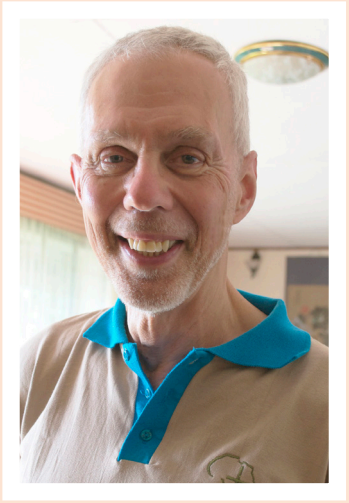
FAITH TO ACTION NETWORK

INTERVIEW SERIES

ISSUE NO.3 | FEBRUARY 2015

PROVIDING FAMILY PLANNING & REPRODUCTIVE HEALTH SERVICES THROUGH CHRISTIAN HEALTH ORGANISATIONS

Interview with Dr Douglas Huber, Reproductive Health Specialist, Innovative Development Expertise & Advisory Services & Co-Chair, Family Planning/Reproductive Health Working Group, Christian Connections for International Health (CCIH)



Dr Douglas Huber

Douglas Huber is an international health expert with 40 years of experience in reproductive health, research and innovative community health implementation. He has been a board member of Christian Connections for International Health (CCIH) and the co-chair of the Family Planning/ Reproductive Health working group at CCIH. Dr Huber was a leading contributor to the formation of the Faith to Action Network serves on the Steering Council of the Network. His international health work extends to Africa, Asia, Latin America, the former Soviet Union and the Middle East.

Dr Huber served as the Medical Director for both Pathfinder International and the Association for Voluntary Surgical Contraception (now EngenderHealth). He was a member of several WHO Expert Working Groups that developed the Medical Eligibility Criteria for Contraceptive Use and WHO training materials for health providers.

Dr Huber designed and led an innovative community-based family planning program in Matlab, Bangladesh that helped guide the national family planning program in its early years between 1975 and 1979. Between 2006 and 2008, he designed and directed the Afghanistan Accelerating Contraceptive Use project which the Ministry of Health has replicated nation-wide.

As a missionary for the Episcopal Church, 2002-2004, he was the HIV/AIDS Advisor to the Council of Anglican Provinces of Africa that represents 25 countries.

Dr Huber was trained in medicine at the University of Colorado School of Medicine, in medical epidemiology at the US Centers for Disease Control and in public health at the London School of Hygiene and Tropical Medicine. In November 2014 he received the Carl Taylor Lifetime Achievement Award in International Health from the American Public Health Association.

How did you begin your work with faith-based organisations that provide family planning and reproductive health services?

My interest in faith-based organisations started a long time ago when I was a medical director for a secular organization, the Association for Voluntary Surgical Contraception that provided voluntary contraceptive sterilisation in a large number of countries and supported high quality services. The church-based groups that were providing health services were often some of the best service providers. This goes back to 1985 and 1986 when for example CHAK, the Christian Health Association of Kenya, was providing postpartum sterilisation for women as well as other types of contraception in some of its hospitals. They were doing an excellent job characterised by quality; they promoted informed consent and they made sure clients' decisions were voluntary, mature and well thought out. In some of the other churches, where there was more community outreach; the concept of community health workers was already in place. For example, in Kenya, the Anglican Bishop, Joseph Wasonga, had a project with Pathfinder International in the Diocese of Maseno West to provide pills and condoms through community health workers.

Are churches still offering good-quality sexual and reproductive health services?

Churches have continued to be key providers of information, education and sexual and reproductive health services. However, what has happened with faith-based organisations, such as the Diocese in Western Kenya, is that the financial support was not continuous and services were scaled down. The AIDS epidemic had a lot to do with that; it overwhelmed health services and took a large share of the financial resources of the donors. Combating the AIDS epidemic was a priority. However, it resulted in donor and other funding being diverted from other sexual and reproductive health and rights services, such as family planning, reproductive health, maternal and child health. There has been a big gap between the need for family planning services and access.

