

Religion is not a barrier to family planning

Faith-based organizations around the world are working with governments and secular institutions to promote birth control, says Shareen Joshi.

Public policy debates in the United States might suggest that faith and family planning are fundamentally incompatible. Some religious writers object to contraception on the grounds that it can “damage or destroy the image of God in other human beings” and that the idea of using contraception is “associated with increased likelihood of acceptance of abortion”¹.

The actual practices of many women in the United States, however, tell a very different story – one in which religion and contraception coexist peacefully. The 2017 US National Survey of Family Growth found that 94% of US women and girls aged 15–44 who have ever been sexually active regard religion as at least somewhat important to them in daily life. Yet 99% have relied on contraception at some point in their lives: 79% have used contraceptive pills, 25% have used periodic hormone injections and 17% have been sterilized. The US abortion rate, meanwhile, has been falling steadily. The relationships between religiosity, contraception and abortion are clearly complicated.

Across the world, people of all faiths use contraception, and family-planning programmes have emerged and thrived in the most unlikely places. In the 1970s, a remote rural region of Bangladesh called Matlab had some of the highest rates of fertility, maternal mortality and child mortality in Asia. The religiously conservative Muslim population was sceptical about Western contraceptives. In 1977, a collaboration between the US Agency for International Development and local organizations established an innovative family-planning programme in which local women were recruited and trained to go to the homes of other women and offer them a wide array of contraceptive choices, as well as follow-up care.

Contraceptive use increased almost immediately. Over the next three years, women who took part in the programme experienced a 15% reduction in fertility, which translated into around one birth fewer than the average woman in a control group who had to visit a clinic to obtain contraceptives. In the subsequent 20 years, women’s health, household earnings and the use of preventive health care all improved for the families who took part². Even in this religious population, faith was just one of many factors that the women considered when making their decision.

Some countries have even based their family-planning



“The relationships between religiosity, contraception and abortion are clearly complicated.”

Shareen Joshi is an economist at Georgetown University in Washington DC. e-mail: shareen.joshi@georgetown.edu

services on the guidance of religious leaders. In Egypt, the Al-Azhar mosque and Al-Azhar University in Cairo have regularly issued fatwas (Islamic decrees) to promote the use of modern contraception. Almost half of all Egyptian women now rely on modern contraception. Even in strictly religious countries, such as Iran, attitudes are evolving. In 1979, just days after the Iranian revolution, the Islamic government abolished the country’s family-planning programme because it was perceived as a Western ploy to hurt the country. Ten years later, the regime reversed the policy and established a successful family-planning programme. Today, more than three-quarters of Iranian women rely on modern contraception. The policy might have worked too well because in 2017 the government cut back on the availability of family-planning services as a means of slowing the rapid decline in the country’s birth rate.

Partnerships between religious leaders, governments and non-state actors have also emerged around the world. In Pakistan, for example, the government worked with religious leaders and the Population Council in New York City to establish the Family Advancement for Life and Health initiative. As in Bangladesh, family planning was repositioned as a health intervention, with an emphasis on increasing the time interval between consecutive births. In Afghanistan, a pilot contraceptive project deployed in three parts of the country found that local mullahs (religious leaders) were in favour of working with community organizations towards similar goals. In 8 months, the use of contraceptives in the project areas increased by about 25%³.

Partnerships between governments and religious establishments are not confined to Islamic countries. In Rwanda, the Presbyterian Church organized family-planning workshops in collaboration with the Ministry of Finance. In a speech at the workshop in 2010, Pastor Emmanuel Muhozi, who was in charge of training, said: “The word of God doesn’t contradict the message of family planning. The Bible calls upon parents to be blessings to their children, not a curse.” Driving home the point, he asked: “How will a parent with uncountable children ever bless them in any way?”

The polarized debate in the United States between conservative Christian viewpoints and women’s advocates is exceptional. Elsewhere in the world, a consensus is emerging between religious groups and policymakers on the importance of family-planning services. The Faith to Action Network, founded in 2010, now includes more than 200 religious leaders and faith-based organizations that represent the world’s major religions. They signed the Interfaith Declaration to Improve Family Health and Well-Being to serve as ‘first movers’ in the endorsement and implementation of government family-planning policies and programmes in their respective countries.

Religious leaders and policymakers alike recognize that safe and voluntary access to family-planning services can be an investment in the health of women and their children. But both also recognize that when it comes to creating life, religion and tradition are powerful forces that shape human behaviour.

1. Wubbenhorst, M. C. & Wubbenhorst, J. K. *Dignitas* **24**, 11–21 (2017).
2. Joshi, S. & Schultz, T. P. *Demography* **50**, 149–180 (2013).
3. Huber, D., Saeedi, N. & Samadi, A. K. *Bull. World Health Org.* **88**, 227–231 (2010).