

THE LIBERATION OF SEX:

Liberation Theology as Defense for FBO-Distributed Comprehensive Sex Education and Contraceptives in Honduras

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Abstract: Poor sexual and reproductive health (SRH) is highly correlated with poverty and is a form of social injustice. As one of the poorest countries in the world, Honduras particularly struggles with promoting SRH among its female population, reflected by restrictive SRH policies and its disconcerting SRH indicators, like unintended adolescent pregnancy. Faith-based organizations (FBOs) play an increasingly large role in international development and global health initiatives and are prevalent in Latin America and the Caribbean, including Honduras. Because Christian theology proscribes extramarital sexual relations and Roman Catholic theology strictly forbids contraception, FBOs operating under these directives often implement abstinence-only programs that do not achieve their desired outcomes for improved SRH, and sometimes even exacerbate problems like UAP and STI incidence. Liberation theology demands that Christian FBOs working in Honduras provide comprehensive sex education and contraceptives to Honduran adolescent women to adequately address reproductive injustice.

“I see very clearly that I cannot entrust my destiny just to biological chance. As a woman who is trying to create a happy balance of work and family, I know effective family planning is essential. A woman who cannot control her own fertility, who must remain vulnerable to chance conception, is a woman who cannot hope to be much more than a baby-machine.”

Rosemary Radford Reuther

Introduction

Faith-based organizations (FBOs), non-governmental organizations founded in religious commitments,¹ play an increasingly important role in humanitarian assistance, often aiding those unreached by government anti-poverty interventions (Hefferan et al. 1). These organizations are involved in a wide array of international development activities, including the provision of health services in impoverished countries. The Latin American and Caribbean (LA/C) region is home to many of the poorest countries in the world, with poor sexual and reproductive health (SRH)² as a chief issue. Within the region, the country of Honduras has the lowest GDP per capita besides Haiti, some of the highest rates of sexual violence in the world, restrictive reproductive health policies, and high adolescent pregnancy rates (Center for Reproductive Rights 1), rendering its

¹ This definition is expounded in Section III of the paper.

² The UNFPA defines SRH as “a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. To maintain one’s sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. And when they decide to have children, women must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby.” (UNFPA “Sexual & Reproductive Health”)

population uniquely vulnerable to SRH neglect and injustice. In addition to its economic and social costs, this injustice violates human rights. Unfortunately, FBOs' religious beliefs often prevent them from responding to this crisis by promoting and protecting SRH.

Christian theology generally proscribes sexual relations outside the bounds of a marital union, so many Christian FBOs provide abstinence-only sex education programs, teaching adolescents that refraining from sexual intercourse is the only way to avoid unwanted pregnancies, STIs, and other negative consequences of early sexual initiation. This curriculum leads to inefficient and even detrimental outcomes, including increased unintended adolescent pregnancy (UAP). Because Roman Catholic teaching strictly forbids contraception, this problem may be even more endemic among Catholic FBOs.

Liberation theology, a Christian movement born in Latin America in the 1960s, urged that Christians and the Church must counter social injustice and inequality. It framed poverty and its accompanying miseries as sinful and demanded a liberative praxis. As such, liberation theology provides theological grounding for Christian FBOs working in Honduras to counter SRH injustice. This requires providing comprehensive sex education and contraceptive services to Honduran adolescents.

The first section of this paper will establish the reproductive justice framework to be used throughout the argument. The second section will describe the current state of SRH and UAP in LA/C and Honduras, examining trends, correlates, determinants, and policies. The third section will examine access to contraceptives in Honduras and the comparative effectiveness of comprehensive sex education as opposed to abstinence-only education. Finally, the fourth section provides a theological argument asserting that Christian FBOs working in the health sector in Honduras should provide comprehensive sex education.

I. Reproductive Justice

The paradigm of reproductive justice merges reproductive rights with social justice concerns. Although rights language has dominated the discourse about SRH, it overlooks systemic social inequalities contributing to health disparities impacting marginalized groups, like people of low-socioeconomic status (SES). Reproductive justice, on the other hand, attends equally to both. It has been defined as: “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (SisterSong). The Colorado Organization for Latina Opportunity and Reproductive Rights offers a more comprehensive explanation of the origination and intent of this model, detailed below:

