Christian Aid's Policy on Family Planning

Christian Aid recognises that the issue of reproductive rights is a sensitive topic for many of our sponsoring churches, but we also know that our churches care deeply about the poverty, powerlessness and inequalities that are faced by women and men across the globe, often with fatal consequences.

This document outlines our position on family planning.

Summary

Christian Aid's fundamental purpose is to eradicate poverty. For us, poverty is not simply about having a low income or lacking the basic essentials of life, although it includes these things. Our understanding is that poverty is a lack of power.[1]

In the context of reproductive health, this lack of power is demonstrated not only by a lack of access to essential health services but also a lack of information and knowledge, as well as the means with which women and men might control their own fertility and thus the size of their families. The World Health Organization (WHO) estimates that some 215 million women around the world lack access to, or are not using, an effective method of contraception.[2] This lack of power to make fully informed decisions around fertility has profound effects on the lives of women, their partners, families and communities. Moreover, it is all too often within a context of fundamental gender inequalities that mean women and girls are without voice or control over their own bodies.

Christian Aid acknowledges the many uncertainties and complexities around the relationships between fertility rates, poverty, access to modern methods of contraception and primary healthcare, women's status in society and their participation in education and work, as well as other factors such as urbanisation, HIV/AIDS, cultural differences and government policies. We recognise that the relationships between these factors are not mechanistic and nor are they uniform across the world.

Christian Aid rejects the simplistic notion that issues of family planning can be summarised as 'the poor have too many children'. We do not support coercive 'population control'. We believe that the only acceptable route to lower fertility rates is through the empowerment of women and men with the knowledge, confidence and right to exercise free choices about the timing and number of children they have.

Importance of reproductive health and family planning

Reproductive health is vitally important in any discussion of global poverty and population levels. The WHO states that reproductive health 'implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

'Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.'[3]

Recognition that poor reproductive health undermined the achievement of other major goals, such as reducing the number of children who die and cutting the extent of hunger and malnutrition, led to the amendment, in 2007, of the Millennium Development Goals (MDGs). As a result, goal 5 (to improve maternal health, with the target of reducing maternal mortality by three-quarters between 1990 and 2015) includes the aim of achieving universal access to reproductive health by 2015.[4] As things stand, with the MDGs near expiry, goal 5 is one of the most off-track with almost 300,000 women having died from causes related to pregnancy and childbirth in 2013.[5] Progress has been achieved in reducing maternal mortality, but still only half of pregnant women in developing countries are receiving the recommended healthcare.[6] As new development goals are negotiated to come into effect in 2016, reducing maternal mortality and ensuring universal access to reproductive healthcare remain crucial.

The links between poverty, fertility and family planning

There is abundant evidence that, in general, poorer women give birth to more children than richer ones. This holds true both within particular countries and across different countries.[7] Some of the highest birth rates in the world occur in countries where women and men are already struggling with extreme poverty and, in some cases, with conflict. Twenty-eight of the least developed countries, most of them in sub-Saharan Africa, have fertility rates of more than five

children per woman.[8] In developing countries, high fertility rates are also closely correlated with poor reproductive health.[9] This is not static, of course, and there have been significant changes in the birth rate in many developing countries, especially where there have been efforts made to tackle poverty.[10]

Christian Aid sees the relationship between poverty and high fertility rates as two-way. At country level, limited investment in women's education and reproductive healthcare contributes to high fertility rates. At the same time, having a rapidly growing population makes it difficult for governments to provide adequate education, healthcare, clean water, sanitation and other public investments that would lead to economic and human development.

Likewise, at household level, poverty and lack of access to family planning services lead some couples to have more children than they would like, adding to their poverty because they have more children than they can afford to care for.

In already poor households, large family size and insufficient time between having one child and the next have negative impacts on the health of women, as well as on the overall productivity and resilience of those households. Constant cycling between pregnancy, post-partum recovery and breastfeeding takes a toll on women's health and wellbeing, and limits women's opportunities to engage in income-generating activities. Early weaning and inadequate nutrition lead to poorer health and educational outcomes for older siblings as each new child is added to the family. In addition to the short- and long-term effects on the children themselves, acute and chronic illnesses place additional demands on a family's already strained financial resources. Finally, a large family size limits household resilience and the ability to respond to changing circumstances or opportunities.

