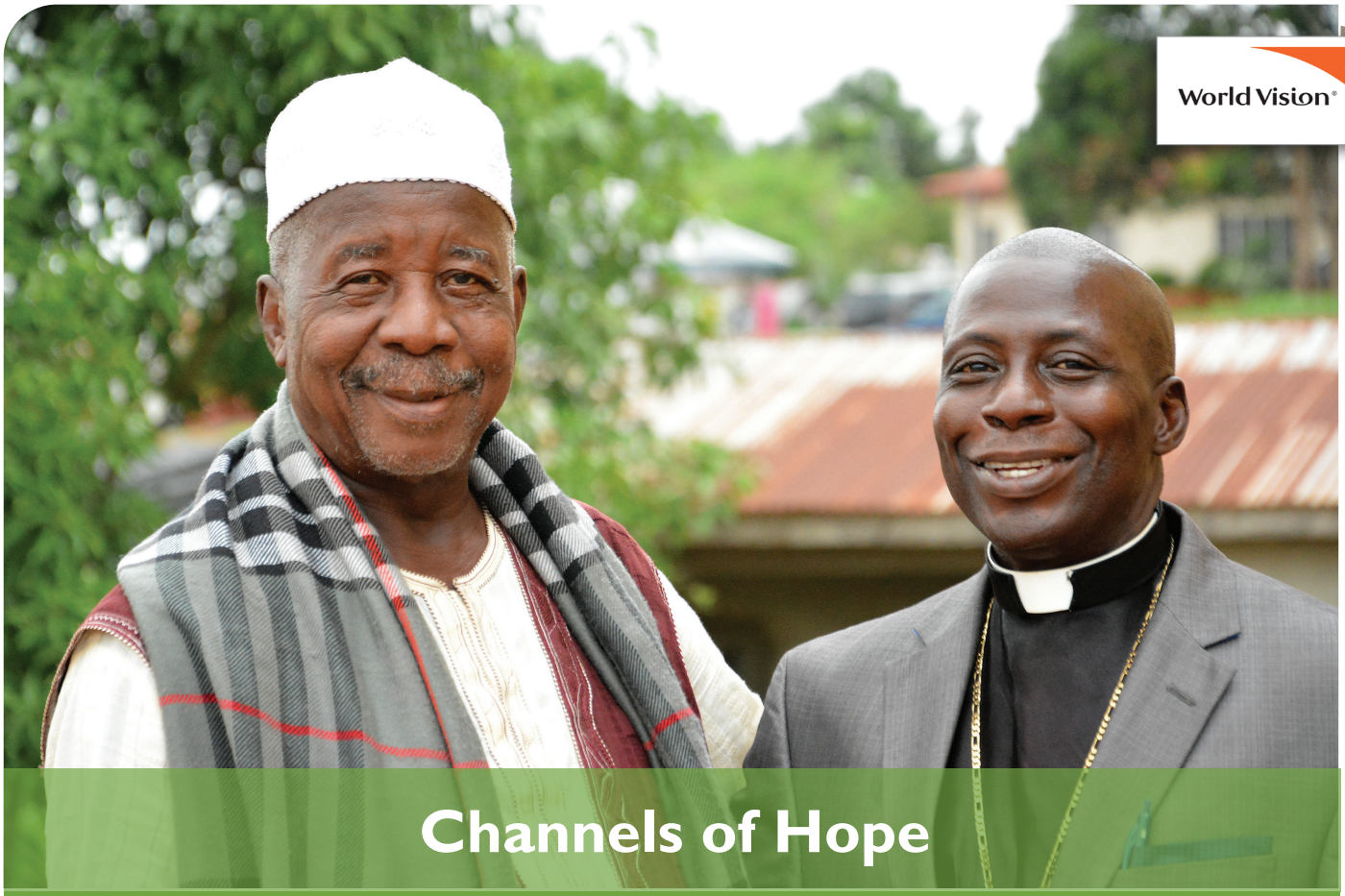

Channels of Hope

An effective behaviour change and advocacy methodology for faith leaders and faith communities

PRIMARY TARGET GROUP

Channels of Hope (CoH) targets faith leaders, their spouses and faith community members to become active participants in child well-being through factually-correct information and insight from sacred scriptures and faith traditions.

