

SHOULD EVANGELICAL CHRISTIAN ORGANIZATIONS SUPPORT INTERNATIONAL FAMILY PLANNING?

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Introduction

Evangelical churches and international organizations today face considerable pressure to promote family planning overseas, for reasons including improved maternal health and child health, population control, poverty alleviation, and development. Some proposed ventures such as Christian Connections for International Health (CCIH) involve working with non-Christian entities that promote abortion worldwide, while eschewing abortion in their cooperative ventures with Christian organizations. Although the promised benefits of such cooperation can be attractive, there are serious issues to consider before evangelical Christians "sign on" to such initiatives. These include the wisdom of the Bible, Christian history, and theology; the effects of contraception where it has been widely practiced; the close connection between contraception and abortion; alternative solutions to the problems contraception and abortion purport to solve; and the possible pitfalls of alliances with non-Christian organizations.

To begin, an "evangelical by belief" may be defined as someone who agrees with

the following four statements: "The Bible is the highest authority for what I believe; it is very important for me personally to encourage non-Christians to trust Jesus Christ as their Savior; Jesus Christ's death on the cross is the only sacrifice that could remove the penalty of my sin; only those who trust in Jesus Christ alone as their Savior receive God's free gift of eternal salvation."¹ This definition was specifically formulated for purposes of research by the National Association of Evangelicals. Of greater importance, each person engaging in Christian work should test their beliefs against historic Christian orthodoxy and Scripture to see if they and their work are in fact "in the faith" (2 Cor 5:8–12).

Family planning may include contraceptive technologies, pregnancy prevention, induced abortion, birth spacing, birth limiting, or the ambiguous terms "reproductive health care" and "sexual health care." It is vitally important for Christians to consider what *Christian* family planning consists of, and to precisely and scripturally define this term.

Scriptural Foundations

The Bible provides a framework for understanding family planning by describing the origin and sanctity of human life. As the crowning act of His creation, God created humankind (male and female) uniquely in His own image. He further dignified human life through the incarnation of Jesus Christ as a man and promised the resurrection of the physical body at the end of time. Thus, all human life should be treated as a gift from God and worthy of respect.

In Old Testament times, God's people

were forbidden upon penalty of death to practice child sacrifice as the surrounding nations did (Lev 18:21; 20:5). This is the context for considering the ethics of abortion, which Old Testament Judaism always forbade: life is a gift of God. The preciousness of an unborn human life is celebrated in Psalm 139, where David writes,

For it was you who formed my inward parts; you knit me together in my mother's womb. . . . I am fearfully and wonderfully made. . . . Your eyes beheld my unformed substance. In your book were written all the days that were formed for me, when none of them as yet existed [Ps 139: 13–14, 16, NRSV].

Even *in utero* at the earliest stages of development, God recognizes the humanity of the embryo (see Gen 20:18, 29:31, 30:2, 30:22; Judg 13:2–3; Ruth 4:13; 1 Sam 1:6; Jer 1:5; Luke 1: 13–15 and 1:24–25, 1:44). In other words, life is sacred from the moment of conception.

Given this biblical evidence, it is clear that Christian family planning should have nothing to do with elective abortion, including "safe abortion." Surprisingly, however, even some leaders among professedly Christian organizations may condone "safe abortion" where it is "legal" despite the fact that abortion destroys human life.² However, the historic position of the church has always been emphatically against abortion. Not only this, but the Church has viewed contraception in a similar light. A brief history of the Church's position on contraception and abortion illustrates this.

Historical Views

Contraception and abortion are nothing new; the earliest known mention of contraception was in the Egyptian Petrie Papyrus from 1850 B.C.³ The Hippocratic Oath (5th century B.C.)

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explicitly prohibited abortion by physicians, but abortion was nonetheless widely accepted in Greek culture. In his *Republic*, Plato (424–347 B.C.) advocated mandatory abortion for any women over the age of 40.⁴ In his *Politics*, Aristotle (384–322 B.C.) stated, “There must be a limit fixed to the procreation of offspring, and if any people have a child as a result of intercourse in contravention of these regulations, abortion must be practiced.”⁵ In the 4th century B.C., Aristotle mentioned contraceptive methods, and many other cultures worldwide practiced contraception, abortion or both. Abortion and contraception were very common in the Greco-Roman culture in which Christianity emerged, being approved at the highest levels of society though induced abortion was often fatal for the mother.⁶

However, the Church departed from the societal norms of the time and radically cherished life at all stages and conditions. Contraception and abortion were condemned, along with the widespread practice of infanticide. For example, the *Didache*, a first-century church manual, stated, “Thou shalt not murder a child by abortion nor kill them when born.”⁷ Athenagoras (mid-2nd century A.D.) wrote: “women who use drugs to bring on an abortion commit murder, and will have to give an account to God for the abortion. . . . [for we] regard the very foetus in the womb as a created being, and therefore an object of God’s care.”⁸ Epiphanius of Salamis (c. 375 A.D.) denounced those who sought to prevent the conception of children,⁹ as did others including St. Hippolytus, Jerome, Chrysostom, Minucius Felix, Origen, Ambrose, Basil, Clement of Alexandria, Tertullian, and Augustine.¹⁰