When the term “reproductive justice” emerged in 1994, the movement for reproductive freedom was dominated by the voices of white, cisgender, resourced women who had a singular focus on abortion. Many women of color, and black women in particular, felt excluded from the movement and wanted to see it include an analysis of the multiple oppressions marginalized communities face. Economic, sexual, racial, disability, immigration, and religious factors keep many people from being able to make genuine choices about their reproductive lives. Recognizing the need for a more intersectional approach to addressing barriers to reproductive health, women of color activists launched a movement for “reproductive justice” rooted in human rights values, cognizant of all our identities and circumstances, and addressing a range of issues. (Colorado Organization for Latina Opportunity and Reproductive Rights)

Advocates for reproductive justice argue that choice cannot exist without access (SisterSong). If the chief objective of reproductive rights is to protect the legal right of women to abortion and other reproductive healthcare services, reproductive justice emphasizes a more diverse set of goals, such as the securement of planned and healthy pregnancies and the elimination of unwanted pregnancies (Unitarian Universalist Association). They argue the government is responsible for ensuring three minimal requirements of access to reproductive

health services: safety, affordability and availability (Ibid.). This comprehensive access contributes to the preservation of human dignity.

The Christian interpretation of human dignity aligns with reproductive justice. Catholic Social Teaching holds that the basis of human dignity “is that humans were created in the image and likeness of God,” and every human life is sacred with “inherent and immeasurable worth” (*Livesimply* “Human Dignity”). As such, any worldly circumstance that devalues a human life, such as poverty, violates human dignity. The social determinants of reproductive health result from unequal social structures created and maintained through human choice and action. The reproductive justice framework calls for the dismantling and transformation of these structures as a precondition for exercising reproductive choice. This framework is particularly apt for analyzing the situation of poor adolescent Honduran women.

II. Poverty and SRH: The Link

In recent decades, the global sexual and reproductive health landscape has changed substantially: “Rates of sexual initiation during young adulthood are rising or remaining unchanged in many developing countries, childbearing and marriage are increasingly unlinked, and in many countries, high HIV prevalence adds to the risks associated with early sexual activity” (Hindin and Fatusi 58). These trends are disconcerting considering the disproportionately adverse implications of poor SRH on people experiencing poverty.

Poverty and SRH are inextricably linked, as both are associated with large family size. In comparison to smaller families, large families are both more susceptible to and less likely to recover from poverty (WHO “Social Determinants” 3). In addition, large family size increases maternal mortality risk and decreases parental investment in children’s education, and unwanted

pregnancies augment unsafe abortion rates (Ibid. 3). The following findings from population-based surveys also affirm the association between poverty and SRH:

...women from the poorest households are less likely to use preventive and curative sexual and reproductive health services and products than women from the wealthiest households including use of modern contraceptives, antenatal care, skilled attendance at birth, and seek treatment for self-reported symptoms of sexually transmitted infection. (Ibid. 4-5)

Because the world's poorest countries face the highest population growth rates,³ these findings are consequential (UNFPA "Sexual and Reproductive Health for All" 18).

This paper specifically focuses on unintended adolescent⁴ pregnancy as an indicator of poor SRH due to its pervasive implications for well-being and disproportionate impact on those of lower SES. Adolescent motherhood is much more prevalent among this group, intensifying pre-existent economic strains. Early pregnancy and childbearing can be extremely disruptive for an adolescent's education, training, employment, and economic security. In fact, adolescent motherhood is positively associated with dropping out of school and lower educational attainment, unemployment and low wages, and welfare dependency (UNICEF *Young People and Family Planning*), and adolescent mothers are at a higher risk of single motherhood due to disproportionate absenteeism and irresponsibility among adolescent fathers (UNICEF "Teenage Motherhood" 7). Early childbearing also increases the risk of maternal health dangers like obstetric fistulae, which can be socially isolating and physically injurious, and further restricts economic security (Ibid. 6). Another consequence of inadequate SRH is HIV and other STI contraction, which can be both a cause and outcome of poverty (Hindin and Fatusi 58, ILOAIDS

³ Fertility rates in less-developed countries are almost double that of more-developed countries (2.9 versus 1.6 births per woman), with rates of more than 5 births per woman in the least-developed countries (WHO "Social Determinants" 3).

⁴ Most of the data used in this paper use the term 'adolescent' to denote ages 13-19.

1). Moreover, the stigma associated with adolescent pregnancy, HIV/AIDS, and poverty only exacerbate the situation. These burdens associated with adolescent reproduction are problematic, especially in high-poverty areas. Contraception might avert the economic strains, health risks, and stigma associated with single adolescent motherhood, but access to modern contraceptives is often insufficient in developing countries such as Honduras.

