

PROJECT SUMMARY



PROGRAM LEARNING: FAITH LEADERS ADVOCATE FOR INCREASED HEALTHY TIMING & SPACING OF PREGNANCY/FAMILY PLANNING USE & STRONGER MATERNAL & CHILD HEALTH OUTCOMES: OPERATIONS RESEARCH IN KENYA & GHANA

**Who can benefit from this paper?**

Policymakers, program managers, faith leaders, sexual and reproductive health workers, and donor community

**What is included?**

Program learning on Channels of Hope and faith leader engagement in family planning

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World Vision is a Christian humanitarian organization dedicated to working with children, families, and their communities worldwide to reach their full potential by tackling the causes of poverty and injustice.

## The Problem

In Africa, more than four in every 10 women of reproductive age want to avoid pregnancy, a total of 125 million women. However, 47% of African women who do not want to become pregnant—58 million in 2017—either use no contraceptive method or use traditional methods, which typically have low levels of effectiveness. These women who are defined as having an unmet need for modern contraception, account for 90% of all unintended pregnancies in Africa. If all unmet need were satisfied, there would be a decline of about 80% in the annual number of unintended pregnancies (from 23 million to five million per year), unplanned births (from 12 million to two million) and abortions (from nine million to two million). The above analysis by Guttmacher Institute further indicates that if full provision of modern contraception were combined with adequate care for all pregnant women and newborns, maternal deaths would drop by 73% (from 211,000 to 56,000 per year), and newborn deaths would drop by 84% (from 1.1 million to 185,000 per year<sup>1</sup>).

## The Response

With funding from the John Templeton Foundation, World Vision implemented a three-year operational research project to measure change in contraceptive prevalence rate (CPR) among women of reproductive age in communities where faith leaders—Christian and Muslim—were exposed to the CoH maternal, newborn,

According to the 2014 Demographic and Health Surveys, in Kenya, 18% of currently married women had an unmet need for family planning (FP) services, with 10% in need of spacing and 8% in need of limiting. In Ghana, 30% of currently married women had an unmet need for FP services, with 17% having an unmet need for spacing and 13% having an unmet need for limiting.

Recent analyses recognize the unique and vital role of the church and faith-based groups in successful developmental work in developing countries<sup>ii</sup>. World Vision uses a faith-based delivery methodology called Channels of Hope (CoH)<sup>1</sup> to promote use of FP through messages on healthy timing and spacing of pregnancy (HTSP). The impact of faith leaders' support for FP through contraceptive use has never been measured and compared to that of a community without similar support.

and child health (MNCH)+HTSP training, as compared to a comparable community without CoH MNCH+HTSP interventions. Ghana and Kenya were chosen for their levels of need, ready organizational infrastructure, and mixed faith populations. In Kenya, Laisamis and Isiolo-Oldonyiro program areas were selected as the

1. World Vision's CoH approach provides education and training for faith leaders on sensitive issues and those traditionally associated with stigma and marginalization, including HIV and AIDS, gender-based violence, MNCH, and, child protection. CoH has helped faith leaders to understand and value HTSP/FP. Congregations learn to talk about MNCH services, including immunization, healthy fertility, and modern methods of contraception that will help them meet their fertility intentions.

intervention and comparison sites respectively. In Ghana, West Gonja and Zabzugu Districts represented the intervention and comparison areas respectively.

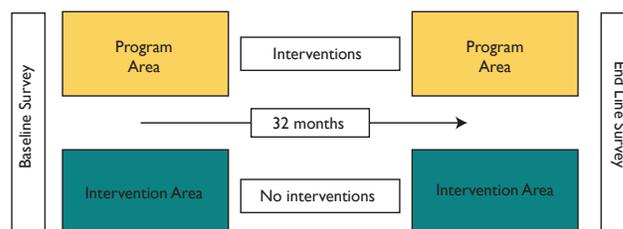
The operations research was conducted to answer the following two questions:

1. What is the impact of using the CoH methodology to deliver messages related to HTSP on the prevalence of contraceptive use among mothers of children under 2 in rural areas of Kenya and Ghana?
2. Does using the CoH methodology to deliver those messages influence faith leaders to change their own attitudes toward HTSP and to educate their congregants on FP and HTSP?