While it is clear that large family size can severely restrict poor families' ability to escape poverty, Christian Aid recognises that poor people often make very rational choices to have many children and that the desired number of children varies widely across the world. In some contexts, children work to bring in money or food for their families and/or care for their parents in old age. In the absence of social security or pension schemes, this is often the only support available to people as they age. In places where child mortality rates are high, couples may factor the number of children they expect to survive to adulthood into their decisions about conception. In cultures where male children are valued above female children, there is often a powerful incentive to keep trying for a male child.

When economists speak about rational choice theory, their basic assumption is that individuals make decisions by weighing costs against benefits to arrive at a course of action that maximises personal advantage, which they refer to as utility.[11] Thus a poor couple that makes a decision to have a large number of children may well be acting rationally given the context in which they are making that decision. But the theory of rational choice rests on an assumption of 'perfect information', the idea that the individual has all of the information needed to arrive at an appropriate decision. In the case of family planning decisions in resource-poor settings however, a case of 'imperfect information' often exists. Either a woman or couple may be unaware that family planning services exist, they may have received misinformation about the risks and side effects of contraceptive methods, they may simply not be equipped to fully weigh the hidden consequences of issues related to family size and child spacing,[12] or they may find that the health services they want to access are unavailable.

Understanding choices on family planning

Historically, and even today, donors tend to focus on the supply side of the family planning equation – on simply ensuring availability of family planning commodities such as condoms, oral or injectable contraceptives, intrauterine devices, etc. There is a widely-held assumption that if modern contraceptive methods are made available in the places where they are needed, uptake will follow, regardless of other factors. This approach either fails to account for the contextually rational choices that women and couples in poor countries make regarding family planning or simply regards those choices as illogical. Such choices might include a desire to have a large family because of culturally accepted norms, or fear of using family planning due to locally-driven misunderstandings. Decisions about family planning are, of course, made within a cultural context, in which the roles of men and extended family members (including mothers-in-law, traditional leaders and faith leaders) may play a part.

Christian Aid believes that efforts directed at increasing demand for family planning must involve not only women and men but also the wider community and, in particular, traditional and faith leaders, so that everyone is included in supporting women to make positive, well-informed and healthier reproductive choices for themselves and their families. The teachings of faith communities, love, faithfulness and respect for others, echoes in an approach to reproductive health that helps women have more power over the shape of their family.

Christian Aid's approach to increasing family planning uptake therefore focuses on giving women and couples the knowledge and information necessary for them to make more fully informed choices about their fertility. We believe that increasing access to modern methods of contraception is necessary, but not in itself sufficient, for individuals (and women in particular) to have power over their reproductive lives. For that, we believe there must also be work done to stimulate demand.

Promoting a gender-responsive approach

Inevitably, it is only women that directly suffer the potentially fatal problems associated with pregnancy and childbirth. In the world's poorest countries, having children remains a high-risk activity. The average maternal mortality ratio in sub-Saharan Africa declined from 990 per 100,000 live births in 1990 to 510 in 2014,[13] with spikes of 850 in Sierra Leone and 730 in the Democratic Republic of the Congo.[14]

Women also typically bear the burden of obtaining and using contraception – and suffering any side-effects. Furthermore, women across the world bear a disproportionate part of the responsibility of caring for children, including unplanned children. Women's unequal status in many societies, and societies' failure to enforce their right to freedom from sexual and domestic violence and coercion, intensify the lack of power over their reproductive lives. Women's powerlessness is a root cause of their poverty and further compounds other aspects of poverty such as economic deprivation.

While Christian Aid believes that women's special vulnerability to the many different dangers associated with having children should give their needs and decisions around reproduction precedence over men's, we recognise that a woman's use of contraception without her partner's consent can exacerbate gender-based violence and, in some cultures, can be grounds for abandonment and/or divorce. Traditional approaches, which have portrayed family planning as strictly a women's issue, have tended to alienate men and broader communities in many developing countries.

Christian Aid recognises that the best approach to promoting family planning is one that makes a convincing case to both women and men of the benefits of family planning and that encourages healthy dialogue around sexuality and reproduction between partners, which is in and of itself empowering to women. Often the most powerful arguments in favour of smaller family size and better child spacing are those that revolve around the tangible health and economic benefits to the household. These arguments can be particularly persuasive with men and help create an environment where men actively support their partners in seeking out family-planning services.