What is this approach?

Channels of Hope (CoH) partners with, and empowers, churches and faith communities to contribute to child well-being. It equips faith leaders with both factually-correct information and insight into their scriptures and faith traditions, guiding them to become powerful change agents. Faith leaders and community members are equipped to take practical actions in prevention, care and advocacy in order to promote child well-being for the most vulnerable in their communities. At the time this guide was published, five curricula were available:

1. Channels of Hope for Child Protection (CoH-CP)
2. Channels of Hope for Ebola (CoH-E)
3. Channels of Hope for Gender (CoH-G)
4. Channels of Hope for HIV (CoH-HIV)
5. Channels of Hope for Maternal, Newborn, and Child Health (CoH-MNCH)

When would this project model be used?

Channels of Hope can be used wherever a faith community is present and where deeply entrenched, long-lasting beliefs, convictions and culture may contribute to harmful attitudes, norms, values and practices that hinder child and community development.

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Acronyms

AP	Area Programme
ARV	Antiretroviral
CBO	Community based organization
CC	Christian Commitment (Coordinator)
CHARMS	Core HIV and AIDS Response Monitoring System
CHAT	Catalysing and Community Hope Action Team
CVA	Citizen Voice in Action
CoH	Channels of Hope
CoH-E	Channels of Hope - Ebola
CoH-G	Channels of Hope - Gender
CoH-CP	Channels of Hope - Child Protection
CoH-HIV	Channels of Hope - HIV
CoH-MNCH	Channels of Hope - MNCH
CWBO	Child Well-Being Outcome
DF	Development Facilitator
DME	Design, Monitoring & Evaluation
DPA	Development Programme Approach
DVD	Digital Video Disc (storage disc)
FBO	Faith-based Organisation
GBV	Gender-based Violence
GC	Global Centre
GEM	Gender Equitable Men
I-GATE	Improving Girls' Access through Transforming Education
IQA	Implementation Quality Assessment
LLIN	Long Lasting Insecticide treated Nets
MNCH	Maternal, newborn and child health
MoU	Memorandum of Understanding
NGO	Non-government organization
NO	National Office
PMTCT	Prevention of mother-to-child transmission of HIV
TP	Technical Programme
TtF	Train the Facilitator
WV	World Vision
WVI	World Vision International

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Part 1

1. What is this model?

1.1. What are the expected benefits or impacts of this model?

Channels of Hope (CoH) addresses deeply entrenched, long-lasting beliefs, convictions and culture that may contribute to harmful attitudes, norms, values and practices and hinder child and community development outcomes. Though laws may be in place to bar such harmful practices, laws do not change attitudes or socio-religious beliefs. However, faith leaders have considerable influence over culture and the behaviours encouraged or prohibited in their communities. Unfortunately, due to a lack of relevant skills and information, faith leaders and faith communities can create barriers to or fail to promote child well-being.

The CoH project model equips faith leaders with factually correct information and insight from sacred scriptures and faith traditions, and guides them to be powerful change agents. As role models they can inspire entire communities and play a significant role as part of a multidisciplinary team to support the most vulnerable community members, also helping to achieve development goals.

Well-facilitated CoH workshops should result in the following positive outcomes among participants:

- A decrease in harmful attitudes towards the specific issues addressed by the various CoH curricula
- Increased motivation to support (through care, restoring and advocacy) the most vulnerable children and adults
- Increased competency to engage with local child well-being issues.

The primary target groups of the CoH project model are faith leaders and their spouses (at local and national levels), faith-based volunteers and other community leaders (such as traditional leaders like chiefs and clan leaders). These individuals will have the greatest influence in changing harmful attitudes in their wider communities. They will also continue to support, advocate and care for the most vulnerable children and people long after World Vision (WV) transitions out of an area. Working across Christian denominational lines and with other faith groups is essential to the success of the CoH project model.

