unmet need for FP information, services and supplies.
2. FBOs will have variable approaches that are consistent with their religious teachings and values.
3. A single FBO may work differently in different countries, and sometimes differently between regions within the same country.
4. Terminology is important, and many FBOs need to be explicit and clear about definitions of “family planning”, “reproductive health” and “contraception”.
5. Be prepared to address mechanisms of action for various contraceptive methods, particularly the IUD, giving evidence for prevention of fertilization.
6. Some FBOs may request information and training for their own leadership, donors and constituents, about the need for FP as a health measure and a part of comprehensive care that includes child health, postpartum and postabortion services, and HIV/AIDS (prevention, care, testing, and preventing mother-to-child transmission).
7. Some FBOs will want to take ownership of FP as a health measure, driven from within their organization, rather than being seen as externally driven.

Appendix A

CCIH organizational members participating in the FP/RH Survey, May, 2008

1. Adonai Missions International
2. Adventist Development and Relief Agency International, Inc.
3. Adventist Health International
4. American Leprosy Missions
5. AMFA Foundation
6. Balm in Gilead
7. Baptist General Conference
8. Blessings International
9. Buses International
10. Byas Foundation
11. Calvin College International Health & Development Club
12. Cameroon Baptist Convention Health Board
13. Catholic Relief Services
14. Child First Meds
15. Christian Church (Disciples of Christ)/ United Church of Christ
16. Christian Health Association of Kenya
17. Christian Hospitals Association of Pakistan
18. Christian Medical Association of India
19. Christian Reformed World Relief Committee
20. Christian Social Services Commission
21. Churches Health Association of Zambia
22. Community Health Global Network
23. CrossLink International
24. Drugs for AIDS & HIV Patients
25. Eastern Mennonite Missions
26. Ecumenical Pharmaceutical Network
27. Eglise du Christ Congo-DOM (Protestant Church of Congo Medical Services)
28. Elim Bible Institute
29. Emmanuel Hospital Association
30. Equipping Leaders Internationally
31. Ethiopian Evangelical Church Mekane Yesus - Development and Social Services
Commission
32. Food for the Hungry
33. He Intends Victory
34. HospiVision
35. IMA World Health
36. International Aid
37. International Christian Medical and Dental Assoc HIV Initiative
38. Jamkhed International Foundation

39. Kerus Global Education
40. King College Global Health Care Training Program
41. Life Builders Ministries International
42. LifeRise AIDS Resources
43. LifeWind International (former Medical Ambassadors Intern'l)
44. Lutheran Church in Liberia, HIV and AIDS Programme
45. Maitaimako Medical Mission
46. MAP International
47. Medical Teams International
48. Mennonite Central Committee
49. Moravian Board of World Mission
50. Presbyterian Church USA
51. Presbyterian Community Services and Development Department of the Presbyterian Church of Nigeria
52. Salvation Army World Service Office
53. Samaritan's Purse International Relief
54. Science With A Mission
55. Servants in Faith and Technology
56. SIM USA
57. Southern Africa HIV/AIDS Collaboration
58. TouchGlobal
59. Uganda Christian University
60. United Methodist Church - GBGM
61. Universal Chastity Education
62. Vellore CMC Board
63. Visions, Inc.
64. World Hope International
65. World Relief
66. World Vision International
67. Zimbabwe Association of Church Related Hospitals

Christian Connections for International Health

Promoting Health and Wholeness from a Christian Perspective

CCIH began in 1987 as a forum for Christian agencies and individuals concerned about international health to discuss areas of mutual interest. It serves all Christians, as it:

- Facilitates networking among Christian programs and individuals working internationally.
- Relates to secular, professional and government international health organizations.
- Shares information, experiences and learning from one another.
- Seeks ways to promote interagency cooperation and partnership.
- Develops relationships with religious and secular organizations with common interests.
- Raises awareness and addresses key international health issues facing the Christian community at large.
- Provides field-oriented information resources and a forum for discussion.
- Promotes Christian health work in developing countries, focusing on national and indigenous programs.
- Fosters the nurture and renewal of Christians working in international health, and fellowship among them.