

**Multi-religious Collaboration for Maternal and Child Health in Kenya**

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**Overview**

While there have been significant declines in maternal mortality, particularly in Sub-Saharan Africa and South Asia, the number of deaths are still well above the designated millennium development goals (MDGs). According to 2013 UNICEF statistics[[1]](#footnote-1), there are approximately 510 deaths per 100,000 live births in Sub-Saharan Africa. The World Health Organization (WHO) estimates that 800 women die every day due to preventable causes related to pregnancy and childbirth and that 99% of these deaths occur in developing countries. Some of the primary causes of these preventable deaths are lack of information and cultural practices.[[2]](#footnote-2)

The progress towards achieving the MDGs for child survival are also lagging behind. Children in Sub-Saharan Africa are more than 15 times more likely to die before the age of five than children in developed regions and more than half of these deaths are preventable[[3]](#footnote-3). As with maternal mortality, many of these deaths can be prevented by behavior changes that can be promoted and taught by religious communities.

**Why Multi-religious Collaboration for Advocating for Enhanced Maternal and Child Survival**

The shift in antenatal, postnatal and neonatal care practices are needed for the survival and wellbeing of mothers and children in the developing world. Religious communities have the assets – social, spiritual and moral – to reach out to these people and bring about the needed change. They can –

**Reach Vast Numbers of People:** Faith communities are collectively the largest civil society organization, including up to 80% or more of some nation’s populations. They reach the most people, including the hardest to reach. *If appropriately equipped, faith communities can be a great avenue to promote needed life‐saving household practices.*

**Use Existing Social Infrastructure:** Religious and faith‐inspired communities have a wealth of interconnected infrastructure — congregations, schools, clinics, hospitals, etc. — that reaches from a nation’s capital into its remote communities. Today, they are overwhelmingly led and staffed by local nationals. *If appropriately equipped, religious infrastructure and related clerical staff, community groups and other volunteers can be harnessed to promote life‐saving household practices.*

**Overcome Barriers:** Faith leaders are influential and trusted and hence, can help overcome the barriers to the promotion of needed life‐saving household practices, shaping new social norms, while also mitigating suspicions surrounding new, unfamiliar public health or development initiatives. Faith leaders also have unparalleled access into the family sphere, and it is that family unity which holds primary and utmost responsibility for the care and well-being of children.

**Engage Moral Authority:** The world’s religions, while differing in doctrines, are increasingly uniting around a moral consensus that human life has inalienable dignity and that the well‐being of children is of unique and special importance. A focus on the health of children and mothers lies at the heart of a growing moral consensus across many faith traditions. *Religious leaders can make clear that it is the duty of families and communities to provide for the health of children and their mothers. They can use their moral authority to promote the adoption of life‐saving household practices.*

**Faith for Life Case Study – Kenya**

The Interreligious Council of Kenya (IRCK), *Religions for Peace’s*national affiliate, joined with UNICEF and key Kenyan national and local authorities to develop a comprehensive communication strategy to promote maternal and child survival. Through the *Faith for Life* (F4L) Project, IRCK’s religious leaders effectively improved child survival and development strategy (CSD) interventions within their community by lending moral authority and engaging their social assets.

As a part of the F4L Project, more than 14,000 religious leaders were trained, reaching over 2.8 million people in the selected regions. With more than 98% of Kenya’s population identifying with a faith tradition, the religious leaders were able to have an extensive reach throughout the some of the most remote areas. This project has contributed to an increase in positive health practices and a decrease in preventable deaths. Malarial deaths are down by more than 50%, the exclusive breastfeeding campaign has yielded a 10% increase in six months exclusive breastfeeding in communities. Religious leaders have been able to stem negative beliefs surrounding healthcare, promoting trust in the healthcare system and decreasing beliefs in traditional myths by 15%.

Active partnership with the Ministry of Public Health and Sanitation from the onset ensured that the F4L materials had a wider ownership and were compliant with the CSD. The early engagement with the Ministry is heralded as one of the greatest factors for success of this program. Working together, religious communities received accurate information from their trusted leaders, increasing acceptance and likelihood of behavioral change. In addition, multi-religious action also contributed to inter-faith harmony amongst the different faiths as they worked together on a common goal, thereby strengthening social cohesion and security in the region.

**Recommendations to Policy Makers**

* Religious communities’ extensive reach and moral authority allows them to reach wide audiences and achieve significant results with small amounts of funding. Governments should provide grants to religious communities to support the implementation of nation-wide health programs.
* It is imperative to engage with religious leaders early on; religious leaders can provide additional insight on their communities and co-development of strategies will yield greater results by providing expertise on the needs and challenges of the beneficiaries, and the role that the religious communities can play.
1. UNICF Data: Monitoring the Situation of Children and Women : <http://data.unicef.org/maternal-health/maternal-mortality>. Retrieved 6/2015. [↑](#footnote-ref-1)
2. World Health Organization Fact Sheet #348, “*Maternal mortality”.* <http://www.who.int/mediacentre/factsheets/fs348/en/> . Retrieved 6/2015. [↑](#footnote-ref-2)
3. World Health Organization Fact Sheet # 178, “*Children: reducing mortality”*. <http://www.who.int/mediacentre/factsheets/fs178/en/> Retrieved 6/2015. [↑](#footnote-ref-3)