



## **Engaging Faith-Based Organizations in the Response to Maternal Mortality**

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“Faith-inspired organizations have many different opportunities. The point that is often reiterated is that religions are sustainable. They will be there before the NGOs get there and will be there long after.” Katherine Marshall, executive director, World Faiths Development Dialogue, WWICS, November, 2011

### **Empowering Faith-Based Organizations to Improve Maternal Health**

Faith-based organizations (FBOs) are often at the frontline of healthcare in developing countries and have networks in the most remote regions. Their close links to communities provide them with an opportunity to promote behavior change and address other cultural factors contributing to maternal mortality rates such as early marriage and family planning. Working in collaboration with FBOs and other stakeholders is critical to promoting demand for maternal and reproductive health services; however, limited knowledge about faith-based maternal healthcare exists and FBOs are often left off the global agenda.

As part of the *Advancing Dialogue on Maternal Health* series, the Woodrow Wilson International Center for Scholars’ Global Health Initiative collaborated with the World Faiths Development Dialogue and Christian Connections for International Health to convene a small technical meeting on November 15, 2011, with 30 maternal health and religious experts to discuss case studies involving faith-based organizations in Bangladesh, Nigeria, Pakistan, and Yemen. The country case studies served as a springboard for group discussion and offered a number of recommendations for increasing the capacity of FBOs working on maternal health issues.

Recognizing the importance of local cultural and social norms to successful program implementation, donors and policymakers should shift from small, short-term, project-oriented activities to local, regional- and national-level advocacy programs that build sustainable change. To realize the promise that civil society organizations, including FBOs, hold for addressing maternal health issues, country-level mechanisms should be developed to coordinate efforts between government agencies, FBOs and other NGOs, and across faiths. These organizations’ capacity to document and assess what they do also needs strengthening.

The maternal health community needs to show greater will in engaging the faith-inspired community. Working with FBOs requires special attention to building relationships. Most religious leaders are willing to engage and promote behaviors and values that support health and respect for women, and they can appreciate aspects of a human rights approach to maternal health. But gaining their trust may require special sensitivity and acknowledgement of their stature in the community, and a nuanced understanding of how they frame early marriage, family planning, and other maternal health-related topics.

### **Case study: Bangladesh**

“As a faith-based organization, we believe it is a God-given right to safe health care and delivery, so we mobilize communities to support pregnant women to address their needs, [and] educate families about referrals and existing services in the community”, said Elidon Bardhi, country director, Adventist Development Relief Agency (ADRA) in Bangladesh. Through women-run community organizations, ADRA educates men and women about the danger signs of labor and when to seek care. For example, many men in Bangladesh believe that women should eat less during pregnancy to ensure a smaller baby and easier delivery. ADRA addresses such harmful views through a human-rights-based approach and emphasizes male participation in health services as a key strategy by ensuring there are seven male clients for every female.

### **Case study: Nigeria**

The Nigerian Urban Reproductive Health Initiative (NURHI) is a public-private partnership that creates interventions for integrating family planning with maternal health. The term “family planning” is not as acceptable as “safe birth spacing,” so the project drew on research to demonstrate how family planning can help space births and save lives. Religion and culture play an important role in the behavior of any community. The introduction of a controversial health intervention (such as family planning) in a religiously conservative community requires careful assessment of the environment and careful planning for its introduction. According to Kabir Abdullahi, team leader of NURHI, baseline surveys, formative research and net-mapping helped NURHI understand the social context and refine intervention components.

### **Case study: Pakistan**

“When working with religious leaders to improve maternal health, there are some do’s and don’ts,” said Nabeela Ali, chief of party with the Pakistan Initiative for Mothers and Newborns (PAIMAN). The PAIMAN project worked with 800 religious leaders (*ulamas*) to increase awareness about pregnancy and promote positive behavior change among men. To ensure their impact, the project leaders selected influential *ulamas* with large congregations. The *ulamas* who participated in the PAIMAN project did not like the word “training,” so instead PAIMAN labeled their educational outreach “consultative meetings”. In the presence of senior religious scholars, who also attended the consultations, the *ulamas* learned about maternal health interventions and developed key messages to share during their sermons. More than 200,000 men and women were reached during the sermons, and the strategy has been adopted by the government of Pakistan as a best practice, and written into in the Karachi Declaration signed by the Secretaries of Health and Population in 2009.

### **Case study: Yemen**

“Religion is a main factor in decisions Yemeni people make about most issues in their lives, and religious leaders can play a major role in behavior change,” said Jamila AlSharie, a community mobilizer with Pathfinder International. Eighty-two percent of women say the husband decides if they should receive family planning, while 22 percent of women say they do not use

contraception because they believe it is against their religion – they instead tend to view their fertility as the will of God.<sup>1</sup> The adoption of behavior change for health therefore required the involvement of key opinion leaders and the alignment of messages based in religious values. Trainings with religious leaders covered family planning from an Islamic perspective, risks associated with early pregnancy, nutrition and education, and healthcare as a human right.

