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Reducing Maternal Mortality: Actual and Potential Roles for Faith-inspired Institutions and Communities

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HIGHLIGHTS

Religious institutions and leaders can and should contribute more directly to global and national efforts to address shockingly high levels of maternal mortality in the poorest countries. There is untapped potential for better partnerships. Areas for attention include: a greater focus on faith-run health facilities, efforts to address specific cultural and attitude threats to maternal health; and advocacy for action and priority to the topic in political arenas. Impediments include poor knowledge about actual and potential work of faith-inspired organizations, poor coordination of programs (public and private), and mistrust fueled by negative preconceptions that arise in part from polarized positions on reproductive health and gender equality.

This brief highlights potential areas for dialogue and action that build on common concern for families and social justice. It draws on the Georgetown University Berkley Center/World Faiths Development Dialogue (WFDD) 2011 review of faith and maternal health.

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WHY FOCUS ON MATERNAL HEALTH?

Maternal mortality rates (maternal deaths per 100,000 women of reproductive age during a given time period) are today's most unequal global public health indicator. Of the estimated 1000 women who die from pregnancy-related factors each day, 99 percent live in the world's poorest countries. Women in Sierra Leone and Afghanistan are 966 times more likely to die during pregnancy and childbirth than women in Sweden. Maternity-related conditions are the largest contributor to disability and disease burdens on women of reproductive age; conditions like anemia, fistula, nerve damage, and infertility disable an estimated 15 million women a year . The sad but also hopeful fact is that most maternal deaths and related disabilities are preventable with simple medical treatment and well-known health practices.

Millennium Development Goal (MDG) 5 sets a clear target: to "reduce maternal mortality by three quarters between 1990 and 2015," and "to achieve universal access to reproductive health by 2015." This is the MDG farthest from its targets, but global momentum to act is building. The UN secretary general declared maternal health a central priority. Several global campaigns have been launched. The UN Population Fund's (UNFPA) Maternal Health Thematic Fund supports capacity building for national health systems to provide quality maternal health services. Women Thrive Worldwide and the White Ribbon Alliance, two transnational NGOs, advocate vigorously for women's health in the United States and abroad. US Secretary of State Hillary Clinton announced the global "Saving Mothers, Giving Life" partnership, that brings together the US government, Merck pharmaceuticals, the government of Norway, the American College of Obstetricians and Gynecologists, and the US-based NGO, Every Mother Counts. A major conference on maternal health will take place in Malaysia in May 2013. The unifying aim is aggressive action over the next five years to reduce maternal mortality in the most at-risk countries.

WHY ADDRESS RELIGION?

Though religious beliefs and practices and maternal health are related in important ways, this dimension has not figured prominently in strategic analysis or in the emerging global and regional alliances. Maternal health has complex and intertwined cultural (and religious), medical, and logistical dimensions, all inextricably linked. Faith-inspired approaches and faith-inspired organizations offer distinctive assets on several fronts, at global, national, and local levels. Religious beliefs and teachings can also hinder action to improve maternal health if negative practices are not addressed and if underlying disagreements and misunderstandings are not well engaged.

Gender inequalities are arguably the most important factor impeding progress on maternal health and they are often linked to religious beliefs, teachings, and practices. Attitudes toward sexuality and marriage are shaped (albeit in complex ways) by cultural and religious beliefs. The common faith focus on family values is a social force for good but can be associated with restrictions on women or acceptance of traditional views of women's subordinate status. Reticence to promote healthy child spacing or family planning, encouragement of or indifference to early marriage, condemnation of unmarried mothers, and lower priority to women's needs are quite often associated with religious teachings. All are important impediments to improving maternal health.

Positive engagement of faith ideas and actors can help shape behaviors that reduce maternal mortality and improve the health of women and families. Personal faith can be turned into a positive impetus for healthy behaviors. Strong positive messages from religious leaders and communities can help break through long accepted negative beliefs and behaviors about pregnancy and childbirth.