Poverty and SRH in Honduras. With the highest level of economic inequality in Latin America,⁵ 63 percent of its population living in poverty in 2014, six out of 10 households living in extreme poverty in rural areas, and some of the highest rates of violent crime in the world (The World Bank), Honduras unsurprisingly struggles with high UAP rates and promoting SRH in general. The Guttmacher Institute reports that, in Honduras, only 33 percent of 15-24-year-old women have a comprehensive knowledge of HIV and AIDS⁶ (Guttmacher Institute, and International Planned Parenthood Federation 2), which points to insufficient sex education. Additionally, half of recent births to women younger than 20 were unplanned, and 42 percent of sexually active, never-married women aged 15-19 have an unmet need for contraception (Ibid.

2). In fact, with 137 births for every 1,000 15-19-year-olds, the country has the highest adolescent birthrate in Central America (Guttmacher Institute 2). Furthermore, because socioeconomic status is a substantial determinant of early childbearing, these rates are even higher for those living in rural areas (162 per 1,000) and with little to no educational attainment

⁵ The average Gini coefficient for Latin America was 50 in 2012, while Honduras's was 57.4 (Development Research Group).

⁶ The term 'comprehensive knowledge of HIV and AIDS' is defined as knowing the two major HIV-prevention methods (condom use and having one uninfected partner), knowing that a healthy-looking person can be HIV positive, and rejecting two common local misconceptions about HIV transmission (Guttmacher Institute, and International Planned Parenthood Federation 1).

(194 per 1,000 among those with one to three years of schooling and 254 among those with no schooling) (Ibid. 3).

The high unintended pregnancy rates among Honduran adolescents reflect barriers to contraceptive security—consistent access to a variety of modern contraceptives—which can motivate the pursuit of alternative methods of avoiding unplanned births and single parenthood. Two of these methods are abortion and emergency contraception; however, as I will detail below, these services are banned in Honduras along with six other LA/C countries (Chile, Dominican Republic, El Salvador, Haiti, Nicaragua, and Suriname) (Guttmacher Institute *Abortion*). These countries are in the minority as the rest of LA/C legally permits abortion in specified cases, like to save the life of the mother or for socioeconomic reasons (Ibid.). Some women turn to unsafe abortion,⁷ which poses severe, sometimes fatal, health risks. In 2009, a woman in a developing nation died every eight minutes due to complications from an unsafe abortion (Haddad and Nour 122), and LA/C specifically had the highest unsafe abortion rate of any region—more than two times the rate of the world average (31 per 1,000 women 15-44 compared to 14) (Ser). In addition to the many concrete health consequences of unsafe abortion, like hemorrhage, sepsis, genital trauma, and infertility, non-measurable ramifications include impairment to economic productivity and mental health (Ibid. 123). These physical and mental health consequences are enormously detrimental to economic security. Early childbearing and unsafe abortion could be totally avoidable if alternative solutions were available. However, Honduras's restrictive reproductive health policies render them far too common, exacerbating reproductive injustice.

⁷ WHO defines unsafe abortion as “a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both” (Haddad and Nour 122).

Honduras's Ban on Abortion and Emergency Contraception. Despite numerous and ongoing pleas from United Nations bodies, Honduras currently maintains a total ban on abortion and emergency contraception (Center for Reproductive Rights 2). All abortions, including those necessary to save pregnant women's lives, were illegalized in 1997, and the Honduran Supreme Court upheld a ban on all emergency contraception in 2012. Punishments apply to sellers, distributors, and users of emergency contraception and are equivalent to those for performing or obtaining an abortion.⁸ These punishments include prison sentences ranging from three to ten years and fines ranging from L.15,000 to L.30,000⁹ ("Delitos Contra La Vida" 32-33), which disproportionately impact low-SES women even further.

As a sign of progress, the Honduran government signed the ministerial declaration titled "Prevenir con Educación," which translates to "Preventing through Education," with the goal of ensuring SRH for all young people in 2010. Specifically, the declaration establishes goals to accomplish the following: "By 2015, reduce by 75% the number of schools under the jurisdiction of the Ministries of Education that have failed to institutionalize comprehensive sex education" and "By 2015, reduce by 50% the number of adolescents and young people who are not covered by health services that address their sexual and reproductive health needs appropriately" (Latin America and the Caribbean 1). Some of the mechanisms through which the government seeks to achieve these goals are delineated below in excerpts from the declaration:

3.4. Before the end of the year 2010, the Ministries of Education will update the contents and didactic methods of their curricula to include comprehensive sexuality education, in

⁸ According to Honduran penal code, abortion is defined as "la muerte de un ser humano en cualquier momento del embarazo o durante el parto," which translates to, "the death of a human being at any time during pregnancy or during childbirth" ("Delitos Contra La Vida" 32).