The rejection of contraception and abortion transcended the rift of the Protestant Reformation. Martin Luther, the father of the Reformation, said, “How great, therefore, the wickedness of human nature is! How many girls there are who prevent conception and kill and expel tender fetuses, although procreation is the work of God!”¹¹ Such Protestant leaders as John Calvin, Cotton Mather, and John Wesley

also held this view.¹² In fact, up until the 20th century, the three major branches of Christianity (Orthodoxy, Roman Catholicism, and Protestantism) all condemned contraception.¹³

The Birth Control Movement

This unified Christian ethic across millennia was broken largely through the work of the birth control movement, led by Margaret Sanger and her allies, in the first three decades of the 20th century (though its roots go back to the 18th century). Sanger and others exploited Christian disunity and anti-Catholic sentiment by asserting that birth control was “prohibited . . . by an alien, half-Americanized Roman Catholicism,”¹⁴ even though at the time all Protestant denominations condemned birth control.¹⁵ She also appealed to the eugenics sentiment by pitching birth control as a method to guide the evolution of the race by suppressing the reproduction of the “unfit.”¹⁶ Sanger’s strategy worked: as one historian noted, “eugenics gained popular support in large part through the endorsement of mainstream and progressive Protestant spokespersons,”¹⁷ including African American leaders and clergy.¹⁸

These efforts led to a breakthrough at the 1930 Lambeth Conference of the Anglican Church, where, in marked contrast to previous Lambeth Conferences, a resolution passed approving the “cautious” use of contraceptives in extreme cases within marriage.¹⁹ Other Protestant groups soon began to follow. In the same year, Pope Pius XI defended the historic Christian opposition to contraception with his encyclical *Casti Connubii*, but by the end of the 1930’s nearly all Protestant denominations in the United States had abandoned 1,800 years of Christian consensus on contraception. Many later abandoned their condemnation of abortion as well.²⁰

The issue of modern contraception exploded to significance in the 1960s with the introduction of the birth control pill, and the subsequent United States Supreme Court 1967 ruling in *Griswold v. Connecticut* upholding the

“reproductive rights” of married people to use contraception, though the right of privacy was not explicitly included in the Constitution. This ruling essentially agreed with the Lambeth Conference resolution of 1930. In 1968, Pope Paul VI’s encyclical, *Humanae Vitae*, reiterated the historic Christian opposition to contraception but Protestant leaders attacked the encyclical as trying to impose “Catholic views” on the world. In 1972, the Supreme Court expanded the right of privacy to include unmarried people in *Eisenstadt v. Baird*, setting the stage for *Roe v. Wade* (1973) that declared abortion a “right.”

With some exceptions, this elicited little protest from Protestants, both evangelical and non-evangelical, since they had already conceded contraception and abortion as compatible with Christian ethics by the end of the 1960s.²¹ For example, one month after the Pope issued his encyclical, an evangelical symposium sponsored by *Christianity Today* and the Christian Medical Society came to the defense of contraception and, in some cases, abortion: “The Christian physician will advise induced abortion only to safeguard greater values sanctioned by Scripture. The values should include individual health, family values, and social responsibility.”²² Five years later, some Southern Baptist voices even defended the 1973 *Roe v. Wade* decision that legalized abortion. Prominent evangelical pastor W.A. Criswell, for example, claimed, “I have always felt that it was only after the child was born and had life separate from its mother that it became an individual person.”²³ This widespread acceptance among Protestant churches was cited by the Supreme Court in *Roe v. Wade*:

The view that life does not begin until live birth. . . . may be taken to represent also the position of a large segment of the Protestant community, insofar as that can be ascertained; organized groups that have taken a formal position on the abortion issue have in general regarded abortion as a matter for the conscience of the individual and her family.²⁴

In saying this, the Court underlined the connection between contraception and abortion, and acceptance of these effectively left the Catholic Church alone to uphold the ancient Christian tradition of condemning contraception. And, although these attitudes toward abortion and contraception among Western evangelicals likely differed greatly from those of Christians outside the U.S. and Western Europe, the outsized impact of Western international policy (and funding) made it inevitable that there would be pressure on the Church (especially in the Global South) to embrace contraception and abortion.

Contemporary Christian Approaches

Since 1973, many evangelicals have reconsidered their position on abortion, and some are rethinking their position on contraception. For example, Albert Mohler, president of the Southern Baptist Theological Seminary, noted that “in an ironic turn, American evangelicals are rethinking birth control even as a majority of the nation’s Roman Catholics indicate a rejection of their Church’s teaching.”²⁵ In a later interview, he stated,

I cannot imagine any development in human history, after the Fall, that has had a greater impact on human beings than the pill. . . . the entire horizon of the sex act changes. . . . the pill gave incredible license to everything from adultery and affairs to premarital sex, and within marriage to a separation of the sex act and procreation.²⁶

These were, of course, among the four outcomes predicted by *Humanae Vitae* in 1968: a lowering of moral standards, an increase in infidelity, decreased respect for women by men, and the coercive use of contraceptive technology by governments. In her book, *Adam and Eve after the Pill*, Mary Eberstadt examines empirical evidence largely derived from secular social scientists and notes that all of these predictions have come true.²⁷ Jesus declared that you will know a tree by its fruit (Matt 12:33). Has the wide-scale use of contraceptives borne good fruit? Has it been an aggregate good to societies that have adopted it? If not, should it be

exported to other societies?

