



Faith and Family Planning Webinar

# Educating Religious Leaders about Family Planning: What Does the Research Reveal?

25 April 2024

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## DR. AGREY MWAKISOLE

### SPEAKER

Dr. Agrey Mwakisole is Principal Emeritus and Professor at Mwanza Christian College in Mwanza, Tanzania. He received his BA from Pan-Africa Christian University in Tanzania and his MA in Leadership from Pan-Africa Christian University in Nairobi. In 2015, he received his Doctorate of Intercultural Studies (D.I.S.) from Fuller Theological Seminary (California, USA). Dr. Mwakisole is also Director of Theological Education for Pentecostal Churches of Tanzania, and Chairman of the Interfaith Council that oversees Christian and Muslim dialogue in the Mwanza and Kagera regions in Tanzania. In these roles, he oversees church leadership education at several Tanzanian seminaries and works with Muslim leaders to promote peace between Christians and Muslims in Tanzania.





## DR. JENNIFER DOWNS

### SPEAKER

Dr. Jennifer Downs is an Associate Professor of Medicine and the Ehrenkranz Family / Orli R. Etingin, M.D. Associate Professor of Women's Health at Weill Cornell Medicine. She conducts research and teaches at the Weill Bugando School of Medicine in Mwanza, Tanzania. Dr. Downs received her M.D. from Weill Cornell Medicine and her Ph.D. in Parasitology from Leiden University and is board-certified in Internal Medicine and Infectious Diseases. A major focus of her research is women's health, including female genital schistosomiasis and mucosal immunity in girls and women in Tanzania. She also conducts community-based implementation science studies to improve access to family planning and uptake of health prevention interventions in rural Tanzanian communities.





MONA BORMET, MPH, CHES

MODERATOR

Mona Bormet, MPH, CHES serves as Program Director for CCIH. Mona directs a global portfolio of initiatives that improve timely access to quality health services in communities and facilities, by working with faith-based partners and CCIH members around the world. She also directs CCIH's annual conference. Mona began working with CCIH as an individual member and volunteer, and since 2010 has been on staff, first focused on US advocacy efforts. Previously, Mona served as Advocacy Program Specialist for the Asian & Pacific Islander American Health Forum. Mona has an MPH from the University of Minnesota School of Public Health and a BS from Illinois State University. She received the American Public Health Association International Health Section Mid-Career Award in 2023.



**Weill Cornell  
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# Educating Religious Leaders about Family Planning: What does the research reveal?

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25 April 2024



# We're presenting on behalf of many co-investigators...

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**Weill Cornell Medicine**



Mwanza  
Christian  
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# Promoting healthcare in rural Tanzania

- Many people in Mwanza reported trusting health guidance from a religious leader more than guidance from a doctor<sup>1,2</sup>
- Two principal religions: Christianity and Islam
  - 93% rate religion as “very important” in their lives<sup>3</sup>
  - 83% attend religious services at least weekly<sup>3,4</sup>