## Study Design and Methodology

To answer the above questions, a two-arm quasi-experimental design was adopted. A baseline quantitative and qualitative survey was conducted prior to using the CoH MNCH+HTSP methodology for interactive training of faith leaders in the experimental group, and a similar endline survey was conducted to compare results to those in communities in the comparison group not receiving the intervention, Figure 1.

Figure 1: Two-arm quasi experimental design



## Results

1. **The results below answer the question on the impact of exposing faith leaders to the CoH methodology to deliver messages related to HTSP, to increase knowledge and acceptance of contraceptives:**

### Kenya

- **Contraceptive Prevalence Rate (CPR)** increased from 5% to 12% in the intervention site among mothers with a child under 2 (CU2). CPR stayed the same in the control site: 32.5% vs. 32.3%. After CoH intervention, the likelihood of using modern contraception significantly increased by 150 percent ( $p < 0.005$ ); conversely, in the control site, it remained the same.
- **Knowledge of adequate birth spacing** increased among mothers with CU2. Women reported knowing to wait at least 24 months after giving birth before attempting another pregnancy. In the intervention site, the increase was 13 percentage points higher than in the control site.
- Significant increases in **knowledge of three or more modern methods of FP** was observed in the intervention site—increasing from 41% to 76%, compared with an increase from 73% to 83% in the control area. According to a Difference in Difference analysis, knowledge of modern contraception methods was significantly higher in intervention sites compared to control sites (20 percentage points vs 10 percentage points, respectively).
- **Unmet need for spacing** increased significantly ( $< 0.001$ ) by 23 percent points in the intervention site, with no significant change ( $= 0.05$ ) in the control site. This is another indication that CoH might positively influence faith leaders to speak about FP programs and help increasing knowledge and understanding thus increase demand that surpass existing supply (Table 1).

## Ghana

- **Contraceptive Prevalence Rate:** There was a slight increase from baseline to endline in mothers with CU2: 19.5% to 20%. Interestingly, the CPR increased modestly in the control area: 9% vs. 13% which could be attributed to stronger Ministry of Health (MoH) FP programming. There was no significant change in contraceptive use prevalence in Ghana.
- **Knowledge of Adequate Birth Spacing:** Mothers of CU2 who know a woman should wait at least 24 months after giving birth before attempting another pregnancy saw similar increases in both sites: from 32% to 86% in the intervention site, and from 30% to 80% in the control area.
- **Knowledge of three or more modern methods of FP** increased from 89% to 95% in the intervention area, compared with no increase in the control area (90%). According to a Difference in Difference analysis, knowledge of modern contraception methods was significantly higher in intervention over control sites (6 percentage points vs 1 percentage point, respectively).
- **Unmet need for spacing** significantly increased in both sites, nonetheless, with higher intensity in the intervention site (Table I).

Indicator	Laisimis			Isiolo			West Gonja			Zabzugu		
	% point	OR	P Value	% point	OR	P Value	% point	OR	P Value	% point	OR	P Value
Fertility intention	+12.1	1.65	<0.001	+9.7	1.5	<0.01	+57.8	14.2	<0.001	+38.7	5.3	<0.001
Total unmet need	+29.8	3.6	<0.001	+5.8	1.3	=0.05	+35.3	4.6	<0.001	+26.6	3.0	<0.001
Unmet need for spacing	+22.8	3.1	<0.001	+7.8	1.5	<0.05	+38.2	6.4	<0.001	+27.1	3.4	<0.001

## 2. Does using the CoH methodology to deliver those messages influence faith leaders to change their own attitudes toward HTSP and to educate their congregants on FP and HTSP?