CoH contributes to child well-being outcomes (CWBOs) in a number of ways:

Child well-being outcome	How CoH contributes
• Children protected from infection, disease, and injury • Children and their caregivers access essential health services • Children are well-nourished	• Both CoH-HIV and CoH-MNCH contribute to a number of improved health outcomes. • CoH-HIV, in a multicounty study, was shown to increase voluntary testing. • CoH-MNCH in Zimbabwe has increased mothers seeking prenatal care.
• Children access and complete basic education	• CoH-G in Zimbabwe, as part of the Improving Girls' Access through Transforming Education (I-GATE) education project, has contributed to an increase in girl's education in the project area.
• Children are respected participants in decisions that affect their lives • Children registered and celebrated at birth • Parents provide well for their children • Children cared for in a loving, safe family and community environment with safe places to play • Children grow in their awareness and experience of God's love in an environment that recognises their freedom.	• CoH-CP and MNCH contribute to improved birth registration. • CoH-CP contributes to faith communities becoming safe spaces for children as well as promoting family relationships.

• Children enjoy positive relationships with peers, family and community members • Children value and care for others and their environment (indirect) • Children have hope and vision for the future (indirect).	• CoH promotes caregiver knowledge and actions that improve relationships with children, including positive discipline and awareness of the challenges facing children.

1.2. Key features of the model

CoH provides a series of training and workshops for faith leaders and faith community members in order to catalyse faith leaders into action, through providing factual information and scriptural reflection to attitudes and actions that provide child well-being. Sustained dialogue and relationships across faith communities. and between faith communities and other community actors lead to stronger child well-being systems. Faith communities and partners demonstrate positive changes in attitudes through collective action for social change in prevention, advocacy and care.

The CoH approach includes four phases, fully outlined in the *CoH Field Guide*.

Phase 1: Prepare

The National Office (NO) plans for CoH implementation. This requires developing a plan and ensuring budget and staff resources for full implementation.

The *Prepare* phase also includes the *Train the Facilitator* (TtF) events. These rigorous training events equip facilitators to lead the *Faith Leader Catalysing* and *Community Hope Action Teams (CHATs) Strategising* workshops at the community level. Participants take two written assessments (on technical content and faith response) and do two practice facilitation sessions at the end of their training. At the time of publication, this training involves 6 to10 days of face-to-face training.

Phase 2: Catalyse

Faith Leader Catalysing workshops are for faith leaders and their spouses at the community level. CoH aims to help catalyse and equip faith groups with knowledge and inspire them with a vision of how they are uniquely called to respond to local issues. Factual content engages the head – providing facts and technical information about the issues; the heart is engaged through considering and sharing the ways in which the issue has impacted them and their community as well as by studying what scriptures have to say on the topic; and the hands are engaged by encouraging practical steps, in partnership with other community actors, to address the issue. *Faith Leader Catalysing* workshops are generally 3 to 4 days long.

Phase 3: Strategise

Faith Leaders identify key members of their communities to be part of the Congregational or Community Hope Action Teams (CHATs) and to attend a CHAT workshop. CHAT members then attend a workshop highlighting the same specific CWB information which has already been shared with the faith leaders. They will plan for their congregational or faith community responses, collaborate with partners and develop monitoring plans. They will also share any capacity or learning needs they have. CHAT workshops usually take 4 days, with one day devoted to developing a faith community action plan.

Phase 4: Empower

Faith communities then implement their action plans. Six-monthly meetings with WV staff, present an opportunity for additional capacity building, deepening connections with local partners, and monitoring progress against goals. The CoH process intentionally guides congregations to engage with other faith communities, congregations, local groups, stakeholders and organisations to establish themselves as relevant actors that can contribute meaningfully within the community systems and structures on an on-going basis.

1.3. What is the level of evidence for this model?

Channels of Hope, in its various forms has, and continues to build, a strong evidence base around the effectiveness of the methodology. The model changes workshop participants' stated beliefs about topics, increases their chances of seeking care, support or assistance personally, as well as increasing the likelihood of them engaging in actions that contribute to child well-being (for example visiting children impacted by HIV, speaking out against an unhelpful behaviour or advocating for changes in child well-being.)

A range of evaluations and research projects have contributed to this CoH evidence base. After a series of evaluations and qualitative studies of CoH-HIV, a multi-country, longitudinal operational research study in 2009 showed that:[1]

- At baseline in 2005, 86% of faith leaders believed HIV was a punishment from God. After CoH interventionin 2009, only 58% held this belief afterwards in these intervention areas.
- Before CoH was introduced to communities, 26% of faith leaders would not allow a faith leader living with HIV to preach. After the implementation of CoH, that percentage reduced to just 9%
- A CoH area resident was 2.5 times more likely to participate in a support group for people affected by HIV.