Contraceptive prevalence has been declining because commodities are not available and providers are not being trained in such important procedures as minilaparotomy technique[1] for voluntary female sterilization. How to bring the balance back has been a big concern amongst the faith community as well as the international health community. We need to catch up. Everybody understands and accepts how the gap came to be, but now we need to take action. That is one of the reasons why I am happy to be working in this area where there is a harmony between what the faith community wants to do and what the international health community supports. This is where jointly, we can make real progress.

What is needed for progress?

As noted, one of the challenges that church-based sexual and reproductive health services have faced is declining financial and technical resources. What we hear from CCIH members is that they need good information, education and training. They say their staff have not been trained in twenty years; therefore they need an update on methods, especially on the new ones which they have not been exposed to. We have also witnessed that people who are visionaries in their faith communities want to move the services from the facilities out to the community. Some are even saying that the church is the biggest missed opportunity for delivering services. What they mean is giving right information and even family planning methods through their church. Donors should consider supporting such innovations.

Current innovative initiatives include training of pastors, mothers' guilds and fathers' guilds and community health workers who are already working through the church. They are being trained to provide comprehensive information about family planning methods and services with the support of the pastors, priests and lay leaders. With financial and technical assistance, this can be scaled-up and help transform the whole community through good information and better access to services.

Equally, increasing the age at which a girl starts having children is necessary. Education and training gives the opportunity to delay child-bearing. It provides girls with a chance to mature physiologically, psychologically and intellectually. Both education and training build their capacity to effectively care for children. Comprehensive education, information and services can yield very positive results.

How can you ensure uptake of comprehensive reproductive health and family planning information at the community level?

One way is to show the importance of birth spacing. We emphasize the need for every new mother to allow an adequate interval before her next pregnancy. Mothers need time and appropriate methods that are suitable while breastfeeding. Breastfeeding is very important for infant and child health but it is not a sufficient means for preventing pregnancy, except in the first months. Hence, a woman needs effective methods of family planning in order to protect herself and her baby against another pregnancy too soon. As soon as another pregnancy starts, breast milk begins to dry up, so the baby is forcibly taken off the breast before it is safe. It is harmful for that baby and it is harmful for the next soon-to-be born child. A short birth interval increases the risks of infant mortality, preterm delivery, and neonatal death for the next baby. Malnutrition and stunting are also increased, plus maternal death rates are higher if births are spaced too close. This is newer information that did not exist twenty years ago and that can be very powerful.

Equally, men need to be brought in the conversation to understand what is best for their family. However, ensuring their cooperation for adequate birth spacing can sometimes be challenging, and the faith community can help.

You have highlighted the need for better information. What other skill gaps do you see in faith-affiliated health facilities? What can be done to bridge or address these gaps?

Training in service delivery for a full range of contraceptive choices is a big need. Training needs to include doctors, nurses and midwives, especially in clinical methods like IUDs, implants and voluntary sterilization. Training is also needed for community health workers who can provide some methods in the community and can refer couples for the clinical methods that are highly effective and long-acting.

There are also gaps in management and in monitoring and evaluation. Partnerships with secular organizations could be helpful in strengthening these areas. Contraceptive and reproductive health commodity management and logistics is another area that needs strengthening.

Do you see a potential for faith-secular collaboration in addressing the above mentioned gaps?

There is great potential. Many secular organisations know how important the faith community is in serving the needs of the poor, especially those who are most underserved in more remote and rural areas. The faith community is dedicated to serving the poorest and most deprived. Their services and infrastructure are long-term. They belong to and are owned by the people. The faith community has a special mission and it serves large populations. Donors and secular organisations also want to reach these groups, and the best way to do so is often in partnership with the well-established community structures and leadership within the faith community.