⁹ The letter 'L' denotes lempiras, which is the currency of Honduras. In US dollars, L.15,000 is approximately \$640 and L.30,000 is approximately \$1280.

collaboration with the Ministries of Health. This update will be guided by the best scientific evidence available, recognized by the relevant international organizations, in consultation with experts, and taking into account the views of civil society and communities, including children, adolescents, youth, teachers, and parents. (Ibid. 4)

3.8. Ensure that health services provide effective access to: counselling and testing for HIV and STI; comprehensive clinical care for STI; condoms and education in their correct and consistent use; counselling about reproductive decisions, including for people with HIV; and counselling and treatment for drug and alcohol abuse, for everyone, especially for adolescents and young people. (Ibid. 5)

These proposed actions appear to be practical steps in addressing the SRH issues in Honduras.

Article 3.4 addresses the problem of abstinence-only sex education, and 3.8 tackles inadequate access to HIV testing and treatment. Notable, however, is the absence of reforms to the stringent abortion and emergency contraception laws.

The act of the Honduran government signing this declaration is noteworthy in and of itself as a sign of commitment to the enhancement of SRH services and the promotion of reproductive justice. Nonetheless, commitment does not necessarily entail concrete change, demanding evaluation of the implementation and efficacy of these policy changes. The International Planned Parenthood Federation (IPPF) evaluates the implementation of the ministerial declaration annually to analyze progress towards its goal of improved SRH in the LA/C region. IPPF published their final report in 2016, which shows that the region had aggregately implemented 58 percent of the commitments made in the declaration as of 2012 (IPPF 4). This progress varied across countries with Cuba showing the most progress (99 percent) and Bolivia showing the least (24 percent) (Ibid. 5). Honduras exhibited less extreme progress in either direction with 51 percent implementation of the declaration's commitments (Ibid. 5). Other than these progress indicators, the evaluation does not detail country-level action in achieving the goals demanded in the ministerial declaration. This deficiency is problematic as

it does not allow for comprehensive policy analysis to inform future directives and necessitates a more thorough analysis of family planning services and sex education in Honduras.

III. Family Planning and Sex Education

Family planning is defined as the practice of determining the desired number and spacing of children (WHO “Family Planning”). Family planning methods can be divided into two categories: traditional and modern. Traditional family planning methods include abstinence, the calendar method,¹⁰ and withdrawal, while modern services are much more varied, with oral contraceptives and condoms as two of the most commonly known methods (Ibid.). Modern contraceptives are markedly more effective than traditional methods, with some researchers noting pregnancy rates of 3% for women using the pill and 1% for those using intrauterine devices (IUDs), as compared to 19 percent for those using withdrawal and 20 percent for those using rhythm (Hubacher et al. 163). Barriers to these services create unmet contraceptive need among women, decreasing contraceptive security and contributing to SRH injustice. Some of these barriers include: limited access to contraception (particularly among young people, poorer segments of populations, or unmarried people); fear or experience of side effects; cultural or religious stigma; and poor quality of available services (Ibid.). Considering the disproportionate implications of UAP on adolescent women of low-SES, many of whom are unmarried and may

¹⁰ Calendar method or rhythm method refers to when “Women monitor their pattern of menstrual cycle over 6 months, subtracts 18 from shortest cycle length (estimated 1st fertile day) and subtracts 11 from longest cycle length (estimated last fertile day)” (WHO “Family Planning”).

rely on religious organizations as contraceptive providers,¹¹ these barriers are disconcerting to say the least.

Modern Contraceptive Access in Honduras. Approximately 329,000 Honduran adolescents are sexually active, and only 46.2 percent of them report using contraceptive methods (WHO *Republic of Honduras* 1-2). Of these women, 21.6 percent use male condoms, 5.6 percent use oral contraceptives, and 1.3 percent use IUDs (Ibid. 2). The equity gap—“the gap in contraceptive use between the poorest and wealthiest segments of the population”—in Honduras in 2001 was comparatively high at 31 percent (Siow), in part signifying inequitable access to contraceptives. This access problem is apparent in the 42 percent of unmarried adolescent Honduran women who exhibit unmet need for contraception (Guttmacher Institute, and International Planned Parenthood Federation).