Dialogue and cooperation among faith and non-faith actors in both global campaigns and local efforts to address maternal health is partial and often distorted. Knowledge gaps contribute. Deep divisions about the ethics and rights to abortion polarize debates. Misconceptions about attitudes of faith-linked institutions about family planning (these are very diverse) impede dialogue and partnerships.

WHAT NEEDS TO BE DONE TO REDUCE MATERNAL DEATHS AND IMPROVE MATERNAL HEALTH?

The major risk factors for women are poverty and poor access to healthcare. Several medical, political, physical, and cultural factors interact to cause maternal deaths:

1. *Complications relating directly to childbirth*, like hemorrhage and ec¬lampsia (increased blood pressure), lead to three out of five maternal deaths, yet can generally be prevented with **trained medical attendants and modern medicine**. **Poor infrastructure** hampers access to medical care at the critical moments. Similar issues apply for prenatal and postnatal care.

2. *Poor care during childbirth* can result in **dangerous postpartum conditions**. Women often survive obstructed labor (the third leading cause of maternal death) but the resulting obstetric fistula debilitates and stigmatizes at least six times the number of women who die in childbirth. Existing data on such problems are poor. Most women who suffer are isolated and ignored.

3. *Medical issues that threaten women's health prior to childbirth or pregnancy* are leading causes of maternal deaths. Two-fifths of maternal deaths result from **health issues like HIV and AIDS, tuberculosis, malaria, and malnutrition**. These challenges are significant: nearly one in three pregnant women in Africa is HIV-positive.

4. *Women are affected before, during, and after childbirth* **by unequal and discriminatory treatment linked to deep-seated social attitudes towards women**. These include early marriage, child-headed households, and rapid succession of pregnancies. Girls married before their bodies are fully developed are at greater risk of labor complications; pregnancy and childbirth are the leading causes of death among adolescent girls in most poor countries. Regardless of maternal age, stigma related to taboo topics, such as bodily fluids and reproductive health, detracts from efforts to address maternal health at every stage.

All four factors involve a complex web of cultural practices, limited education, poor services, and poverty. Traditional attitudes towards childbirth may keep women away from modern health clinics and negative attitudes towards women may result in low priority to their health needs at

government and family levels. **Religious values, leaders, institutional activities, and spiritual beliefs about gender, fertility, and health are powerful factors affecting women's access to care and support (or lack thereof), especially when it comes to reproductive health.**

ASSETS TO BUILD ON AND RISK FACTORS

Ubiquitous presence and community trust. Faith communities and faith-inspired healthcare providers are present virtually everywhere, especially in very poor communities. They enjoy well-documented influence and trust. Their work and roles (both positive and negative) are, however, lightly mapped, with significant knowledge gaps. A first priority for strengthening partnerships is to know what faith communities actually do. Evidence building is urgently needed.

Holistic programs. Many faith-inspired organizations emphasize (quite properly) a broad healthcare approach to pregnancy and maternal health and thus gravitate towards holistic rather than targeted programs. Such approaches fit well with the comprehensive strategies needed to reduce maternal mortality, which require a full spectrum of interventions (including HIV and AIDS care, nutritional resources, awareness about healthy timing and spacing of pregnancies, emergency obstetric care, and post-abortion care). This tendency does, however, make the task of defining motherhood-specific programs and monitoring and evaluating them more difficult.

Community presence and focus. Dense networks of faith-run facilities in many communities are a pivotal resource because local presence and community-focused approaches are critical to better access to quality obstetric care. Faith and community leaders (including mothers' and youth groups) can shape and transmit effective messages about healthy behaviors and contribute to better understanding of risks and options for care. Some communities and individuals are more receptive to medical advice if it comes with at least the blessing of religious leaders. FIOs can leverage existing relationships, networks, and bases of trust through respected religious leaders or faith-based community groups to influence, positively, local cultural and religious norms. FIO healthcare services like mission clinics, community health worker programs, and medical supply and personnel mobilization networks in remote areas or underserved urban slums are, however, often underutilized.