Faith leaders are not just leaders of the spiritual side of people and their communities. They are also respected leaders in other aspects of life such as health. This occurs among Christian, Muslim and other faith leaders. In my work with secular organizations, I had the privilege of working with

1 Minilaparotomy, generally referred to as "minilap," is a female sterilization procedure for permanently occluding the fallopian tubes. It is performed through a small incision (less than 5 cm in length) in the abdominal wall (EngenderHealth).

many Muslim leaders, mullahs and imams during the development of training, client education and policy initiatives. They agreed that family planning is consistent with teachings of the Holy Quran and that a woman should breastfeed her child and delay births for at least two years before becoming pregnant again. They recognized that another pregnancy too soon is bad for women's health and that birth spacing is aligned with the teachings of Islam. Therefore, they promoted family planning at Friday prayers in the Mosque and taught men in their community that injectable contraceptives, pills and other suitable methods of family planning are good for family health and compatible with Islam.

Working across several major faith communities needs cooperation and synergy. It requires accepting that each religious community does things a little bit differently, based on their own faith, but that they all support improving the health of families.

However, some religious views oppose family planning, others accept only the natural methods. How can you reconcile the beliefs of religious health care providers with patients' right to health?

All health providers should respect the right of their patients to appropriate health care, and should avoid imposing their own religious beliefs on others. The right for couples to have the number and timing of pregnancies they want and to have choice in family planning methods is now seen as a human right in the context of sexual and reproductive health and rights. In reality, most health providers respect this right to choose family planning methods, though sometimes their religious institutions place restrictions. This appears to be changing in the direction of better serving the sexual and reproductive health needs of patients. There is also the obligation to help couples achieve a pregnancy when they are having difficulty doing so.

How would you describe Christian approaches to sexual and reproductive health and rights, including family planning? What similarities and differences can you see between the Catholic, Anglican, Lutheran and other Christian denominations? Do they have any shortcomings when compared to international health standards of WHO or UNFPA and vice versa?

All Christian denominations agree that couples should be enabled to have the number and timing of pregnancies that they want, including access to voluntary family planning methods. There is a great deal of common practice across denominations when it comes to use of family planning methods and other reproductive health services. For example, in the USA, Catholics, Evangelical Protestants and mainline Protestants all use effective modern contraceptive at a high level, even though church teachings may vary. The "primacy of conscience" is a principle that often instructs devout Christians to choose the right action for themselves and their families based on their own conscience, even when church teachings do not agree. Individual choice is largely how practicing Christians of all denominations decide on their family planning methods in most countries, and many would say this is their right.

Sometimes there are differences between Christian teachings and the international guidelines of WHO and other international health organizations. Some of this results from being uninformed about contraceptive methods, such as their safety or how they work. Many misunderstandings can be addressed through better information and updates, though some institutional differences require individuals to make decisions in light of their own conscience and beliefs.

What positive examples of faith-affiliated work on family planning and reproductive health could you give, based on your experience of working as a health professional?

Two occur to me. One is from Al-Azhar University in Egypt and the other from the Christian Health Association of Kenya (CHAK). Al-Azhar University brings together its spiritual foundation and health knowledge and expertise in teaching about the importance of family planning, drawing from the legacy of Islam. I would love to see more Christian and Muslim leaders follow the same example. Some religious and medical leaders promote good health amongst Christians and Muslims, educate their communities, and advocate with policy makers.

CHAK is implementing a project that spans religious leadership down to the community level. The project educates religious leaders within the catchment area of a CHAK affiliated health facility about the importance of health messages. It also involves trained community health workers in the provision of contraceptives and lay church leaders in the dissemination of health information. I had the privilege of being personally involved in some of these discussions. I realized the eagerness of church leaders, from Pentecostal, Anglican and Catholic churches to dialogue about family planning. In one setting they also brought the mullah from the local Mosque to join the dialogue.

They were very interested in spreading information and health messages and they recognized this as being important for the wellbeing of their communities. They saw family planning not as something controversial but rather as a service that would actually raise their esteem and bring good to the community. They also recognised the importance of bringing trained staff such as the community health workers to answer people's questions and to provide services. There was a general consensus that good quality services from the facilities should be brought to the community and to the church.