1. Downs J et al, *BMJ Open* 2013

2. Aristide C et al, *BMJ Sex Reprod Heal* 2019

3. Lugo L, *Pew Research Center* 2010

4. Bullington B et al, *Sex Reprod Heal Matters* 2020

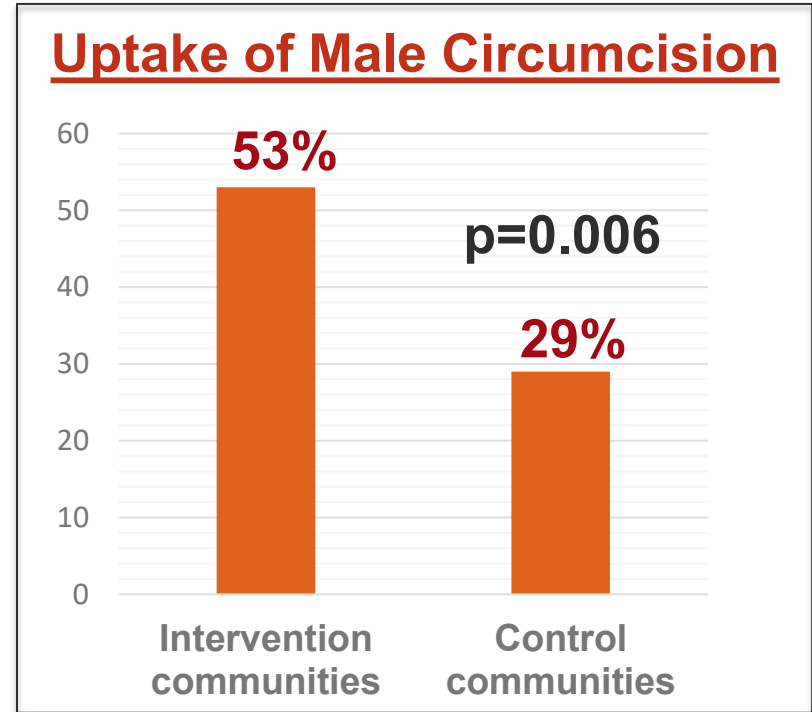


# Devout religious faith in sub-Saharan Africa

- In a survey of 19 sub-Saharan countries:<sup>1</sup>
  - 76% of people reported confidence in religious organizations
  - 51% reported confidence in health systems
  - 46% reported confidence in government
- A critical approach to community-level health:  
**Promote health using messages that are viewed as concordant with religious beliefs**

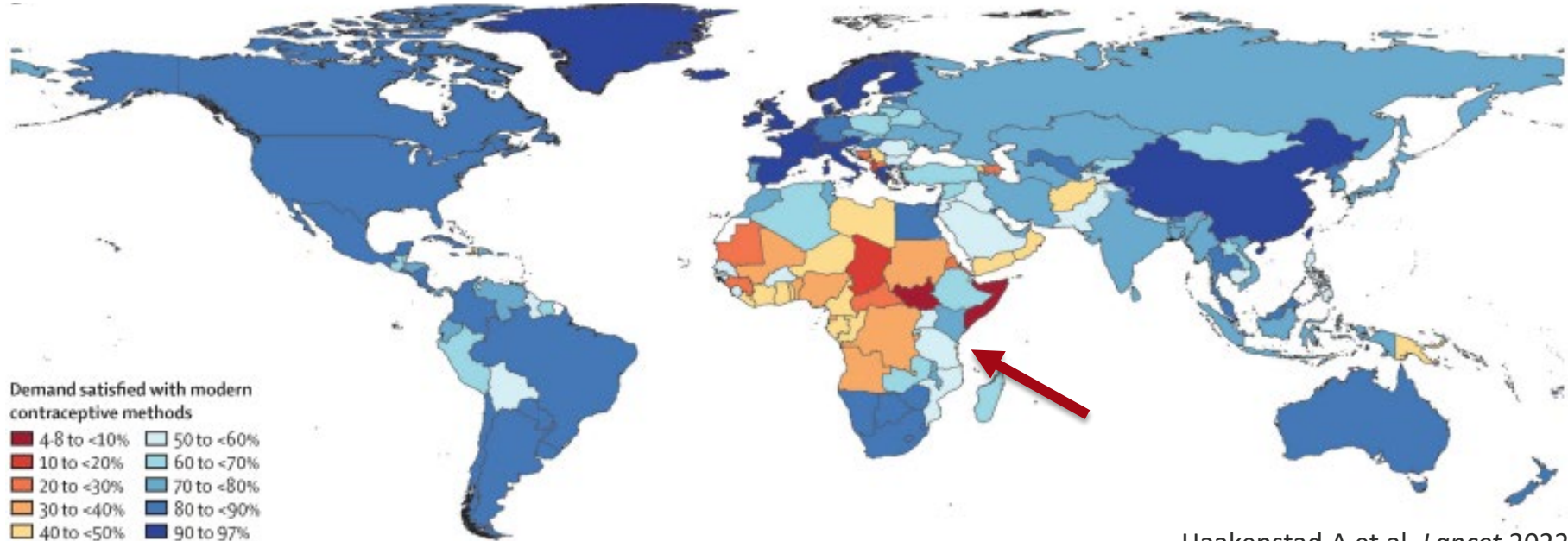
# Educating religious leaders is an effective way to promote healthy behavior