The push to bring contraceptives to other countries appears to be driven by ideology and not by the targeted nations’ own perceived needs. For example, Nigerian writer and women’s advocate Obianuju Ekeocha declares, “Many countries in the West . . . have decided. . . . to raise millions of dollars that they are dedicating to the so-called safe abortion. . . . [but] have not even thought of asking the Africans what they want!”²⁸ She cites a 2014 Pew Research survey showing that upwards of 80% of people in African countries found abortion to be “morally unacceptable.”²⁹ Ekeocha speaks of this as “the new colonialism,” “cultural imperialism,” and “the dictatorship of the wealthy donor.”³⁰ One might even call this “sexual colonialism” or “sexual imperialism.”

The Contraceptive Mentality

This ideology may originate in “the contraceptive mentality” which is deeply rooted in American and Western European culture. Dr. Donald DeMarco, drawing upon writings by Carl Jung, describes a mentality as a notion existing in a society: “when enough people react automatically to a situation without thinking of the long-range consequences.”³¹ Jesuit sociologist Stanislas de Lestapis was the first to draw attention to the “contraceptive mentality.” Dr. Demarco states the following:

In his book, *La limitation des naissances*, published in 1960, de Lestapis provided sociological data that indicated the presence of what he termed a “contraceptive state of mind.” In England, for example, the Royal Commission on Population noted that in 1949 the number of procured abortions was 8.7 times higher among couples who habitually practiced contraception than among those who did not. In Sweden, after contraception had been fully sanctioned by law, legal abortions increased from 703 in 1943 to 6,328 in 1951. In Switzerland, where contraception was almost unrestricted, abortions were alleged to equal or outnumber live births by 1955, and so on. Such figures offered compelling evidence for the claim that more contraception does not reduce the

incidence of abortion. In fact, the figures suggested 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. . . . Malcolm Potts, the former medical director of the International Planned Parenthood Federation, accurately predicted in 1973, “As people turn to contraception, there will be a rise, not a fall, in the abortion rate.”³²

Lawrence Lader, a champion for abortion and contraception whose influential 1966 book, *Abortion*, provided much of the scientific foundation for *Roe*, ratified this concept, lamenting that contraception

[has not] been scientifically perfected to meet every requirement of dependability, cost, and esthetic preference. . . . until medical research discovers the final solution, abortion is the essential emergency measure, the inalienable right of all women in a free society. . . . As long as a reasonable chance of contraceptive failure persists . . . abortion must be included as a part of birth control to insure every child’s becoming a wanted child.³³

He quotes Garrett Hardin, professor of biology at University of California-Santa Barbara, as saying,

no matter how good a method of contraception is, we can never expect it to be perfect. . . . Even one with a 1 percent failure rate produces a quarter of a million unwanted children a year [based on the US population at the time]. . . . abortion is the much-needed backstop in the system of birth control.³⁴

This explicit connection between contraception and induced abortion shows the fruit of the contraceptive mentality.

Operationally, recent research by Nguyen and Budiharsana has shown that high contraceptive prevalence and receipt of family planning services paradoxically were associated with high rates of abortion in Vietnam.³⁵ This study was especially noteworthy because even though the majority of women were using the IUD, a “modern, highly effective” type of contraceptive technology, abortion rates were high. Existing as it does in a

materialist and utilitarian ethical framework, the contraceptive mentality cannot help but lead couples to turn to abortion when contraception fails. George and Tollefsen make the point that within any such utilitarian ethic,

there will always be human beings who are dispensable, who must be sacrificed for the greater good. Utilitarianism. . . treats the greater good, a mere aggregate of all the interests or pleasures or preferences of individuals, as the good of supreme worth and value, and demands that nothing stand in the way of its pursuit.³⁶

Beyond ideology, we question what is behind the impetus for evangelical organizations to promote contraception internationally. There is a clear economic incentive; contraceptive drugs and devices are manufactured and marketed

U.S. or overseas become dependent on funding from pro-abortion organizations, they may not be able to serve Christ without compromise.

The question should be asked: are we entering into an “unholy alliance” with non-Christian, pro-abortion organizations? In the Bible, Amos 3:3 states, “Can two walk together, unless they are agreed?” (NKJV). Christian organizations should consider not supporting or entering into a partnership with any organization that performs or promotes abortion, or which is associated with organizations that do so. By extension, when considering international FP programs, some fundamental questions need to be asked from a Christian perspective and their theological basis examined carefully. This does not mean that Christians should withdraw from

is problematic from a Christian perspective.

First, it is an overstatement to say that with “family planning” couples can *determine the number and timing of pregnancies*. At most, they can try to *prevent* or space pregnancies (birth spacing). But what happens when a woman becomes pregnant while using contraception? In the context of the contraceptive mentality, could abortion (birth limiting) become the “backup,” as stated earlier?

Couples can also *hope* when they stop contraception and *try* to become pregnant that they will succeed. But prolonged contraceptive effect and delayed return of fertility is well known with Depo-Provera.³⁸ Sadly, it is also well-documented that many women have contracepted past the limits of their own natural fertility (for an especially poignant discussion of this modern dilemma, see *Creating a Life: Professional Women and the Quest for Children* by Sylvia Ann Hewlett).³⁹ Human beings cannot decide infallibly that they will or will not become pregnant when they want to. “Family planning” is a mirage which promotes the illusion that we have a degree of control over life that, as humans, we simply do not have. The Bible states that God has the ultimate power to open and shut the womb (Gen 20:18, 29:31, 30:2, 30:22; Judg 13:2–3; Ruth 4:13; 1 Sam 1:6; Luke 1:13–15, 1:24–25).

