Channels of HOPE
MATERNAL, NEWBORN AND CHILD HEALTH

World Vision

EXECUTIVE SUMMARY

Spirituality as a conduit for social transformation?

Rethinking secular and religious assumptions in development practice

Report and Critical Research Reflection on Channels of Hope HIV&AIDS and MNCH – Zimbabwe

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Centre for Religion, Conflict and the Public Domain

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Congregants after a day of prayer service held by Robert Sinyoka ADP. This is one of the various activities that the ADP has done in partnership with the church.
photo: Leonard Makombe/World Vision

Faith and spirituality in development

Channels of Hope (CoH) provides education and training for faith leaders on issues traditionally associated with stigma and marginalisation in developing contexts. Issues include HIV and AIDS; gender-based violence; maternal, newborn and child health (MNCH); and child protection. CoH has seen tremendous success in altering attitudes of local religious leaders and motivating them to change the attitudes in their communities in project areas with varying religious, cultural and socioeconomic demographics. Yet exactly how and why such dramatic shifts in attitudes occur, the effectiveness of engaging explicitly with faith and the extent of CoH's success are largely unknown.

This report has been prepared as part of a broader research project funded by the NWO (the Netherlands Organisation for Health Research and Development).[1] The purpose of the project was to explore these dimensions to contribute to better practice in development as well as broader societal and academic understandings of the place of faith and spirituality in development. The objective of the data collection, evaluation and report is twofold:[2]

1. to provide direct and immediate feedback to World Vision International on its CoH MNCH and HIV&AIDS programmes for strengthening and improvement of these programmes
2. to generate insights regarding the significance for religion and spirituality in addressing widespread societal problems and encouraging attitudinal and behavioural change.

This report focuses predominantly on CoH MNCH, incorporating some reference to CoH HIV&AIDS. Data was collected through individual and group semi-structured interviews with key informants and stakeholders on different levels in two World Vision area development programmes (ADPs) in Zimbabwe.[3] This included:

- male church leaders/congregants (exposed and not exposed to CoH)
- female church leaders/congregants (exposed and not exposed to CoH)
- local leaders
- individual interviews with faith leaders exposed to CoH
- ADP staff (exposed and not exposed to CoH).

Initial findings were presented at a workshop in The Hague in June 2015.[4] Feedback from workshop participants contributed to the analysis in the final report.[5]

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[1] This research project developed out of an existing collaboration among three groups: the Centre for Religion, Conflict and the Public Domain at the Faculty of Theology and Religious Studies, University of Groningen; the Knowledge Centre Religion and Development at Oikos in Utrecht; and World Vision.
[2] The full report focuses predominantly on the first of these objectives. Discussion pertinent to both issues may be found in Part II of the report.
[3] Detailed discussion of the interviews and informants' identification of problems, challenges, successes and weaknesses of CoH is provided in Part III of the report, with the discussion of in-depth biographical narrative data in Part IV.
[4] The workshop, titled 'The Spiritual Is Political: Exploring Transformations in Religion and Development', explored questions related to the themes of the research project.
[5] These issues are addressed in Part V, the conclusion and recommendations section of the report.

Key findings[6]

Robert Sinyoka and Lupane ADPs

Key changes in the last five years noted by the community

HIV

- Increased community knowledge about HIV.
- Reduced stigmatisation of people living with HIV.
- Increased access to medication.
- Improved hygiene practices.
- Increased unity in the communities, which interviewees stated was largely due to sensitisation through CoH.
- Increased community ownership of education activities to raise awareness about HIV.

MNCH

- Greater awareness of the importance of men's roles in the birthing process.
- Increased knowledge of medical issues, including the importance of breastfeeding, postnatal care.
- Increased willingness (among women) to be tested for HIV.
- Greater openness to discussions about HIV and MNCH.
- Development of special programmes, including community and after-church meetings, social and sporting events, for men promoting gender equality (primarily an outcome of CoH participation.)
- Increased openness in churches to engage in awareness raising, advise women to visit clinics and encourage spouses to accompany them, running special education weeks.
- Increased rates of clinic bookings and hospital births, reducing infant and maternal mortality.
- CoH highlighted as an important factor in positive community changes, even by interviewees who had not participated in a workshop.
- Some increase in male participation in pregnancy and postnatal care.
- Bible and religious teachings highlighted by interviewees as significant components in producing change.
- Clinics giving preference to couples attending the clinic together to encourage male involvement. (This can also have negative effects for single mothers and therefore should be monitored carefully.)