Abstinence-Only versus Comprehensive Sex Education. Abstinence-only sex education refers to curricula that teaches abstinence as the only acceptable sexual behavior outside of marriage and avoids “controversial” topics like contraceptive use and STIs prevention. Comprehensive sex education refers to curricula that emphasizes abstinence as the safest way to avoid unintended pregnancies and STIs, but provides instruction on contraceptive use and STIs to promote safe, healthy sexual behavior and prevent negative consequences of early sexual initiation, like the risk of UAP.

¹¹ About 52 percent of all modern contraceptive methods are obtained at public sector facilities, while 43 percent are obtained at private facilities, including FBOs, or retail outlets (Health Policy Plus).

An abundance of literature has concluded that abstinence-only sex education is ineffective at decreasing adolescent pregnancy and can even exacerbate it. Findings from various studies on sex education consistently show abstinence-only programs do not reduce unintended pregnancies, STI incidence, or average sexual initiation (Alford 2, Murdock 4, Kirby 8, Kohler et al.) and sometimes even increases teen pregnancy rates (Stranger-Hall and Hall 4). Furthermore, abstinence-only programs have been known for disseminating distorted or misleading information. For instance, one investigative study found that some programs were teaching adolescents that “HIV can be spread via sweat and tears” and “pregnancy can result from touching another person’s genitals” (Alford 1). These falsehoods are obviously not scientifically sound. Studies on comprehensive sex education, on the other hand, robustly indicate achievement of the programs’ desired effects, like reductions in the number of sexual partners and increased condom and contraceptive use (Advocates for Youth). Regardless of these longstanding, consistent findings, government agencies continue to distribute funding to abstinence-only programming and religious organizations continue to advocate for it.

IV. Ethics & Religion

Over the past few decades, non-governmental organizations (NGOs) have proliferated as humanitarian groups, progressively involving themselves in a wide variety of global affairs. Tara Hefferan et al. report estimates of the existence of 37,000 international NGOs in 2000 as compared to 1,000 at the beginning of the 20th century; by other estimates, there are more than 50,000 international NGOs in the global south and millions of national and local organizations all over the world (Hefferan et al. 4). This proliferation can be partially contributed to NGO-favorable antigovernment ideology and neoliberal reforms in the 80s and 90s that shifted

development aid from the public to the private sector. In fact, between 1970 and 1990, the share of government-transferred global development aid distributed to NGOs increased from about \$200 million to \$2.2 billion, and the total amount spent by NGOs increased from \$1.0 billion to over \$7.2 billion in the same period (Ibid. 4). Elizabeth Ferris cites qualitative evidence of these estimates:

As Ian Smillie and Larry Minear say, ‘Government officials are now aware that the world’s largest NGOs actually provide more aid than do some donor governments. NGOs are active in more countries than many governments, and they carry more credibility with tax- payers than do government aid agencies. Indeed, some individual NGOs have country programmes with larger budgets than the government ministries to which they relate.’ (Ferris 311)

This trend holds true for SRH services in Honduras where the UNFPA spent over \$2 million on SRH programs in 2015, while NGOs spent a little over \$1 million and the Honduran government spent less than \$400,000 (UNFPA “Honduras”).

Of the estimated several million NGOs in existence today, it is difficult to measure how many can be classified as FBOs due to their rapid propagation, the transient nature of smaller operations, the stigmatization of faith as a topic in development literature,^{12,13} vast heterogeneity, and classification inconsistencies (Berger 16, Hefferan et al. 3-4, Ferris 312). Of the many different definitions of FBOs offered in the literature, not to mention the wide array of typologies, Julia Berger’s is adequate for the purposes of this paper: “formal organizations whose identity and mission are self-consciously derived from the teachings of one or more religious or

¹² This stigmatization seems to be eroding as more and more development literature related to faith, religion, and spirituality is emerging (Hefferan et al. 6).

¹³ Though FBOs are controversial—some view them as positive supplements to and even essential components of the development sphere, while others consider them to be culturally imperialistic and criticize their proselytization agendas as exploitative to vulnerable populations and—the purpose of this paper is to discuss their role in this specific area rather than as a general entity. As such, this debate is excluded.

spiritual traditions and which operates on a nonprofit, independent, voluntary basis to promote and realize collectively articulated ideas about the public good at the national or international level” (16). Regardless of technical definition or typology, Berger claims that “an increasingly visible number of organizations are defining themselves in religious terms” (19). This claim is supported by President George W. Bush’s doubling of the percentage of U.S. foreign aid flowing through FBOs between 2001 and 2005; additionally, USAID distributed \$1.7 billion in contracts, grants, and agreements to 179 FBOs in this same period (Hefferan et al. 5). In Honduras, Catholic Relief Services is one of the most prominent FBOs in operation, serving 491,563 people each year through their programming in a range of sectors (CRS).