- Cluster randomized trial of >145,000 men
- Intervention: one-day educational seminar for religious leaders about male circumcision for HIV prevention



# Women in communities requested that we return to teach something relevant to them

Demand satisfied with modern contraceptives



# What are the barriers to uptake of FP?

1. Knowledge gaps
2. Refusal by male partners
3. Uncertainty about compatibility with religious beliefs



In-depth interview, 2016

# From obstacles to opportunities for FP

“The Bible hasn’t said anything about FP for Christians. Instead, it is **God himself who said to go and give birth**, multiply, and fill the land.”  
*-Christian man*

“When God says that you should fill the earth, he did not mean we should just give birth haphazardly. He meant that ... **you should give birth to the children that you can take care of in your life** ... If you do not take care of them, you just leave them? That is also a sin.”  
*-Christian woman*



# Can we engage religious leaders to promote uptake of family planning?

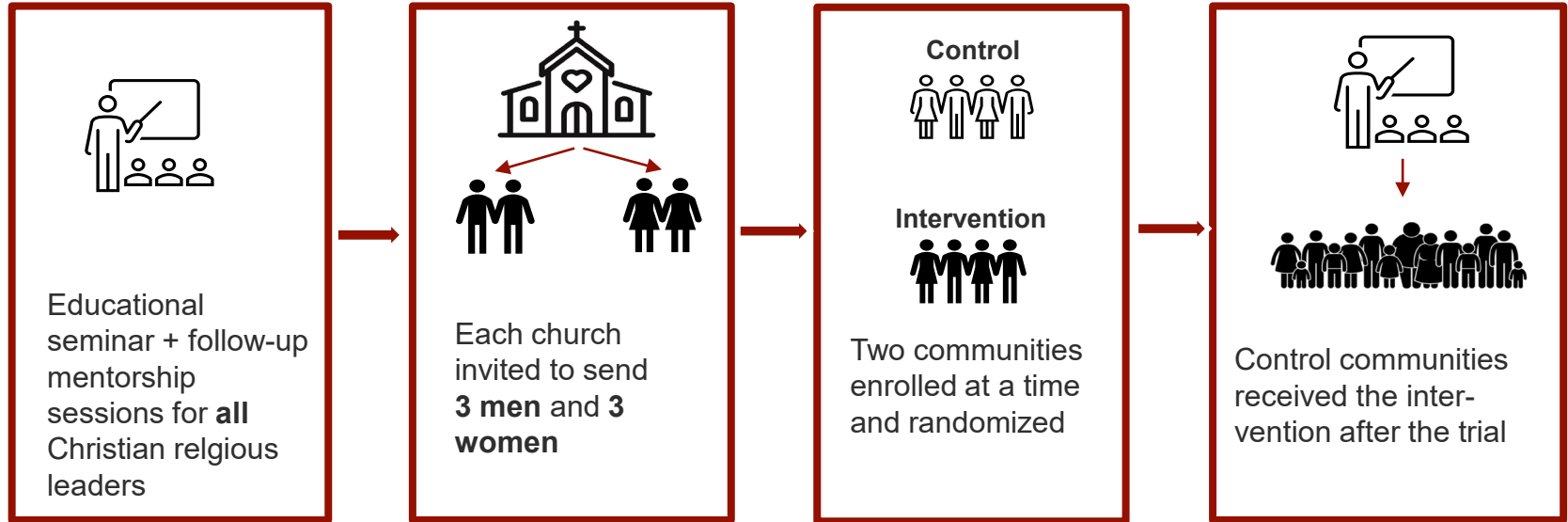
## A complex topic:

- FP use is a sustained health behavior (primary care intervention)
- Decision often depends on partner
- More community fears of side effects
- Requires visit(s) to health facility to obtain contraception
- Data collection for one year



# A cluster randomized trial in 24 communities

## Intervention:



# Intervention: a multidisciplinary educational seminar about FP for Christian religious leaders



- I. Major themes from interviews & focus group discussions
- II. Historical and biblical traditions about FP
- III. Medical teaching about the menstrual cycle & various FP techniques (mechanism, efficacy, side effects)