An external evaluation by the Australian National University and their Community Voice 4 Change project on the implementation of CoH-Gender, found participants had increased recognition of women's rights, openness to discussion about gender-based violence and commitment to change. The evaluation reported the following impacts:[2]

- The percentage of men who believe a woman can accuse her husband of rape rose from 70% to 83%
- The percentage of women who believe that women should not make decisions fell from 34% to 4%
- The percentage of men who believe the Bible says that 'man is boss' fell from 83% to 66%
- Men and women now talked openly about community perceptions of gender based violence (GBV), the role of the church and experiences of gender inequality and domestic violence
- Women and men hear messages on GBV and gender inequality in church differently, with 63% of women but only 34% of men believing that pastors tell them to never use violence.

A Sponsorship Research study looked at the sustainability of CHATs in a CoH-HIV project in Masaka Kaswa, Uganda after completion of the project. It found more than half of the CHATs surveyed continued to be active on a regular basis more than five years after the life of the project.[3]

In the aftermath of Ebola, a Lancet article highlighted the important role of the faith community in combatting the disease, and referred to CoH-Ebola as a mobilising mechanism.[4]

Early evaluations of CoH-MNCH and CoH-CP note similar qualitative data around the role of CoH in transforming attitudes and decisions to alter behavior as well as engaging faith communities in relevant community activities that contribute to child well-being. A number of research studies are now underway including:

- CoH-CP multi-site longitudinal research study in partnership with Queen Margaret University (in design phase)
- CoH-MNCH longitudinal study on the impact of CoH on the healthy timing and spacing of pregnancies in Ghana and Kenya with the Templeton Foundation
- CoH-Ebola, in partnership with the World Bank on the effectiveness of mobilising faith leaders in prevention and care seeking.

Full CoH evaluation and research summary information can be found here.

[1] Chege, Jane et al. CoH HIV Operational Research. April 2009.
[2] Honaira Community Voice for Change Project Evaluation. Australian National University. October 2014.
[3] Lavin, Bridget. WVI Sponsorship Operational Research: Chat Performance Summary. October 2014.
[4] Marshall, Katherine et al. *Religion and Ebola: learning from experience.* The Lancet , Volume 386 , Issue 10005 , e24 - e25.

1.4. In what contexts has this model worked

WV has successfully tested, adapted and applied this project model with various audiences, contexts and religions in Africa, Asia, Latin America, the Middle East and Eastern Europe. Since September 2014, CoH (in one or other of its five adaptations) has been implemented in 59 countries.

The project model's strong participatory nature allows participants to grapple with their specific, local issues thus making CoH suitable for many contexts; from rural to urban settings and for groups with both low and high literacy levels. Becoming a trained CoH facilitator requires a high level of literacy and fluency in one of the languages into which the materials have been translated.

Relationships with faith leaders at all appropriate levels (local, national and international) are required for successful implementation. (See Part 3 for guidance in Field Guide Addendum 14.)

Ecumenical contexts

CoH does not follow any one Christian doctrine and is not meant to change church or faith beliefs. Special adaptations ensure that the curricula work across the ecumenical spectrum, including Catholic[5] and Orthodox contexts. This remains a work in progress, with final copyrighted materials expected in 2016.

Muslim Contexts

> *'We recognise God's call to engage in communities, including diverse Muslim contexts, where our vision, skills, and capabilities can contribute to the improved well-being of vulnerable children. Therefore, our strategic programme priorities will be set primarily based on our Mission and Ministry Goal rather than by the faith identity of communities.' (WVI's 2013 Statement of Strategic Intent for Multi-faith Contexts)*

Existing relationships with Islamic organisations and leadership at national level are crucial to implement CoH in a combined Christian-Muslim context. WV has worked with Islamic scholars to develop Islam-specific content for some of the CoH curricula. See *CoH Field Guide Addendum 5* for more information on ensuring policies align and on establishing and maintaining good relationships. Before implementing in a Christian-Muslim context, WV staff should have an understanding of the Muslim faith from a Christian perspective, ideally through attending an Exploring Islam workshop. It is also essential to facilitate combined Christian-Muslim CoH workshops in collaboration with a Muslim who is also a trained CoH facilitator. Both Christian and Muslim facilitators should have some formal faith-based education or training. For more information on CoH curricula adapted for Muslim contexts, email channels_of_hope@wvi.org.