Second, the methods used to prevent pregnancy matter. Most contraceptives have pre-ovulatory, pre-fertilization, post-ovulatory, or post-implantation effects (or a combination of these). While a complete discussion of this topic is beyond the scope of this paper, briefly, contraceptives with pre-ovulatory and/or pre-fertilization effects may prevent the union of sperm and egg (such as barrier methods and some hormonal methods); may be gametocidal (such as spermicides); or may act to suppress ovulation (many hormonal methods). Contraceptives with post-fertilization effects may prevent the embryo from implanting. These distinctions are extremely important, because whether

“Family planning” is a mirage which promotes the illusion that we have a degree of control over life that, as humans, we simply do not have.

working with pro-abortion governments. Rather, we must obey the New Testament command to not be unequally yoked together with unbelievers (2 Cor 6:14). This scripture refers to a close relationship between believers and unbelievers which is not pleasing to God and which always leads to negative consequences. The Bible gives examples of the dangers of such alliances such as those between Joshua and the Gibeonites, Jehosaphat and Ahab, and Joram and Ahaziah (Josh 9–10, 1 Kgs 20–22, 2 Kgs 9:21–24).

Toward a Christian Definition of Family Planning

The definition and purposes of “family planning” should be explicitly stated and examined carefully. For example, one Christian group describes family planning as enabling “couples to determine the number and timing of pregnancies, including the voluntary use of methods for preventing pregnancy—not including abortion—that are harmonious with their values and beliefs.”³⁷ This definition

by drug companies whose goal is profit for their shareholders. Certainly, the use of “safe abortion,” or abortion as family planning or as a backup to contraception, is contrary to Christian morality as noted above. Some Christian organizations respond to this by renouncing the promotion of abortion while advancing the use of contraceptives. However, by forming partnerships with pro-abortion organizations, the latter may be further empowered in their pro-abortion activities. Since the Mexico City Policy has been reinstated, it would not be surprising if pro-abortion organizations seek support and/or legitimacy from Christian international organizations or offer them training, educational materials, etc. For pro-abortion organizations, legitimacy, credibility, and access are important benefits. Churches and organizations overseas, which might otherwise reject such partnerships, could be encouraged to do so based on relationships with evangelical churches or organizations in the U.S. Further, if Christian organizations in the

or not the use of a specific contraceptive method is acceptable to evangelical Christians worldwide may depend on when they believe human life begins.

Physicians and scientists have long stated that human life begins at conception.⁴⁰ In contrast, the pragmatic recent view that life begins with implantation is based on the discovery that upon implantation, the embryo sends out a hormonal signal (hCG)—which can be detected in the mother's urine and blood. But defining pregnancy and life as beginning at implantation does not accord with newer scientific evidence and may concede to views that make the embryo less than human. Fertilization triggers a detectable calcium wave *in vitro*.⁴¹ Further, at the same time as intracellular activity begins in the new embryo, a zinc "spark" is released into the extracellular space within the mother's body, distinct from the newly formed human organism.⁴² There is also evidence that maternal recognition of pregnancy is prompted by a signal from the preimplantation embryo.⁴³

For Christians who believe that life begins at implantation, methods that disrupt an implanted pregnancy are abortifacient and, therefore, not acceptable. These may include the drug ulipristal (Ella, which blocks the action of progesterone) and mifepristone (part of medical abortion protocols). The mechanism of action of both drugs appears to be embryocidal, but they are recommended as emergency contraception (EC). EC is universally promoted alongside other types of contraception.⁴⁴ Conversely, for Christians who believe that life begins at conception, contraceptive methods that prevent or interfere with implantation and are therefore indirectly embryocidal are unacceptable.

A third problem with the above definition is that organizations that promote the involvement of Christians and Christian organizations with "family planning," do not appear to encourage health workers or educators to pray with couples and seek God as to the number and timing of pregnancies. Couples also may not be encouraged to pray about

God's will for themselves, their marriage, and families. God requires of us that we seek Him for even the seemingly unimportant decisions in our lives. Biblical examples where people of God did not do this include Abraham, whose attempt to have a son based on his human understanding resulted in the birth of Ishmael, and Hezekiah, whose request that God save his life made possible the birth of Manasseh, who brought judgment on the nation of Judah (Gen 16, 2 Kgs 20–21). In contrast, Christ's life models a complete dependence on God for everything (John 5:19).

Fourth, "family planning" often mentions neither God nor marriage. "Couples" mentioned could be unmarried couples including adolescents, or those in adultery, in which case family planning facilitates sex outside of marriage without the (perceived) risk of pregnancy. Such relationships are explicitly prohibited and described as sin in Scripture (1 Cor 6:9–10). The vague mention of couples' "values and beliefs" in the brochure quoted above 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? Here we should be aware that even good intentions, when not employed in the context of biblical values, can and often do hurt the people we are trying to help.