In support of the quantitative findings, and leveraging the social capital of faith leaders in both Kenya and Ghana, our study findings seem to:

- Indicate that after faith leader exposure to the CoH MNCH+HTSP methodology, attitudes among Christian protestant and Muslim faith leaders are positive towards reproductive health, including approval of modern methods of contraception. The acceptance is based on the understanding of pregnancy and childbirth health risks to newborns and mothers with frequent and multiple pregnancies.
- Indicate associated attitudinal-change to improve use of modern contraception methods mentioned by faith leaders, include documented barriers such as side-effects, misinformation and fear, status of woman, and actual choice of method.
- Illustrate the benefits that a congregational-focused health promotion platform, like World Vision's CoH, provides—knowledge and perception changes towards a specific health subject.
- Generate a healthy and interesting debate from faith leaders and the inter-denomination variance on whether the church should participate in the promotion of family planning methods among youth. This is an area for further investigation.
- Suggest a shift from previous studies on faith leader's perceptions and weak links between health and spirituality.<sup>iii</sup> In our case, most faith leaders, regardless of congregation, expressed finding support from their faith or religion for the link between reproductive health and spirituality.
- Suggest that faith leaders acknowledged issues such as the rising cost of raising children, large families, and economic constraints as molding their changing perspectives on reproductive health—which might be in line with a country's fertility transition and the desire for smaller families.

## Challenges

- A quasi-experiment is an empirical study used to estimate the causal impact of an intervention on its target population without random assignment.
- Intervention dose and program maturity are factors that may explain the two-country difference on outcomes related to knowledge and use of contraceptives. Related to intervention dose, the implementation period in Kenya was almost 6 months longer than in Ghana. Whereas, related to program maturity, Kenya's staff had previous experience and apparently stronger technical support with CoH implementation.
- CoH implementation fidelity presents a realistic problem in general because it is a process. Faith leaders need time to internalize the messages before it results in actions on their part. However, this research is showing potential impact of CoH.
- The operations research provides evidence for “what works” when the CoH MNCH+HTSP model is used. However, it has highlighted implementation gaps, such as collaboration with decision making leaders from a national level, that can be a spring board for recommendations on future implementation.
- Culture and gender balance will be a work in progress as faith leader and spouse combination poses a challenge due to differences in literacy levels.

## Conclusion

The current study demonstrated that the application of the CoH model to increase knowledge of HTSP and demand for modern contraceptive use in rural areas of Ghana and Kenya is an acceptable and effective methodology among faith leaders. We highlight the following broad recommendations:

### A. From Research to practice:

*For national governments, donor community and international development programs*

- The impact of faith leaders' support for HTSP/FP on contraceptive use in a community using CoH has never been systematically measured and compared to a similar community without this support. This is a gap in evidence that needs to be filled. Our study presents a promising practice. Larger regional and county research comparisons are recommended to inform national governments where faith is an integral part of everyday life.
- Consider testing CoH against other community project interventions (faith based and non-faith based) aimed at improving HTSP/FP to further determine the impact of CoH and faith leader attitudinal changes.

### B. Implications for program implementation:

*World Vision Inc. and Peer organizations*

- World Vision's development approaches are implemented through short- and long-term community-driven, sustainable developmental programming strategies, which focus on improving child well-being. Effective integration of the evidence from this study is a platform for mainstreaming and scaling up the learnings into sponsorship, grant-funded, and privately funded programs.



### Endnotes

i Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017, New York: Guttmacher Institute, 2017. Additional data and sources can be found at <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>

ii Jean F Duff, Warren W Buckingham III. Faith-based health care 3. Strengthening of partnerships between the public sector and faith-based groups Lancet 2015; 386: 1786–94. Published Online July 7, 2015. [http://dx.doi.org/10.1016/S0140-6736\(15\)60250-1](http://dx.doi.org/10.1016/S0140-6736(15)60250-1).

iii Webb, B., Melissa Bopp, Elizabeth A. Fallon. 2011. A qualitative study of faith leaders' perceptions of health and wellness. J Relig Health 92013, 52:235-246.