Integration of family planning into broader work on health and economic development

Christian Aid firmly believes that work to reduce unmet family planning must be integrated into both wider community health programmes and wider efforts to end poverty and promote resilience and self-reliance.

We believe that reproductive healthcare should be provided in the context of high-quality primary healthcare for women, men and their children. Women and their families must be able to access all of the services they need in one place and at one time, including family planning, HIV/AIDS care and treatment, malaria prevention and treatment, and management of childhood illnesses. Integrated primary care has many desirable effects, not least of which are to increase children's survival rates and parents' confidence that their children will survive. Such confidence, desirable in itself, could also help to reduce the number of pregnancies that women choose to undertake. It is well known that the risk of maternal mortality rises with each additional pregnancy,[15] and with it the risk of all that families suffer when mothers die.

Christian Aid is also well aware of the interrelatedness of access to family planning and our broader work on gender and poverty reduction. Girls' and women's education and wider empowerment are prerequisites – although far from guarantees – of their having power over their reproductive lives. Education helps women to participate more fully in decisions about how many children to have. Having secondary education or above is correlated, across the world, with having fewer children than less educated women.[16]

At the same time, greater access to and uptake of family planning services increases women's ability to participate in income-generating activities, which can in turn increase their status and power within the household and extended family. In addition, wider child spacing and smaller family size increase a family's ability to invest resources into each child's health, education and wellbeing, and make families more resilient and better able to adapt to changing circumstances and opportunities.

Population, climate change and environmental degradation

In the run-up to the UN climate talks in Copenhagen in 2009, and since then, it has been widely suggested that curbing population growth would help to tackle climate change.

Christian Aid recognises that population growth is contributing to climate change, increasing the number of people suffering its effects and therefore under pressure to adapt.[17] We also accept that population growth is damaging or diminishing environmental resources, including fresh water, trees and topsoil. Such damage further impoverishes poor people, making it more difficult for them to grow food, feed animals and meet their own basic survival needs.

However, there is a danger that this results in a simplistic call for population reduction, and by implication, the reduction of numbers of poor people. The effect of population growth on the world's climate should not be viewed in isolation from the dramatically unequal consumptions of individuals in poor and rich countries. In many parts of the developing world, basic resources such as water, land, forests and minerals are being degraded in order to supply goods to people in over-consuming rich countries. Meanwhile, people living in poverty are pushed to live on increasingly marginal lands and, in some cases, are forced to degrade their environments further, just to survive.

It is both unjust and short-sighted to consider only the effect of poor countries' population growth on the climate, without also addressing the fact that people in rich countries continue to take far more than their fair share of the environment's capacity to absorb greenhouse gases (and other pollutants).

The average person in the UK causes emissions equivalent to 9 tonnes every year. This is almost 100 times greater than people in some poor countries, including Burkina Faso, Malawi, Mozambique, Niger, Mali, Chad, Burundi, Rwanda, Gambia, Sierra Leone and Afghanistan. It is roughly 10 times greater than people in the least developed countries generally.[18]

Christian Aid rejects the notion that poor people should be forced or encouraged to limit the number of children they have, so that rich people can continue to lead the same unsustainable lifestyles that caused climate change in the first place.

As people in the developing world move out of poverty, their carbon emissions will increase. But reaching the emissions levels of people in richer, industrialised countries is not inevitable. If effective low-carbon strategies are put in place and funded through a global climate change deal, developing countries could develop in a far more sustainable way.

Abortion

Unmet need for family planning has a very high direct cost for women and their families. Of the 185 million pregnancies that occur in developing countries every year, some 40% (74 million) are unintended. And of the 35 million induced abortions carried out every year in developing countries, more than half are unsafe and illegal.[19]

Worldwide, unsafe abortions kill around 70,000 women every year, almost all of them in developing countries. Unsafe abortions also leave more than 5 million women temporarily or permanently disabled every year.[20] Such deaths and injuries affect women's families, too. For example, the 220,000 children a year who are left motherless by unsafe abortions are 10 times more likely to die themselves within two years of their mothers' deaths.[21]

Christian Aid does not fund abortion clinics and does not regard abortion as a desirable form of birth control. We work hard with partners to remove or alleviate the extreme conditions of poverty and lack of information and access that may lead to abortion.