Other faith contexts

For predominantly non-Christian or non-Muslim contexts, the adaptation of the CoH curricula for other faith groups is a rigorous process that requires due diligence with scholars from that specific faith group. (See 3.1 *What scope is there to adapt?* below for more information.)

Part 2

2. How to use this Model

2.1. What scope is there to adapt?

Essential elements of the model are outlined in each of the four phases: Prepare, Catalyse, Strategise, and Empower. The Implementation Quality Assessment (IQA) outlines the essential elements for implementation.

Key elements must include:

- *Train the Facilitator* events led by Global Centre (GC) validated training teams
- *Faith Leader Catalysing* workshops, led by trained facilitators, covering core minimum content (outlined in IQA Implementation)

[5] Before working in a predominantly Roman Catholic context, WV staff members need to understand the Roman Catholic Church, its theology on family life issues, and its organisational structures. Buy-in from church leadership at the national level is of the utmost importance. (A strong example of partnership is the Latin American and Caribbean Regional Office region relationship with Latin American Episcopal Council, a decade-long process to strengthen the relationship and form a formal partnership around CoH.)

- *CHAT Strategising* workshops, led by trained facilitators, covering core minimum content (outlined in IQA implementation)
- Follow-up meeting one month later and then every 6 months
- Connections to other engagements and capacity building opportunities.

See IQA Design and IQA Implementation for essential element checklists for full implementation.

Adaptation

The adaptation of any of the CoH curricula for another faith group is possible. It requires a rigorous process that requires due diligence with scholars from that specific faith group. WV staff (in partnership with the CoH Global team) need to first test and validate the material with the relevant faith audience. Ideally the CoH curriculum should be adapted in collaboration with a credible faith-based organisation (FBO) within that faith group. For information and guidance on implementing CoH in the context of other world religions (such as Buddhism), contact the CoH Global team (channels_of_hope@wvi.org).

2.2. Who will WV partner and work with to implement this model?

CoH is a mobilisation tool for faith communities. The strongest partners are senior and lay church and faith leaders at national and local level. Understanding faith community structures and ensuring relationships at the necessary levels (local, national, international) is essential for sustained success. An evaluation of CoH-CP in Malawi showed that pastors of established churches were more active and influential in taking action to promote child protection, than those from large, poorly resourced churches and informal churches.[6]

Local government actors in the relevant sector, other CBOs and NGOs are also important partners that should be present at all levels of implementation (training and workshops). Local government actors have an opportunity during the workshops to share ways in which individuals and faith communities can engage in existing systems, as well as to support them in their planning. All relevant community leaders and groups, parent-teacher associations, informal or traditional structures that are working towards child well-being, are also necessary partners. These partners are particular important for community interaction and can highlight ways in which other community actors can best contribute to, and learn from ongoing work, and during 'The Way Forward' planning session during the workshops.

The *CoH Field Guide* provides guidelines to help select key partners whose input, collaboration and partnership will be key to successfully implementing CoH (See *CoH Field Guide Addendum 6* for more information on partners for the various CoH curricula).

2.3. Local to national advocacy

Faith leaders can be powerful advocates; their moral authority and influence both within communities and hierarchical church and denominational structures is unmatched. Once the CoH methodology catalyses faith leaders, they become personally motivated to speak out and demand equality, just and accessible quality services, policies, practices, law enforcement and adherence. CoH has led to faith leaders advocating for individuals at the local level, joining forces with other faith and community members at the community level and joining national and international advocacy campaigns.

Sometimes faith leaders may need extra skills and opportunities in order to address specific advocacy issues. Local WV staff can link them to opportunities during the *Empower* phase. Faith leaders can engage with advocacy efforts in various ways:

- They can advocate within their own congregations.
- They can address specific advocacy issues in public events. For example, in South Africa, faith leaders engaged in CoH have become key members of the 'Thursdays in Black' campaign against gender-based violence.
- Faith leaders or community members can be trained as Citizen Voice and Action (CVA) facilitators, or encouraged to participate in local level advocacy activities and processes. In

[6] Kachale, B, Eyber, C and Ager, A (2015) Learning from the Implementation of Channels of Hope for Child Protection in Malawi. Report to World Vision UK. Edinburgh: QMU, Edinburgh.