How would you ensure comprehensive provision of services at the community level?

Family planning and other reproductive health services need to be integrated with the community

health work already being done. Not all methods can be provided at the community level, and for some clinical methods there is a need to refer to the health facilities. This requires a partnership characterised by mutual respect and teamwork. Community health workers, the clergy and lay religious leaders can inform about methods and refer to the health facility or district hospital for clinical methods such as implants and IUDs--or sterilization for those who want to stop child-bearing. When you see these kinds of services taking place with the blessing of the religious leaders, you realise this is something that actually works and meets the needs of people in the community. This affirms to me that international experience and ideas are also relevant, acceptable and welcome at the community level. I believe this is the way we always need to test what we are doing. We cannot be sitting around the table in an office deciding what would be a good programme without testing it at the community level.

You have highlighted the importance of working across different stakeholders, both faith-affiliated and secular. Do you see any limitations of such cooperation?

Faith-based and secular organizations often have different priorities that can interfere with finding common ground in how to achieve health objectives. Most of these can be overcome through discussion and joint planning, including a better understanding of the language each uses. Competition for resources can interfere with cooperation, and sometimes there is even concern about the public image for governments and their faith partners. The objective is to formulate win-win collaborations where each is contributing to a common goal and all are given due credit.

How do you see the role of advocacy in addressing the needs of faith-based health institutions?

There are two main types of advocacy. The first is internal advocacy targeting faith leaders and faith institutions. Here, the advocacy aims at increasing support for sexual and reproductive health and rights by faith leaders and institutions. The second is external advocacy targeting governments, donors, the private sector and secular organisations to increase support for faith based health interventions and their involvement in policy making processes.

One area where support is certainly needed is for commodities, the family planning methods themselves. Stock-outs are common problems in Africa, in the government health facilities, and even more so in many faith-based facilities. Contraceptive security needs to be addressed in a comprehensive manner, through ordering the products, doing the paper work and connecting with the right logistical system.

Advocacy should be carried out at multiple levels. For example at the local level, the faith community needs to ask, “If we are not getting enough supplies for the people we want to serve, how can we do better?” If the supplies are coming from the government source, which is the case in many countries, they are provided free of charge but are often not sufficient--or not available at the right time. Addressing such problems requires advocacy and engagement with governments to order sufficient supplies and to get help in making the system work.

How about provision of internal advocacy that is towards faith communities themselves?

Much of the internal advocacy should be about dispelling misconceptions. The long period with little attention to family planning has allowed myths and misinformation about contraceptives to become prominent. In Kenya, a large number of women, even in urban areas, have misconceptions that contraceptives are detrimental to health--for example that they cause cancer or infertility. In fact, hormonal contraceptives prevent a number of cancers. Still, religious leaders are reluctant to discuss family planning if they think is it harmful and if they do not have all the facts.

Correcting misinformation is an important part of internal advocacy that should be based on provision of comprehensive and evidence-based information by faith communities. In addition, advocacy should be conducted across religions, emphasising the need to act together and dispelling misconceptions about the goals of family planning services, including underlying suspicions that faith communities might have of one another. Family planning and reproductive health services are essential to the health and well-being of families in all religions.

The Faith to Action Network’s interview series *aims to provide a multiplicity of perspectives on family health and wellbeing[1], presented in a non-partisan manner that invites open and thorough exploration. It intends to promote knowledge exchange and conceptual debate on diverse faith approaches to family health and wellbeing, recognizing diversity of opinions and promoting productive engagement across the differences. The opinions expressed in the interviews might not necessarily reflect the views of the Faith to Action Network, its Members or its Secretariat.*

Credits

This interview was conducted by Dominika Jajkowicz

Editorial Support*: Angela Mutegi, Matthias Brucker, Peter Munene*

1. *Our operational definition of family health and wellbeing includes: birth spacing, fertility awareness, safe motherhood, prevention of mother to child transmission, maternal and child health, age appropriate sexuality education, gender equity and prevention of female genital cutting, early marriage and all forms of gender based violence.*