24 eligible communities were randomly selected, invited, and randomized (12 to intervention; 12 to control)



# Data collection & analysis

## From each community's health facility:

- Two years of programmatic data (age, sex, contraceptive obtained)
  - One year prior to intervention
  - Prospectively for one year post-intervention

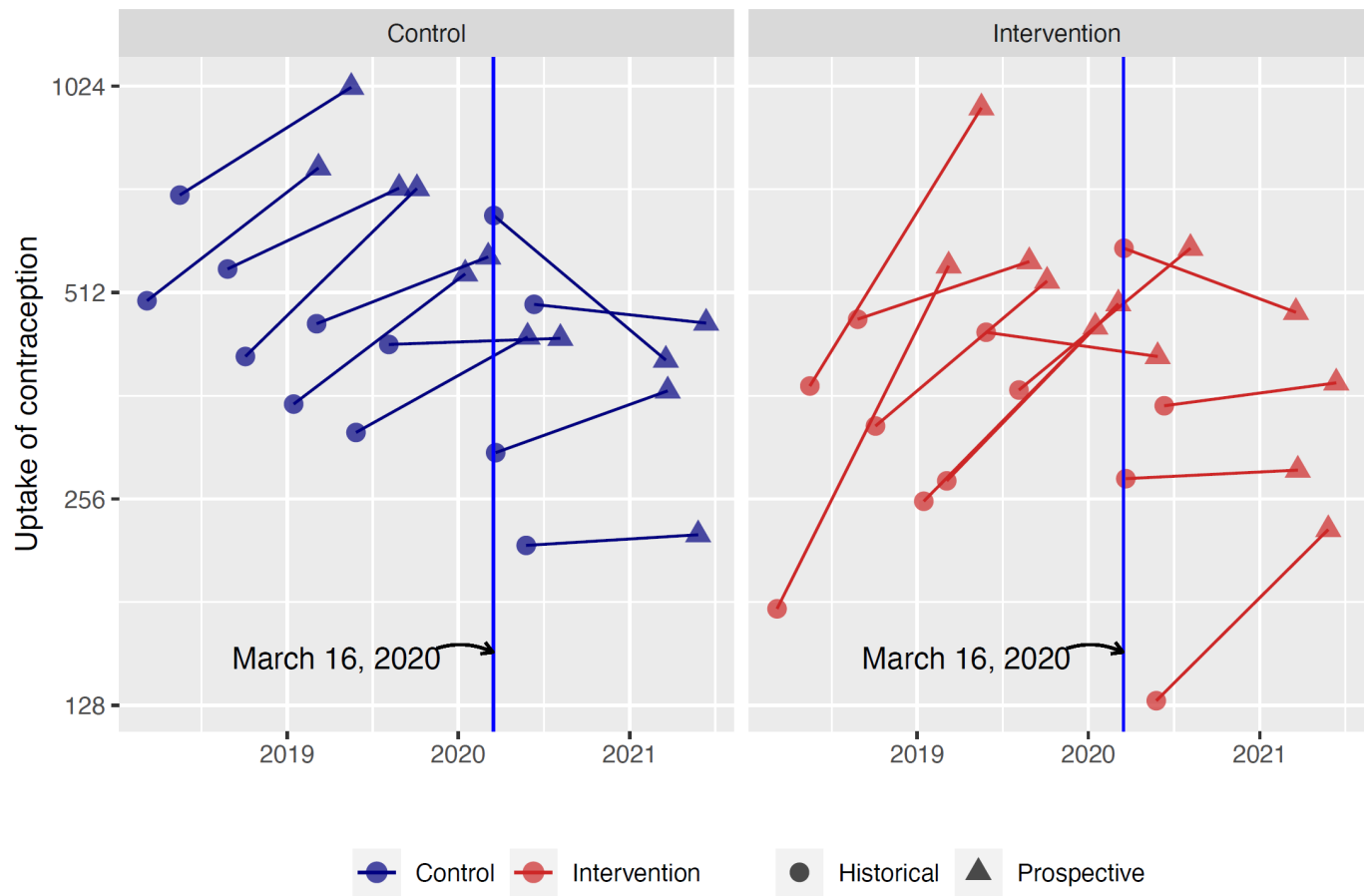
## In-depth interviews with community members & religious leaders