[6] See Part III of the full report for further details and discussion.

Key changes in faith communities

- Previously taboo subjects, such as pregnancy and sexuality, now discussed more openly after pastors were trained in the CoH programme.
- Increased awareness-raising activities on MNCH in churches, offering support services and some discussion in sermons.
- Greater emphasis within the faith community on registering babies and regular check-ups before and after the birth, education on danger signs of health complications for mother and child, free lectures on health and nutrition during pregnancy.
- Increased support and acceptance for all children, including those previously marginalised because of their gender (primarily girls) or because they were born out of wedlock, through child celebrations and similar events.
- Increasing interdenominational cooperation in general, attributed by interviews to participation in ecumenical CoH MNCH workshops.
- Greater openness of churches to people in the communities, offering educational and support programmes on HIV, including marriage counselling and intervention if one partner becomes infected (attributed to impact of CoH).

Ongoing challenges

- Continued reluctance of men to be involved in MNCH and how to encourage involvement, particularly amongst those men not involved in church.
- Teenage pregnancy attributed to poverty, peer pressure, and experienced lack of support and acceptance.
- Need to engage more young people in CoH, including education on MNCH, HIV and sex education.
- Financial constraints preventing or inhibiting organisation of workshops.
- Distance and lack of transport preventing many women from reaching the clinic in time when leaving from their villages; as a result, women sometimes give birth on their way to the clinic, contributing to birth complications.
- Involvement of men in birth and postnatal care has improved but is still low.

Recommendations (made by the community)

Gender/male involvement

- Engage men in creative, direct ways, such as after-sports events, men-to-men teaching/workshops, funerals, at their workplaces or in their homes.
- Involve community leaders more directly and actively in outreach to men on MNCH and HIV.
- Introduce role model/mentor programme where men who have been through CoH become role models/mentors for other men.

Sexuality, education and youth

- Organise social activities and vocational trainings for youth to address poverty and unemployment as factors contributing to early sexual activity and teenage pregnancy.
- Include young people in CoH MNCH and HIV workshops.
- Develop age-appropriate children/youth module about puberty and sexual education (this must be undertaken with caution).
- Provide education for teachers and parents.
- Consider peer-to-peer education approach because of increasing gap in influence between older and younger generations.
- Develop life-skills projects targeting youth or school dropouts so they have something that will help them to stay focused.

Leadership

- Train the village heads/leaders so that they understand these issues better.
- Continue efforts to reduce stigmatisation and encourage understanding and support for pregnant girls in the community.
- Involve elders, traditional and community leaders when workshops are being organised; include elderly leaders who still believe in traditional norms so they become part of the process.
- Include law enforcement agents in the workshops.

Community

- Strengthen existing structures so that everyone can access bookings, health checks and screening (including HIV&AIDS).
- Introduce a mobile clinic for HIV and/or pregnancy screening.
- Use (social) media to advocate certain messages with regard to MNCH and HIV&AIDS.
- Improvement of health facilities.

Sandra's mother passed away and the household of four girls is headed by her father, Sibonginkosi, who underwent Channels of Hope training with World Vision in Lupane ADP.
photo: Michelle Siu/World Vision

Key findings: A faith-based approach[7]