Effects

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. For example, the dire predictions of Paul Ehrlich's famous book, *The Population Bomb*, have spectacularly failed to materialize.⁴⁵ In fact, nations now face the opposite danger, a "demographic winter" where declining birth rates (often influenced by government efforts at family planning) lead to population decline below a sustainable level. If family planning leads to "demographic winter," it is actually hurting, not helping, a society. The present disastrous results of China's

one-child policy, attributed to coercive population control policies, include skewed sex ratios (since many more girls than boys are aborted), social instability, increased crime and sexual trafficking, and an impending crisis in couples' ability to support an aging parent.⁴⁶

Contraceptives are routinely stated to be very safe. But as with any drug or medical device, they may have adverse health effects. These include blood clots and increased risk of stroke and heart attack, especially in smokers and older women with cardiovascular disease (oral contraceptives, the vaginal ring, the contraceptive patch, Depo-Provera). Adverse effects also include weight gain and changes in carbohydrate metabolism (oral contraceptives, Depo-Provera, the vaginal ring, the contraceptive patch); anabolic steroid-type effects (Depo-Provera); mood changes including depression (Depo-Provera, some implants, the levonorgestrel IUD); infection with resultant infertility (IUDs); decreased bone density (Depo-Provera); and increased risk for breast cancer (Depo-Provera, oral contraceptive pills).⁴⁷ These effects are unpredictable and in developed countries medical care is available to manage potential complications. Such care is often limited or unavailable in developing countries. When promoting contraception outside the U.S. and Western Europe, are women adequately counseled regarding these risks? Do they have access to health care in case of side effects or complications?

Meeting Unmet Need?

The push for international Christian organizations' involvement in "family planning" is also made based on perceived "unmet need" for contraception. It is stated that "family planning saves lives" because if this "unmet need" is addressed by increasing contraceptive prevalence, there would be a substantial reduction in abortion, and maternal and infant deaths. The concept of unmet need has received recent scrutiny (see, for example, Rebecca Oas' recent excellent articles in *The New Atlantis* and the *Christian Journal for Global Health*).⁴⁸ "Contraception saves lives," we are told,

by reducing maternal and child mortality and abortion. While a full discussion of this topic is beyond the scope of this commentary, we agree with Oas that the concept of unmet need is, “deeply flawed and frequently mischaracterized,” especially with regards to the impact of contraception on maternal mortality. We further agree with Oas that not using contraception is not the same as needing contraception. It is intuitively obvious that women’s intentions regarding pregnancy are dynamic, as are their life circumstances, and not all women who want to avoid pregnancy and are not using a modern method want modern contraception. Nor does the concept of unmet need speak to the question of whether women would be disappointed or seek abortion if they became pregnant, or whether they even want contraception. Similarly, to state that a person “needs” something implies that they feel the lack of it in their lives. Once again, the concept of “unmet need” might be seen as paternalistic, an imposition of Western contraceptive mentality upon women in developing countries.

Saving Lives?

Population Reference Bureau’s document, *Family Planning Saves Lives* (2009), states that “Family planning saves lives” because it

could prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size.⁴⁹

The document cites Collumbien et al., who used models based on the Demographic and Health Survey to analyze the attributable burden of morbidity and mortality from abortion and childbirth associated with contraception use or non-use.⁵⁰ These authors state that “avoiding unwanted pregnancies will reduce maternal mortality in two ways: by reducing the number of pregnancies and by reducing obstetric risk,”⁵¹ and, “It is estimated that about 415,000 women die each year from obstetric causes,” but, “only a minority of these pregnancies are

unwanted.”⁵² They estimate that nearly 20% of obstetric deaths, “could be prevented each year if all women who desire no more children were to use modern contraceptives.”⁵³ However, they go on to write:

A reduction in unintended pregnancies is not the only pathway to lower levels of disease burden. In industrialized countries, there are still high levels of unintended pregnancies and abortions, but the disease burden . . . is minimal because of the high quality of obstetric and abortion services. Indeed, the avoidable burden in absolute numbers [of maternal deaths] may change more through . . . improvements in quality and provision of safe obstetric and abortion services—than through a decline in unintended pregnancies resulting from the use of effective contraception.⁵⁴

These authors also note “reducing mistimed births by contraceptive practice will have little influence on the incidence of pregnancies as the births will merely be delayed rather than averted. Such delay . . . will thus not reduce the burden of delivery complications.”⁵⁵

Family Planning Saves Lives states, “After giving birth, family planning can help women wait at least two years before trying to get pregnant again, thereby reducing newborn, infant and child deaths significantly.”⁵⁶ There is evidence that both short and long intervals are associated with adverse perinatal, infant, and child outcomes. In one of the few studies to assess the relationship between contraceptive use and maternal and infant health outcomes, Merali noted that users of modern contraception had longer birth intervals (adjusted OR 2.4 (CI 2.0–2.8) but not lower levels of infant mortality (adjusted OR 1.4, CI 0.9–2.0) and “modern contraceptive use was not associated with infant mortality.”⁵⁷

Family Planning Saves Lives states that inter-pregnancy interval of less than 5 months is associated with increased risk for maternal death and cites Conde-Agudelo and Belizan’s study on birth spacing and maternal mortality.⁵⁸ In contrast, Collumbien et al. note, “It is

uncertain whether shorter birth intervals are associated with an increased risk of maternal morbidity or mortality. The only two published studies give conflicting results. It is therefore not justified to regard short intervals as a risk factor for obstetric complications.”⁵⁹ Ronsmans and Campbell make the point that “the statement that short birth intervals increase the risk of maternal mortality has never been confirmed empirically. Instead, it seems to arise from the unproved assumption that maternal and infant mortality behave in the same way, and from the desire to exhort more women to use contraceptives.”⁶⁰ Based on a literature search and data from Matlab, Bangladesh, they found that there was “little support for an association between the length of intervals between births and the risk of maternal death.”⁶¹ They further state that, “Although preventing [higher risk] pregnancies at the extremes of the reproductive ages will have some effects on reducing maternal mortality . . . prolonging spacing will not.”⁶²