**Primary outcome:** Uptake of contraception (count of contraceptives dispensed) one year **prior** to intervention, versus one year **after** intervention

# Characteristics of health facilities in intervention and control communities

Characteristic	Intervention Facilities (n=12) Median [IQR]	Control Facilities (n=12) Median [IQR]
Total catchment area	10,736 [9,699 – 13,669]	12,581 [8,748 – 17,111]
Number of clinicians employed	4 [3.75 – 5]	4 [4 – 6.25]
Number able to place IUD	1.5 [1 – 3]	1.5 [1 – 2.25]
Availability of contraceptives (% in past 3 months)		
IUD	98 [0 – 100]	100 [37.5 – 100]
Jadelle implant	100 [41.75 – 100]	100 [87.5 – 100]
Implanon/NXT implant	100 [41.75 – 100]	100 [84.5 – 100]
Depo-Provera injections	50 [17 – 79]	79 [71.75 – 97]
Combined oral contraceptive pills	100 [100 – 100]	100 [75 – 100]
Condoms	100 [96 – 100]	100 [84.5 – 100]
Weekly visits for FP in year prior to intervention	7.1 [6.0 – 9.3]	9.3 [7.9 – 11.3]

# Both the Religious Leader Intervention *and* the Covid-19 pandemic profoundly affected FP uptake



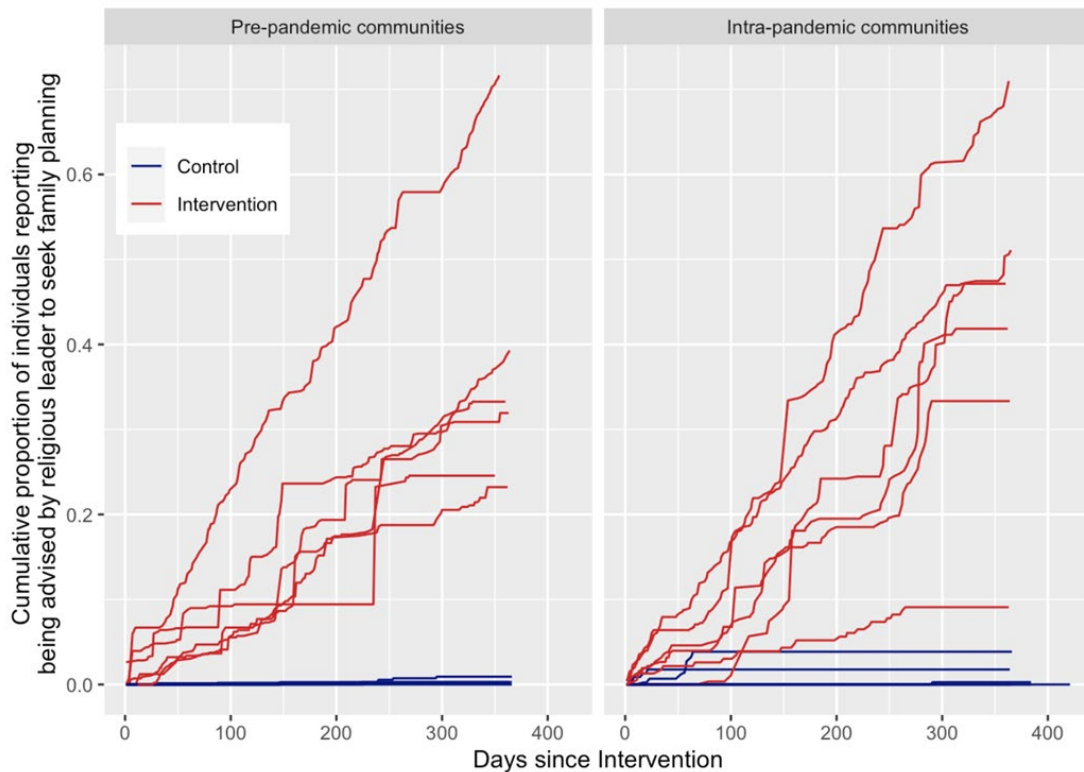
	% Change, p-value
Intervention effect	+19%, p<0.0001
Pandemic effect	-28%, p=0.004