In light of this, we recognise that the most effective way to reduce the demand for abortion is to improve access to, and stimulate demand for, modern methods of contraception and family planning. Our goal is to provide women and couples with the knowledge and services they need to prevent unintended pregnancies before they occur.

Christian Aid also recognises and follows the laws of each country within which it works. This means that in some countries the context in which we work is one where abortion is legal. But even where it is legal, Christian Aid does not fund abortions.

In common with other ecumenical development and aid agencies, Christian Aid funds organisations that provide support to poor women in crisis, including the provision of counselling services to inform them of their legal rights, both in terms of advice on legal abortions as well as the risks of illegal abortions.

Christian Aid also recognises that complications from unsafe abortions are among the leading causes of maternal mortality in many developing countries and that all women should be entitled to appropriate medical care following such procedures, without fear of stigma or discrimination.

We believe in the inherent worth of every person, and believe that all are made 'in the image of God'. For us, the Christian faith inspires and grounds the language of rights. We believe that supporting women and men in making free and informed choices on their reproductive health is crucial in order for everyone to live a life full of dignity, and to see an end to poverty.

Endnotes

1 *Doing Justice to Poverty: Christian Aid's understanding of poverty and its implications*, Christian Aid, 2008, christianaid.org.uk/images/doing-justice-to-poverty.pdf

2 *Unmet need for family planning*, World Health Organization, who.int/gho/maternal_health/reproductive_health/family_planning/en/index.html

3 Reproductive health, World Health Organization, who.int/topics/reproductive_health/en/

4 Millennium Development Goals, Goal 5, United Nations, un.org/millenniumgoals/maternal.shtml

5 *The Millennium Development Goals Report 2014*, United Nations, p27, un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf

6 See note 4.

7 Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J, *Family planning: the unfinished agenda*, Lancet, 8;368(9549):1813.

8 *The World Bank's Reproductive Health Action Plan 2010-2015*, The World Bank, April 2010, p6, siteresources.worldbank.org/INTPRH/Resources/376374-1261312056980/RHActionPlanFinalMay112010.pdf

9 Ibid, p22.

10 In recent decades, fertility has declined at a rapid pace in a majority of developing countries. At the same time, contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57% in 2012. Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method has risen minimally or plateaued between 2008 and 2012. In Africa it went from 23% to 24%, in Asia it has remained at 62%, and in Latin America and the Caribbean it rose slightly from 64% to 67%. There is significant variation among countries in these regions. who.int/mediacentre/factsheets/fs351/en/

11 Milton Friedman, *Essays in Positive Economics*, University of Chicago Press, 1953, pp15, 22, 31.

12 Intervals between pregnancies of less than six months are associated with higher levels of maternal mortality; intervals of 18 months or less are associated with infant, perinatal and neonatal mortality, low birth weight and pre-term delivery. Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland 13–15 June 2005, World Health Organization, who.int/maternal_child_adolescent/documents/birth_spacing.pdf?ua=1

13 See note 5, p28.

14 *Maternal mortality ratio (modeled estimate, per 100,000 live births)*, The World Bank data, The World Bank, data.worldbank.org/indicator/SH.STA.MMRT

15 *Goal 5: Improve Maternal Health factsheet*, United Nations, un.org/millenniumgoals/2008highlevel/pdf/newsroom/Goal%205%20FINAL.pdf

16 See, for example, 'Universal secondary education: now's the time to start', Nature, December 2008, nature.com/nature/journal/v456/n7222/edsumm/e081204-03.html

17 Stern Review: The Economics of Climate Change, p178, webarchive.nationalarchives.gov.uk/+/http://www.hm-treasury.gov.uk/d/Part_III_Introduction_Group.pdf

18 *The rich, the poor and the future of the earth: Equity in a constrained world*, Christian Aid, 2012, christianaid.org.uk/images/constrained-world.pdf

19 *Facts on Induced Abortion Worldwide*, Guttmacher Institute, January 2012, guttmacher.org/pubs/fb_IAW.html

20 Ibid.

21 Ibid, and Goal: Improve maternal health, Unicef, unicef.org/mdg/maternal.html

Christian Aid, 35 Lower Marsh, London SE1 7RL
t. 020 7620 4444 christianaid.org.uk