Other evidence challenges the assumption that younger or older maternal age, parity, and inter-pregnancy duration are associated with maternal mortality. Ganatra and Faundes reviewed the evidence for maternal mortality risk factors. They found that large studies,

analyzing data from many countries . . . have reported that while there is a markedly higher risk of maternal death after age 30, the high risk among adolescents is either of a much lower magnitude than is generally assumed or that there is no increased risk of maternal adverse outcomes among adolescents compared with adults. . . . the risk associated with younger age is more related to socioeconomic than to physiological factors. . . . The association of older maternal age with higher MMR is probably the result of the higher incidence of other coincidental clinical conditions among older women.⁶³

This suggests that screening for medical comorbidities could reduce maternal risk in this age group. These authors go on to state,

The association between parity

and maternal mortality, although identified in several studies and frequently underestimated by a number of authors, is not as clearly documented as the association with maternal age. . . . [and] appears to be biased by a number of other determinants of maternal morbidity and mortality.⁶⁴

Finally, the authors state that conflicting results in various studies, “do not confirm the common assumption that very short inter-pregnancy intervals carry a higher risk of maternal mortality, and that by increasing such interval, it is possible to reduce MMR.”⁶⁵

The most frequently cited mechanism for reduction of maternal and child mortality with increased contraceptive prevalence is that there are fewer pregnancies and births and, therefore, fewer “opportunities” for poor outcomes. But statistically speaking, decreasing the number of pregnancies and live births does not decrease 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 calculated MMR) may be decreased. Fortney states,

The maternal mortality ratio is likely to show significant improvement only with improvements in obstetrical care. Family planning reduces the maternal mortality rate only to the extent that it reduces the proportion of pregnancies to high-risk women.⁶⁶

Ronsman and Campbell also note that reductions in maternal mortality with increasing contraceptive prevalence are only likely to occur if births among women at higher risk for adverse outcomes are avoided. However, all these models are built on the premise that, eliminating all births to women under 20 and over 39 can reduce maternal mortality by 34%, and eliminating births above parity 5 can reduce maternal deaths by 58%. Thus by eliminating births in developing countries in the ‘ages of reproductive inefficiency’ and confining them to ages 18–35, it would be possible to reduce maternal mortality by 20%.⁶⁷

Collumbien et al. also note that averting

high risk births based on maternal age and parity can decrease maternal mortality, though “the effect is relatively small.”⁶⁸

Following this logic, eliminating high-risk pregnancies and births in a population would prevent most maternal deaths. However, 100% pregnancy prevention is not possible with any contraceptive method. As noted above, even with high rates of “modern” contraceptive utilization, contraceptive “failures” will occur resulting in “unintended pregnancies” (outside the United States and

their goals.

“Unless family planning services are offered alongside improved access to and quality of . . . obstetric . . . services,” Ronsman and Campbell state, “the risks associated with each pregnancy will remain unacceptably high.”⁷¹ The underlying problem remains: even if increased uptake of contraception decreases the number of pregnancies and births, neither childbirth nor childhood would be safe. Fortney succinctly sums up the frustrations many feel regarding the problem of maternal mortality in the developing

“..family planning is mentioned exclusively in reference to limiting or preventing pregnancy. But true family planning would also include helping people who want more children...”

Western Europe, where male fertility appears to be declining, this may be especially true).⁶⁹ With “unintended pregnancies,” *birth limiting*—not just pregnancy prevention—would be needed, and birth limiting is not possible without abortion. As Ganatra et al. state, “not all unintended pregnancies can be prevented through increase in contraceptive use . . . [so] access to safe abortion is needed.”⁷⁰

Implications

Thus, the goal of reducing maternal mortality cannot be achieved using contraception alone; birth limiting—through abortion—is also required. “Eliminating all births” to women in the developing world at the ages of “reproductive inefficiency” would be nearly impossible without coercive contraception programs for birth limiting, including abortion. Such contraception programs would not just eliminate births, they would eliminate human beings for whom Christ died. This again demonstrates the inevitable progression of the contraceptive mentality—from preventing pregnancies with contraception to limiting or preventing births with abortion. If family planning programs do not succeed at first, there will be pressure to use the latter to reach

world: “While implementing family planning programs is not easy, it is more feasible than the implementation of significant improvements in the quality and availability of obstetric care.”⁷² We would counter this by stating that the rapid deployment and scale-up of such interventions is entirely possible with appropriate will. This has been demonstrated with many pediatric and infectious disease control programs. Motivation will certainly be lacking, though, if it is felt that the fertility of women in developing countries is the problem and not poor living standards, low maternal literacy, and a lack of available health services.

Finally, and most important, quoting Ms. Ekeocha above, have women in developing countries been asked whether they want modern contraception? “Unmet need” assumes, without considering women’s desires or wishes, that they need Western people to tell them how to control their fertility. The wording used—women “are considered to be in need”—shows clearly that the decision is being made by someone other than themselves. Indeed, the language used above that high-risk births in the developing world must be “eliminated” and/or “confined” to certain age groups is eerily

reminiscent of the language of eugenics. Is this a form of “sexual colonialism” or “sexual imperialism?”