FBOs and Reproductive Health. Among the various spheres of international development, health is commonly addressed among FBOs, which can account for hefty proportions of healthcare delivery in developing countries. Though measuring these proportions is difficult due to data insufficiencies,¹⁴ one study estimates FBOs provide anywhere from 8-44 percent of hospitals, 6.7-38 percent of general health facilities, 22-28 percent of hospital beds and staff, and 4.1-36 percent of all healthcare in low- and middle-income countries (Kagawa et al. 4). For instance, FBOs manage almost 40 percent of hospitals in Rwanda and about 32 percent of the country’s health facilities (Ibid. 4).

Within the field of health, FBOs working in developing countries have specifically focused on promoting SRH in response to increasing adolescent pregnancy rates, HIV

¹⁴ Additionally, the authors of one meta-analysis assert that “the estimates of religious medical contributions vary widely across studies, units of measurement, and geographic regions. Our knowledge of the magnitude of faith-based contributions is limited and imprecise, making it difficult to define the role of faith organizations in health sectors globally” (Kagawa et al. 6).

contraction, and other negative outcomes. Much of their contribution has revolved around the HIV/AIDS epidemic due to swelling global awareness. For instance, FBOs have traditionally partnered with USAID to implement family planning programs internationally, but this involvement multiplied with the introduction of PEPFAR—the U.S.’s global AIDS program (Barot 19). Much of FBOS work in SRH also focuses on policy. For example, the Religious Institute, a multi-faith organization investing in advancing family planning services across the world, published its “Open Letter on Family Planning” in 2013 affirming its “commitment to safe, affordable, accessible and comprehensive family planning services as a moral imperative” (Ibid. 21-22). Over 1,000 religious leaders across the world endorsed this letter (Ibid. 21), demonstrating widespread support across denominational lines for modern family planning services. Furthermore, the United Methodist Church, “the largest mainline protestant denomination in the United States with more than eight million members domestically,” has released several similar texts and frequently lobbies Congress to increase awareness of the problem and act on it (Ibid. 22).

Views on Contraceptive Use: Catholic versus Protestant FBOs. While Catholic and Protestant theology both share unfavorable views on sexual relations outside the bounds of marital union, Protestant denominations have increasingly prioritized the prevention of negative SRH outcomes in acknowledgment of the HIV/AIDS epidemic and SRH injustice. For instance, the Episcopal Church, the United Church of Christ, and the Unitarian Universalist Association have all argued for the inclusion of comprehensive sex education in Christian education curricula, endorsing models that promote abstinence while also teaching about healthy sexual practices, like disease-prevention methods (Boonstra 19-20). This is not to say all Protestant

denominations have aligned with this stance, as the Baptist Church, for example, has long engaged in contentious internal debate on the issue with highly respected Baptist leaders continuing to decry contraceptive use (Lupfer).

On the other hand, Roman Catholicism continues to ban contraceptive use even among married couples and remains committed to abstinence-only sex education. Though some disagreement has ensued within the Church's leadership, magisterial teaching has consistently articulated a strict prohibition on contraception, dictating the act of sexual intercourse to be morally permissible only within the bounds of marriage and only when open to procreation (Miller). Though this prohibition saw some relaxation in the mid-20th century,¹⁵ Pope Paul VI reversed this trend with the tremendously controversial *Humanae Vitae*, in which he reaffirmed the modern contraceptives ban that prevails today (Ibid.). As such, the Catholic Church attests that intra-marital natural family planning—also referred to as the mentioned rhythm or calendar method—is the only morally permissible method of family planning (Office of Population Affairs). Because this method is less effective than most modern contraceptives and is notoriously unreliable (Ibid., WHO “Family Planning), low-SES women whose accessibility to SRH services is limited to FBOs which do not provide or instruct contraception and provide only abstinence-only sexual messages are at a disadvantage, rendering them victims of reproductive injustice.