Kenya, for example, through the MOMENTS grant, faith leaders trained in CVA have actively promoted access to modern family planning tools.

- Faith leaders can use their hierarchical structures to link and enrich national level advocacy campaigns with local level advocacy, for example:
  - By driving national advocacy campaign messages down to local levels so that communities know where and when services and policies are not enforced
  - By communicating local needs and gaps up to national level when policies are not enforced locally, thus creating more pressure and demands for governments to deliver on the promise of various services.

To capitalise on these opportunities, the Area Programme (AP) manager, the Development Facilitator (DF) at the local level, the advocacy lead and the Christian Commitment (CC) coordinator in the national office need to coordinate and develop a plan of action. See *CoH Field Guide Addendum 14* (*National-level guidelines for partnering with churches and denominations*) for guidance on how to carry this out effectively.

3. Programme logic

3.1. Describe the programme logic

The CoH project model works best when embedded alongside other sectoral project models or frameworks. CoH mobilises the faith community to address underlying norms and beliefs which contribute to attitudes and behaviours, and then to take action through prevention, care and advocacy work. As a result, the goal and outcome level interventions will often be determined by the specific Technical Programme or grant. A list of possible sectoral outcome indicators to consider is available in the *CoH Logframe* in the Field Guide.

Illustrative logframe:

	Hierarchy of Objectives	Recommended standardised Indicators	Means of Verification
Goal	Empowered faith communities contribute to the enhanced well-being of the most vulnerable children and community members.	1. Communities have improved child well-being* (indicator defined by overarching project).	1. Focus group discussions and key informant interviews 2. Secondary data from development structures (health, education, legal, and justice institutions) 3. Caregiver survey 4. Other relevant CWB measurement tools.
Outcome 1	Faith communities participate in actions that contribute to child well-being.	Indicators defined by relevant project area reflecting project outcomes. (see examples below) CoH-specific outcomes related to the role of faith leaders and communities are in development.	
Output 1.2	Faith leaders are catalysed (increased knowledge, resources, motivation and protective attitudes).	1. Number of faith leader catalysing workshops conducted (by CoH curricula) 2. Number of faith leader catalysing workshop participants (by CoH curricula, faith, sex, leadership role, faith community/congregation) 3. Number and percentage of catalysed faith leaders who report they are somewhat or highly motivated to act on CoH focus issue (by CoH curricula) *Indicator related to change in attitude and behaviour is being developed.	1. Form 3: CoH Facilitator Workshop Report 2. Form 1: CoH Workshop Attendance Register 3. Form 2a and 2b: Pre and Post workshop Questionnaire and Workshop Evaluation; summary in Form 3, (indicators 2-4).

Output 1.3	CHATs developed and prepared to implement a strategic action plan (increased knowledge, resources, motivation and protective attitudes).	1. Number and percentage of catalysed faith communities who establish faith community groups (CHATs) (based on CoH curricula) 2. Number of faith community strategising (CHAT) workshops conducted (based on CoH curricula) 3. Number of faith community strategising (CHAT) workshop participants (based on CoH curricula, faith, denomination, sex and leadership role) 4. Number and percent of CHAT participants who report they are somewhat or highly motivated to act (based on CoH curricula) *Indicator related to CHAT participant change in attitude is under development.	1. Form 1: CoH Workshop Attendance Register, Form 3: CoH Facilitator Workshop Report 2. Form 2a and 2b: Pre and Post workshop Questionnaire and Workshop Evaluation; summary in Form 3: CoH Facilitator Workshop Report (indicators 2-4) 3. CHAT planning worksheet.
Output 1.4	CHAT participants are empowered (Acting on CoH focus issue).	1. Number and percentage of CHATs implementing an action plan (by CoH curricula, competency area) 2. Number of active volunteers mobilised due to CHATs (by volunteer type) 3. Number of volunteers mobilised in the past 6 months (by volunteer type) 4. Number and percentage of faith communities who have participated in advocacy during the past 6 months (by CoH curricula).	1. Form 4 (during semi-annual follow-up meetings with CHAT representatives), indicators 1-4.