More than Preventing Pregnancy

Another point to be made here is that family planning is mentioned exclusively in reference to *limiting* or *preventing* pregnancy. But true family planning would also include helping people who want more children, who wish to achieve pregnancy and childbearing but for whatever reason have been unsuccessful. Does this project also include helping such couples? While WHO’s definition of FP includes treatment of infertility, in practice this is not a programmatic emphasis. Along these lines, it should be noted that emotional, physical, economic, and psychological benefits accrue more to married couples and children raised in an intact family with a married father and mother. Is this also part of the teaching and care given? Is marriage affirmed and are sexual relationships outside of marriage explicitly discouraged? This is an important aspect of Christian ethics that should be emphasized.

Poverty Reduction

An often-cited rationale for promoting family planning is to combat poverty with the assumption that a family with fewer members will be able to give more to each individual member. USAID is “the lead U.S. Government agency that works to end extreme global poverty and enable resilient, democratic societies to realize their potential.”⁷³ As one of four strategic priorities to prevent child and maternal deaths, family planning is funded to help end extreme global poverty. But how is it accomplished? If contraception is made widely available, how will that help eliminate extreme poverty? Couldn’t a large number of children actually help families come out of poverty by having more working members in the family? The document also implies that making family planning available will enable resilient, democratic societies to realize their potential. But what does this mean? What is our yardstick as Christians for a godly society? Does

FP contribute to a more godly society or detract from it? Should this strategy be employed only in democratic societies? If family planning is employed in non-democratic societies, is there a danger that those governments will use such programs coercively? How does family planning enable resilient, democratic societies to realize their potential? How is realizing potential measured? Is it solely in material, economic terms or in certain health outcomes? While these questions are beyond the scope of this paper, they require consideration.

The econometric evidence that smaller families may lead to increased prosperity may be only a short-term phenomenon. The possible long-term effects of demographic decline are just beginning to be appreciated, most strikingly in Japan, Germany, and China. This is especially remarkable for Japan, whose booming post-WWII economy set a standard for economic development. Not only are birth rates rapidly declining in Japan, poverty is increasing, especially among young single women.⁷⁴ Similarly, China’s impending demographic winter (noted above) and its potential economic and social problems should cause Christians to pause and consider the long-term effects of promoting smaller families through increased contraceptive prevalence.⁷⁵

Biblical Justification

Various biblical rationales are sometimes given for family planning such as the call to take dominion, provide for family, and promote abundant life.⁷⁶ Adam’s naming of the animals with no stated participation by God is sometimes cited as evidence that man is a “co-creator” with God. It is inferred that there are some things that God has left to humanity to decide on their own, and this includes the number and spacing of children. God spoke clearly to Adam and Eve, “Be fruitful and multiply; fill the earth and subdue it; have dominion over the fish of the sea, over the birds of the air, and over every living thing that moves on the earth” (Gen 1:28, NKJV). This is a clear command to procreate. There is

no opposite command to prevent procreation. Dependence upon God, seeking God’s counsel for every important decision (which surely includes decisions around childbearing) is more the scriptural norm than independence. In fact, as our example, Christ’s life models a complete dependence on God for everything. This is true “family planning.”

Avoiding the Contraceptive Mentality

We have seen that the contraceptive mentality has been associated with increased likelihood of acceptance of abortion. So, the argument can be made that the contraceptive mentality moves individuals and societies incrementally toward acceptance of induced abortion. This link was recognized by the Supreme Court in *Planned Parenthood v. Casey* (1992), which stated:

[The *Roe v. Wade* decision] could not be repudiated without serious inequity to people who, for two decades of economic and social developments, have organized intimate relationships and made choices that define their views of themselves and their places in society, **in reliance on the availability of abortion in the event that contraception should fail. . . . It should be recognized, moreover, that in some critical respects, the abortion decision is of the same character as the decision to use contraception**, to which *Griswold v. Connecticut*, *Eisenstadt v. Baird*, and *Carey v. Population Services International* afford constitutional protection. We have no doubt as to the correctness of those decisions. They support the reasoning in *Roe* relating to the woman’s liberty, because they involve personal decisions concerning not only the meaning of procreation but also human responsibility and respect for it [emphasis ours].⁷⁷

Personally and societally, people have tried to draw a strict boundary between contraception and abortion but it can easily collapse. A further case can be made that the acceptance of contraception leads to other things that the Christian church has traditionally denounced. As Eberstadt notes, “If a church cannot tell its flock ‘what to do with my body’ . . . with regard to contraception, then other

uses of that body will quickly prove to be similarly off-limits to ecclesiastical authority.”⁷⁸ She quotes the philosopher G.E.M. Anscombe:

If contraceptive intercourse is permissible, then what objection could there be after all to mutual masturbation, or copulation in vase indebito, sodomy, buggery [anal intercourse] . . . when normal copulation is impossible or inadvisable (or in any case, according to taste)? It can't be the mere pattern of bodily behavior in which the stimulation is procured that makes all the difference! But if such things are all right, it becomes perfectly impossible to see anything wrong with homosexual intercourse for example. . . . You will have no answer to someone who proclaims as many do that they are good too. You cannot point to the known fact that Christianity drew people out of the pagan world, always saying no to these things. Because, if you are defending contraception, you will have rejected Christian tradition.⁷⁹

Like the “firewall” between contraception and abortion, the wall between contraception and sexual sin collapses because it is built on a rejection of God's authority. Likewise, Christian efforts to bring family planning to other countries, even with the intent of excluding abortion, are likely to unleash the same forces as have been released in the United States and Western Europe, starting with the contraceptive mentality and ultimately leading to the acceptance and widespread use of abortion and other moral problems.