These differential priorities offer some explication for the steady decline of Roman Catholic affiliation and rise of Protestant affiliation in LA/C in recent decades. Although at least

¹⁵ Gradually, sex as an expression of marital love rather than solely procreative became more acceptable within the Catholic Church. In the 1950s and 60s, the church began to perceive marriage as a means of both procreation and the development of the person, somewhat relaxing prohibitions on non-procreative sex within marriage (Miller).

90 percent of the Latin American population identified as Catholic from 1900 to the 1960s, this percentage has dwindled to 69 percent (Pew Research Center 4). Furthermore, the LA/C region, like other parts of the developing world, has become increasingly Protestant in recent decades. 84 percent of the Latin American population were raised Catholic, whereas only 69 percent currently identify with the religion; conversely, 9 percent of the population were raised Protestant, and 19 percent currently identify as Protestant (Ibid. 4). In Honduras, 26 percent of current Protestants report being raised Catholic. 61 percent of the Honduran adult population was raised Catholic, and only 46 percent currently identify with Catholicism—a 15-percentage point decline (Ibid. 5). These trends have resulted in an almost equal distribution of Protestants (41 percent) and Catholics (46 percent) in Honduras (Ibid. 14). Regardless, Christianity has been inculcated in LA/C since the colonial era, and Roman Catholicism underwent substantial change in the mid-20th century.

Liberation Theology: An Overview. Liberation theology is a Christian theological and spiritual movement which can be traced to the second Latin American Bishop's Conference (CELAM II) in Medellín, Colombia in 1968. Here, the bishops decried the Church's tepid response to the persistent poverty, income inequality, and social injustice and oppression in LA/C. In this sense, liberation theology represents a response to centuries of division between hierarchical Church officials and LA/C's deprived population (Tombs 3-86). In the 1960s, many Latin American priests and theologians increasingly sought to harness faith to social activism. This pressure culminated at CELAM II, where the bishops demanded action to fight poverty as an integral part of Christian faith (Ibid. 96). Gustavo Gutiérrez, a Peruvian pastor and theological

advisor to CELAM II, pioneered the basic principles of liberation theology in his book, *Teología de la liberación, Perspectivas*,¹⁶ published in 1971 (Ibid. 115).

David Tombs identifies three key elements in Gutiérrez's work (120). First, Gutiérrez asserted that theology must both reflect on and respond to its social context (Ibid. 121-123). He urged orthopraxis—"the dialectic of action and practice guided by reflection and thought"—over orthodoxy—the proclamation and acceptance of correct doctrine (Ibid. 122). As Gutiérrez affirms in his book: "This is a theology which does not stop with reflecting on the world, but rather tries to be part of the process through which the world is transformed" (Gutiérrez *A Theology of Liberation* 12). Second, Gutiérrez aligned the concept of salvation with that of liberation at three levels—from economic exploitation, from fatalism,¹⁷ and from sin¹⁸ (Tombs 123-125). These three levels of liberation address the political, existential, and spiritual components of human existence in a way the term 'development' cannot (Ibid. 125). Third, Gutiérrez called for active and intentional political participation by the church, underscoring the necessity of a pastoral option grounded in solidarity with people experiencing poverty and protest of the oppressive economic structures that contribute to that plight (Ibid. 136).

Liberation Theology, Poverty, and Reproductive Justice. The preferential option for the poor is an axiom of liberation theology that "displays the universality of God's love for all—a love that, in a world structured to the benefit of the powerful, extends even to the least among

¹⁶ The book used for analysis, *A Theology of Liberation*, is a revised version of the English-language translation of Gutiérrez's original book and was published in 1973.

¹⁷ This level of liberation refers to the attainment of personal freedom and control over one's destiny, which Gutiérrez considered complementary to liberation from exploitation, but an independent classification (Tombs 125).

¹⁸ According to Gutiérrez, this type of liberation permits communion with God (Ibid. 125).

us” (Farmer and Gutiérrez 28-29). In other words, while human social structures typically prefer and prioritize those with wealth, power, and status, Jewish and Christian scriptures repeatedly depict God prioritizing and protecting the poor, the lowly, and the outcast. Gutiérrez beautifully illustrates this concept in *In the Company of the Poor*:

...The poor person does not exist as an inescapable fact of destiny. His or her existence is not politically neutral and it is not ethically innocent. The poor are a by-product of the system in which we live and for which we are responsible. They are marginalized by our social and cultural world. They are the oppressed, exploited proletariat, robbed of the fruit of their labor and despoiled of their humanity. Hence the poverty of the poor is not a call to generous relief action, but a demand that we go and build a different social order. (Farmer and Gutiérrez 35).