30% increase  
(6 pre-pandemic communities only, P<0.001)

# Demographic characteristics of those seeking FP in the year post-intervention

	Intervention Communities (n=5938)	Control Communities (n=6718)	p-value
Age (years)	27.4 (SD 7.0)	26.7 (SD 7.0)	<0.001
Number of children	3.8 (SD 2.2)	3.5 (SD 2.2)	<0.001
Contraceptive dispensed			0.010
Intrauterine device	316 (5.3%)	345 (5.1%)	
Jadelle implant	1129 (19.0%)	1170 (17.4%)	
Implanon/NXT implant	2010 (33.8%)	2205 (32.8%)	
Depo-Provera injection	1763 (29.7%)	2077 (30.9%)	
Oral contraceptive pills	389 (6.6%)	379 (5.6%)	
Condoms	280 (4.7%)	357 (4.7%)	
Who advised you about seeking family planning?			<0.001
Religious leader	2422 (40.8%)	35 (0.5%)	
Nurse or doctor	847 (14.3%)	1778 (26.5%)	
Husband or boyfriend	432 (7.3%)	861 (12.8%)	
Friend	168 (2.8%)	522 (7.8%)	
Community announcements	260 (4.4%)	680 (10.1%)	
No response	1774 (29.9%)	2708 (40.3%)	

# Cumulative proportion of individuals seeking contraception who reported being informed about FP by a religious leader, before and during the COVID-19 pandemic



# Qualitative data to understand community perceptions

- In-depth interviews
- Religious leaders and community members
- During the trial and, recently, 4-5 years later

# 1) Religious leaders felt newly equipped to consider FP in the context of faith

**“The Bible hasn’t kept quiet:** it says that a person who doesn’t take care of his family is doing something bad, so you are supposed to have the power of **taking care of those children** so that they can have their basic needs.”

*-Male religious leader*

“I always **advise them to go to the hospital**, where they will get advice on how the family planning methods work.”

*-Male religious leader*



## 2) Women sought FP with optimism after hearing teaching that reconciled religious faith with experienced need

**“I felt relieved** to hear the announcement of family planning by a **religious leader**, it was **a very blessed thing** to encourage FP ... it helps someone to make decisions and say let me relax a little, children will have spacing between them, even the environment of caring for children you will have good one ... I said she has touched me and reminded me to use contraception, **when I went out there I told my husband I want to use contraception.**”

*-Female community member*

### 3) No evidence that religious leaders' teaching compromised women's contraceptive autonomy

“[the religious leader] just said everyone will decide according to her time. **She who would like to follow will follow, and she who would like to ignore it will ignore it...**

Some will see the benefits of family planning, although some will see no benefit and will ignore it.”

*-Female community member*



#### 4) Community members extended teaching they had received beyond religious institutions and into communities

“I have not heard in the church, but when **we sit in women’s groups, there are women who are church elders.** That’s when we start talking [about FP]. They are educating us about how FP is good and how it is safe to practice FP in your family.”

*-Female community member*

# We conclude that education for religious leaders led to increased uptake of FP.

- A longitudinal, primary care intervention
  - 30% increase pre-pandemic
  - 19% increase overall, accounting for pandemic effects
- Could lead to 1 million more women in Tanzania alone who no longer report an unsatisfied demand for FP



# A step towards promoting broader reproductive health goals...

- Uptake of FP is only one indicator
- Additional goals:
  - Women's autonomy
  - FP knowledge
  - Ability to achieve reproductive goals
  - Health of mothers and children

We found no evidence that partnerships with religious leaders reinforced power dynamics or compromised women's autonomy.

- Leaders referred community members to health centers for further information and final decision-making.
- No person to date has described any experience of coercion or loss of autonomy.



# Next steps

1. Quantifying long-term health outcomes
2. Partnerships with Muslim communities



# Conclusions

- Rigorous testing of an intervention that is highly effective to promote women's health and decision-making
- Guided by the community
- Strengths of a multidisciplinary team







# Thank you for joining us!

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