Recommendations

Here are some possible guidelines as well as questions that can be asked to help inform decision-making by evangelical Christian international organizations and churches regarding the promotion of pregnancy prevention and contraception. We believe that such decisions ultimately need to be made by brothers and sisters in the nations we are called to serve. To attempt to dissuade them of their Scripturally-based convictions—especially with financial or other incentives—is paternalistic at best and defiles their consciences at worst.

1. Decide whether or not to make pregnancy prevention a strategic or operational focus, by seeking God through fasting and prayer on the part of the leadership and workers in the organization.

- a. Recognize that the pervasive nature of the contraceptive mentality makes it difficult to see this issue through the lens of Scripture.
- b. Identify potential biases and inconsistencies in thought and practice.
- c. Ask, “Is this something that the target country wants or is asking for, or is it reproductive imperialism assuming ‘The West knows best?’”

2. If God's leading is for the organization to make this a focus:

- a. Work in agreement with the people the organization serves.
- b. Do not be unequally yoked or form unholy alliances.
- c. Formulate a pro-marriage, pro-pregnancy, pro-children orientation based on the Scripture in agreement with the brothers and sisters in the nations you are called to serve.
- d. Acknowledge that God's plans for humans may begin before conception and/or during pregnancy, under unlikely circumstances. For example, the prophet Samuel, John the Baptist, and Jesus Christ, all were born to women in the “ages of reproductive inefficiency.” Perez, an ancestor of Christ, was born of an illicit liaison between Judah and Tamar which was considered incestuous under the Mosaic Law (Gen 38; Lev 18:15).
- e. Celebrate premarital purity and holiness, and marriage as covenantal and ordained by God between one man and one woman; conception as one of God's mysteries; fertility as a blessing; children as the product of the covenant; family as the cornerstone of society.
- f. Dignify women, men, and unborn children as being created in the image of God.

- g. Dignify motherhood and fatherhood.
- h. Do not promote any contraceptive technology that is life-destroying.

- i. Encourage the use of free or very low-cost, low-tech methods (such as Fertility Awareness) which do not require outside inputs, have low or no side effects, require shared responsibility, and for which there is no financial incentive or profit motive.

- ii. Be explicit in counseling women that all contraceptive technologies have risks, side effects, and failure rates, and ensure the availability of health services to manage adverse outcomes that might reasonably occur with specific contraceptive technologies.

- i. Carefully scrutinize teaching materials to ensure that they fully conform to biblical teaching—that they do not just use passages from Scripture to mix truth and untruth.

- j. Avoid financial and other incentives which might encourage the use of contraception.

- k. Use Christian wisdom; direct scarce resources to proven interventions to reduce maternal mortality, increase child survival, and alleviate poverty. Where funds are limited and maternal mortality is high, focus on these needs.

3. If God's leading is for the organization to not make this a focus:

An emphasis on proven interventions to reduce maternal mortality, increase maternal education, improve child survival, and alleviate poverty could assist societies in the developing world to substantially improve the lives of women and children in developing countries with measurable effects.

4. In either case, focus on education to counter harmful messages and promote biblical messages, including the following:

- a. Abstinence and chastity are normative for adolescents and unmarried couples.
- b. The goal of sexual purity (holiness) is

to please God, not to avoid bad consequences.

c. Sex is a gift from God that He gave us for His pleasure, not just our own.

d. Resources and teaching are available for couples who want more children or who wish to achieve pregnancy and childbearing, but for whatever reason have been unsuccessful.

Conclusion

A reflection on the Incarnation could help illuminate our thinking on this contentious subject. Jesus, the second member of the Trinity, could have come to earth as the Savior in any form he chose—as a spirit or as a fully-grown man—and bypassed the process of pregnancy. As God, He had the power to do so. But not only did He lay aside His position through the *kenosis* (κένωσις), Jesus Himself became an embryo. As an embryo, He implanted himself in Mary’s uterus and gestated. Like every other fetus, He grew and developed to the end of pregnancy at which time Mary gave birth to Him. Was God’s decision to send His son to become flesh and dwell among us in the ultimate humility of conception, gestation and birth random? No. Through the beauty of the incarnation, God showed us that human reproduction was different from animal reproduction. God values and esteems human reproduction because, in His wisdom, He deemed the human frame, made from dust, as worthy to contain Christ, the fullness of the Godhead, the glory of God. In turn, Jesus submitted to the will of His Father and in so doing dignified conception, gestation, pregnancy, and women and motherhood. Further, God has given human beings the power, through the act of marriage (sex) to procreate human life in His image and likeness (Gen 5:1–3). Because we are His partners in this, so to speak, the act of marriage (sex) is a sacred privilege and responsibility. This blessing and responsibility was given to us before the Fall. Our understanding of how to prevent pregnancy came to us after the Fall and was tainted by our fallen nature. In light of this, as fallen creatures, we need to exert the greatest caution in promoting

the use of technology in a context that could not only damage or destroy the image of God in other human beings, but ultimately undermine their societies and cultures. Instead, together with those we are called to serve, we should approach and embrace God’s gifts of sex and procreation with the greatest reverence and the greatest care. ●●●

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Editor’s Note: As this Issue was going to press, a new study was released pertinent to this commentary:

Lina Mørch et al., “Contemporary Hormonal Contraception and the Risk of Breast Cancer,” *New England Journal of Medicine* 377, no. 23 (2017): 2228–2239.