## **Ten Ways Forward to Increase the Capacity of FBOs**

Faith-based organizations' close links to communities provide them with an opportunity to promote behavior change and address other cultural factors contributing to maternal mortality rates such as early marriage and family planning.

Working in collaboration with FBOs and other stakeholders is critical to promoting demand for maternal and reproductive health services; however, there is limited knowledge about faith-based maternal healthcare and FBOs are often left off the global health agenda.

1. Move projects to programs: Projects are often donor driven and limited in scope and duration. Donors and policymakers should move from project-oriented activities to local, regional, and national-level advocacy programs to build sustainable change.
2. Coordinate, coordinate, coordinate: Significant resources are wasted due to a lack of coordination between FBOs and development agencies. A country-level coordinating mechanism should be developed to streamline efforts not only between agencies but also across faiths.
3. Context, context, context: A thorough understanding of the local culture and social norms is imperative to successful program implementation.
4. Terminology is important: In Pakistan, religious leaders redefined sensitization meetings around family planning and maternal and child health as “consultative meetings” not “trainings.” In Nigeria, the culture prefers “child birth spacing” over “family planning.” In Yemen, it’s “safe age of marriage” instead of “early childhood marriage.”
5. Most religious leaders are open and with adequate information can produce behavior and value changes. Utilizing the Quran, Hadith, and Bible can support arguments and emphasize the issue of health and gender equity.
6. Relationship building: Winning the trust of religious leaders can be difficult and time-consuming but is necessary for opening doors to patriarchal societies.
7. Rights-based approach: A human rights-based approach can be a very powerful agent of change for addressing negative social structures such as violence against women, but it can also create controversy. In Bangladesh, ADRA utilized the approach to educate men about nutrition, dowry and child marriage, and education of women.
8. Networks: There is a significant need to create forums that bring together the various FBO and global development communities in order to share knowledge and enhance advocacy messages. Networks are needed to streamline resources and inventory existing research, projects, and faith-based models that work.
9. Monitoring and evaluation systems: There is a striking lack of data about the impact and outcomes of FBOs. Increasing the monitoring and evaluation skills of FBO workers can improve evaluation systems and meet the demand for new data.

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<sup>1</sup> Jamila Alsharie, community mobilizer, Pathfinder International, WWICS, November 2011

10. There needs to be greater political will for engaging the faith-inspired community.<sup>i</sup>

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<sup>i</sup>The Engaging Faith-Based Organizations in the Response to Maternal Mortality meeting took place on November 15, 2011, at the Woodrow Wilson International Center for Scholars in Washington, DC, USA, and was jointly organized by the Maternal Health Task Force, UNFPA, Christian Connections for International Health, and World Faiths Development Dialogue. This report attempts to capture the rich discussion generated by the following participants: Kabir Abdullahi, Nigerian Urban Reproductive Health Initiative; Angeli Achrekar, Department of State; Marie Alford-Harkey, Religious Institute; Nabeela Ali, Pakistan Initiative for Mothers and Newborns; Jamila AlSharie, Pathfinder International; Elidon Bardhi, Adventist Development Relief Agency, Bangladesh; Sandeep Bathala, WWICS; Mona Bormet, Christian Connections for International Health; Sarla Chand, IMA World Health; Lisa Cobb, Johns Hopkins Center for Communications Program; Jean Duff, Full Circle Partners; Hahna Fridirici, World Faiths Development Dialogue; Sonya Funna, Adventist Development Relief Agency; Fe Garcia, World Vision International; Anny Gaul, Berkley Center for Peace, Religion and World Affairs; Samantha Lattof, Harvard University; Katherine Marshall, World Faiths Development Dialogue; Ray Martin, Christian Connections International Health; Henry Mosley, Johns Hopkins University; Jacqueline Ogega, Religions for Peace; Calyn Ostrowski, WWICS; Erika Pearl, IMA World Health; Areana Quinones, Catholic Medical Mission Board; Rick Santos, IMA World Health; Kristin Savard, White Ribbon Alliance; Mary Ellen Stanton, U.S. Agency for International Development; Tim Thomas, Maternal Health Task Force; Sharon Tobing, Adventist Development Relief Agency; Rev. Judith VonOsdo, El Milagro; and Claudia Zambra, World Faiths Development Dialogue.

This report was drawn from excerpts in the *Delivering Solutions: Advancing Dialogue To Improve Maternal Health* publication and event summary of the public event which took place on November 16, 2011 at the Woodrow Wilson Center.