Behavior change. Personal, values-driven relationships within families and among individuals are critical in sexual behavior, treatment of girls and women, and practical issues like response to health counsel. Religious teachings and leadership are often effective in encouraging behavior change, including sexual behavior and setting personal priorities. Issues like early marriage, child spacing, contraceptive use, and girls' education lend themselves well to religious influence and leadership. Faith-inspired actors can engage the sen¬sitive issues connected to childbirth and can work to reconcile local beliefs and values with medical interventions perceived as foreign or Western.

POTENTIAL NEXT STEPS

Engage religious actors more actively in strengthening health systems. Primary healthcare systems and emergency obstetric care need determined support on many fronts, from transportation resources to adolescent health education to men who know to recognize prenatal danger signs. Religious actors can help (or hinder) on all fronts.

Work for better knowledge within religious communities. Good information, sensitively framed to relevant populations, is essential. Modern knowledge about what makes a difference and skilled birth attendants or facility-based delivery can be linked to relevant spiritual teachings and traditional wisdom if there is mutual understanding and respect. Addressing maternal health explicitly through teaching modules in theological training institutions can help equip religious leaders with accurate information.

Fill data gaps. Better mapping of existing health assets to capture the work of all actors, including FIOs, will translate into better road maps for future action. Improved data on inputs, outputs, and outcomes can build an evidence base to determine best practices and build capacity, inform training programs and project design, and guide resource allocation decisions. Research that probes aggressively the direct and indirect causes of deaths can help pin down cultural and location specific practices and beliefs and point the way to needed shifts in community attitudes. Building

death registration systems, in collaboration with faith leaders, can bolster these efforts. Maternal mortality is a global issue, but research must take place on a country-by-country basis.

Address poor coordination and weak evaluation. Complex and thorny coordination challenges need to be addressed. Both strategic top down coordination and effective networking can help. Faith-linked programs and institutions work in remote regions where others will not, but tend to be underrepresented in official statistical analyses of health ser¬vices and thus in policies and programs. Poor information and coordination make their insights hard to harvest, contributing to redundant and unsustainable efforts. Religious networks and faith-linked institutions need to be included in mapping of resources to address maternal mortality, above all in the poorest regions and conflict-affected communities.

Dialogue on ethical and policy differences. Actual and perceived tensions around reproductive health issues block meaningful action in too many cases. It is time to work on dialogue that can seek common ground and diffuse tensions. One area where common ground is clearly present is child spacing. There is more room than commonly thought to address family planning and contraception, both critically important for maternal health. Bringing FIOs' holistic healthcare approaches and years of experience in building trust to the maternal health community can go a long way towards enriching the work and discussions taking place.

Favor cultural specificity. There is much to learn from FIOs about designing cultur¬ally specific approaches, informed by faith dimensions and local knowledge. The historical legacies that many FIOs draw upon reflect programming tailored to specific local contexts. This cultural tailoring is especially important when dealing with sensitive, private, and controversial topics like antenatal care, family planning, HIV and AIDS, female genital cutting, and illicit abor¬tion. Identifying specific religious and/or scripturally-based values that relate directly to maternal health can help link faith and maternal health.

Support partnerships and collaboration. FIO-provided healthcare can fill gaps in public healthcare systems, but it is not a substitute. Public-private partnerships are essential for the multi-faceted efforts needed to provide strong support for maternal health. Clear-sighted evaluation to identify areas where FIOs can be most useful is needed. Positive models suggest pragmatic divisions of labor within a framework of mutual knowledge and transparency and respect for common goals as well as differences. Such partnerships between FIOs and other organizations, public and private, offer the best way to reach rural or underserved populations in an effective and trusted manner.

The complete Berkley Center/World Faiths Development Dialogue 2011 review of faith and maternal health is available at: *http://berkleycenter.georgetown.edu/publications/reducing-maternal-mortality-actual-and-potential-roles-for-faith-linked-institutions-and-communities.*

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ABOUT THE WORLD FAITHS DEVELOPMENT DIALOGUE

The World Faiths Development Dialogue works to build bridges between the worlds of faith and secular development. Established at the initiative of James D. Wolfensohn, then president of the World Bank, and Lord Carey of Clifton, then archbishop of Canterbury, WFDD responds to the opportunities and concerns of many faith leaders who have seen untapped potential for partnerships.