- Use of scripture in CoH is a key strength and benefit for faith leaders.
- Interviewees identify pastors and churches as key instigators of change following participation in CoH.
- Emphasis by interviewees on the importance of the spiritual dimension of social transformation at both the individual and community levels, suggesting this should be taken seriously by organisations seeking to support social transformation in these communities.
- Although not identified as necessarily leading to a single moment of transformation for interviewees, CoH is often a significant part of a broader process of transformation, in some cases narrated as part of a life-long process of transformation.
- Language is significant – organisations must be careful to use language that is contextually appropriate and sensitive to the worldviews and needs of the community in which they are working, avoiding secular development terminology which overuses jargon and could be perceived as a Western imposition, whilst at the same time being careful not to use religious language and approaches too extensively.
- Both secular and religious approaches to development can contain normative moral value judgements that sometimes cohere and sometimes conflict; organisations and practitioners need to be critically self-aware and reflective in regard to the presence and impact of these embedded moral norms and the influence of moral values.
- Gendered power dynamics continue to affect and potentially undermine the contribution of faith-based approaches, particularly if the initial targets of CoH workshops are formal faith leaders, who are predominantly male.

[7] See Part IV of full report for further details and discussion.

Conclusions and recommendations[8]

Gender

- Accompany implementation of CoH MNCH with simultaneous **implementation of CoH Gender** to address issues of stigma and gender inequalities that also affect MNCH issues.
- Very positive impact was reported by all groups, yet a difference between women and men was noticed related to women's bodies and the challenges they face. **Women are eager to see change in the communities**. This indicates that CoH has been a success but continued efforts and new energy are needed. Continue efforts to involve men within but also beyond the churches.
- Combine CoH with activities that are explicitly designed to **involve men**, such as sports events, men's forums, or financial training (an example from Kenya) as a way to expose more men in the communities to issues surrounding MNCH. Run men-only CoH trainings (or have part of the CoH trainings gender exclusive) to create safe spaces for men to ask questions about these issues without feeling uncomfortable in the presence of women.

Leadership

- Rather than focusing solely on religious leaders in the initial introduction of CoH in a community, **broaden leadership focus** by bringing together a combination of religious leaders, village heads and ward councillors. Involving village heads and ward councillors will help raise awareness on these issues, increasing possibilities for influencing men in the community. In addition, it will help build relationships for future cooperation amongst religious leaders, village heads and ward councillors.
- Rather than initially focusing solely or primarily on people who hold formal positions of leadership within hierarchical church structures – who, for a variety of reasons, are predominantly men – CoH should **include informal faith leaders** from the very beginning. Leadership can be developed (and has been developed) by people in the community who may have not received the opportunity before due to constraining circumstances including gender, class and education. By acknowledging leadership (rather than formal leaders), CoH could have a secondary influence on improving the position of women as well. This may include other forms of empowerment such as the improvement of women's literacy through, for example, education in scripture.

Sexuality, education and youth

- **CoH could be broadened to address and include other issues such as youth, sexuality education with faith leaders and the community**. In addition, a CoH model for youth that addresses sexuality, health, and relationships as well as sensitive issues such as sexual and gender-based violence is very much needed.
- There is a more general need (beyond CoH and World Vision) for **a good model for youth-friendly sexuality education** that integrates evidence-based information and faith perspectives and that is culturally sensitive.

[8] See Part V of full report for further details and discussion.

Community

- **Challenges** that people in the community report should be acknowledged. While building hospitals or setting up a mobile clinic may be extremely expensive, and not feasible in villages too close to the main hospital, challenges to booking in early or being in time to give birth at the hospital should be taken seriously. Creating or expanding the maternity waiting home could be a way to tackle challenges with regard to early booking and hospital deliveries.
- Introduce **advocacy and citizenship** training following the introduction of CoH to provide CoH participants with skills to address wider social and political structures that inhibit improvements in MNCH, such as lack of access to clinics, insufficient education on breastfeeding and so on.

Monitoring and evaluation

- In the longer term we recommend improved monitoring and evaluation systems that enable measurement of change through, for example, the gathering of baseline statistics on issues such as:
    - maternal and newborn infant mortality rates
    - child mortality rates
    - rates of breastfeeding
    - home births vs hospital births.
- We recommend selecting individuals and communities for research pre-exposure and post-exposure to CoH to determine the extent to which participation in CoH results in lasting attitudinal and behavioural change as well as the types of change that occur.

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