God’s love, both in its universality and in its preferentiality, provides the theological grounding for the Christian doctrine of human dignity.

Gutiérrez characterizes poverty as a violation of human dignity and cites James 2:14-17 (NIV) to illustrate the Christian obligation to combat it:

What good is it, my brothers and sisters, if someone claims to have faith but has no deeds? Can such faith save them? Suppose a brother or a sister is without clothes and daily food. If one of you says to them, “Go in peace; keep warm and well fed,” but does nothing about their physical needs, what good is it? In the same way, faith by itself, if it is not accompanied by action, is dead. (*James*)

Oscar Romero, an El Salvadoran pastor and bishop famous for his dedication to the poor in the mid-20th century, offered the following example to inform this decree:

A building is on fire and you’re watching it burn, standing and wondering if everyone is safe. Then someone tells you that your mother and your sister are inside that building. Your attitude changes completely. You’re frantic; your mother and sister are burning and you’d do anything to rescue them even at the cost of getting charred. That’s what it means to be truly committed. If we look at poverty from the outside, as if we’re looking at a fire, that’s not to opt for the poor, no matter how concerned we may be. We should get inside as if our own mother and sister were burning. Indeed it’s Christ who is there, hungry and suffering. (*Livesimply* “Community & Participation)

Gutiérrez and Romero rebuke Christians who passively acknowledge the evil and injustice of poverty without actively participating in its undoing. Elsewhere, Gutiérrez interprets Micah 6:8 (“What does the Lord require of you? To act justly and to love mercy and to walk humbly with your God.” (NIV)) to mean that “the promotion of justice...is...an element so fundamental to biblical revelation and church teaching that personal decisions made in regard to it become decisions for or against the faith itself” (Gutiérrez *Gustavo Gutiérrez: Essential Writings* 12). Similar verses demanding solidarity with the poor as essential in Christian faith are riddled throughout the Bible (see Proverbs 14:31 and Mark 9:37).

The preferential option for the poor and liberative praxis both require reflection and action on poverty and health injustice. As Gutiérrez explains, many Christians conceive of poverty as a product of fate, nature, or God’s will rather than the product of unjust structures (Farmer and Gutiérrez 28-29). Liberation theology challenges these perceptions, portraying poverty as a grave evil, created and maintained through sinful and selfish human choices and actions. For Gutiérrez, poverty is intimately related to mortality and poor health. He even equates poverty with early death and characterizes humans’ acquiescence or acceptance of poverty as an unacceptable rejection of God’s will (Ibid. 29-30, Gutiérrez *Gustavo Gutiérrez: Essential Writings* 144). Gutiérrez elaborates: “diseases make their own preferential option for the poor...Capitalizing on a lack of access to sanitation, to good food and nutrition, and to basic health care, diseases are most at home in the midst of grinding poverty” (Farmer and Gutiérrez 30). Though he is specifically referring to outbreaks of tuberculosis and cholera, the concept applies to poor SRH, as well, considering the noted association between poverty and HIV/AIDS and maternal morbidities. These health dangers are often a result of the access issues Gutiérrez describes and more, such as contraceptive insecurity. Moreover, there are multiple instances of

Jesus healing the ostracized sick in the Bible. Throughout the Book of Matthew, Jesus heals the blind, the mute, the paralyzed, and others with a variety of infirmities (*Matthew*). These biblical occurrences contribute to the notion that poverty and its resultant health deficiencies are synthetic divergences from God's will. Because reproductive injustice is largely a product of poverty and its corollaries, it should also be considered divergent from God's will and addressed as such.

V. Conclusion

The state of SRH in Honduras is unjust. Because Christian FBOs—especially Roman Catholic FBOs—often fail to provide comprehensive sex education and modern contraceptives, they do not adequately combat this injustice. Liberation theology employs biblical demands to condemn passivity in the Christian response to poverty, thereby decrying the FBOs in question for refusing to implement programming with the most efficacy power. These FBOs do not fully promote human dignity and reproductive justice for Honduran adolescent women; to use Oscar Romero's visual, they are not running into the burning building with the most powerful tools at their disposal to rescue their brothers and sisters in Christ from the flames of oppression. Given their solid position in Honduras, Latin America and the Caribbean, and the developing world in general, faith-based organizations should adhere to the tenets of liberation theology and provide comprehensive sex education and contraceptives to adolescent women expressing need.

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