Examples of outcome indicators

These are examples of various indicators divided by sector:

Child Protection

1. Proportion of parents who use physical punishment or abuse as a means of disciplining their children
2. Harmful traditional or customary practices are no longer the norm in the community
3. Proportion of children who report living free from violence, exploitation and abuse in the past year
4. Proportion of caregivers who report that one or more daughter has been cut for female circumcision
5. Approval of female genital mutilation/cutting
6. Proportion of children under 18 years who are married
7. The strength of the support asset category as reported by adolescents 12-18 years of age (Development Assets for Adolescents)
8. Proportion of children with a birth certificate.

Gender

1. The strength of score on the Gender Equitable Men (GEM) scale (Violence, Domestic Chores & Daily Life, Sexual Relationships Domains)
2. Approval of female genital mutilation/cutting
3. Proportion of caregivers who report that one or more daughter has been cut for female circumcision
4. Proportion of adults who think a husband is justified in hitting or beating his wife under certain circumstances.

HIV

1. Proportion of women who were offered and accepted counselling and testing for HIV during their most recent pregnancy, and received their test results
2. Proportion of infants born to HIV-infected women who received early diagnosis
3. Proportion of HIV-infected pregnant women who received ARVs
4. Proportion of infants born to HIV infected women who received ARV prophylaxis
5. Proportion of youth who have been tested for HIV and received their test results.

MNCH

1. Proportion of women married or in union who are using a modern contraceptive method
2. Proportion of women practising birth spacing
3. Proportion of children exclusively breastfed until 6 months of age
4. Coverage of essential vaccines among children

5. Proportion of children under 5 with diarrhoea who received correct management of diarrhoea
6. Proportion of children under 5 with presumed pneumonia who were taken to appropriate health provider
7. Proportion of households where all children under 5 years slept under long lasting insecticidal nets (LLIN) the previous night
8. Proportion of infants whose births were attended by a skilled birth attendant
9. Proportion of mothers who report that they had four or more antenatal visits while they were pregnant with their youngest child
10. Proportion of mothers of children aged 0–23 months who received at least 2 post-natal visits from a trained health care worker during the first week after birth.

3.2. Information flow and use

There are five separate monitoring forms and one Excel workbook available to capture the data used in the CoH programme. The following table is a summary of the five forms and how they relate to every step in the CoH process (outlined in full in the Field Guide) with instructions on how to use each form.

The roles of three primary actors: the Development Facilitator (DF), the CoH facilitator and the NO CoH point person are outlined below. A complete description of the actors is outlined in Section 5.1 Management Consideration: Guidelines for Staffing.

The CoH monitoring and evaluation information serves the following purposes:

1. It ensures there is adequate staff capacity and time to provide and prioritise support.
2. It shares with WVI Leadership the scale and scope of CoH programming in engaging faith communities.
3. It enables the sharing of learning from implementing NOs about best practices, innovations and other areas.
4. It facilitates communication both internally and externally about the scale of CoH, contributing to a range of commitments and opportunities including 'Every Women, Every Child'. - a global movement to mobilise and intensify international and national action by governments, the UN, multilaterals, the private sector and civil society to address major health challenges facing women, children and adolescents.

How to use Channels of Hope monitoring

Data collection tool to use (and its purpose)	How to action the data
Form 1: *CoH Attendance List* **Purpose:** For the DF to follow up with participants from CoH workshops, CHAT workshops, and follow-up meetings.	Attendance lists at CoH events provide local and NO colleagues with a record of faith-based partners in any particular CWB area. These lists are essential for arranging ongoing 6 monthly meetings, as well as providing a list of faith-based partners for any future capacity building and training.
Form 2a & b: ***(CoH Pre and Post-Workshop Questionnaire)*** **Purpose:** The pre-workshop questionnaire focuses on attitudes of CoH workshop participants. Participants answer the same questions at the end of the workshop to determine changes in attitude. **Note:** Each CoH curriculum has its own Form 2a & b.	Pre and Post workshop questionnaires help to provide local and national office staff with information regarding key beliefs and attitudes within a community related to the CWB outcome. During the workshop, CoH facilitators can use this information to target which portions of the content need to receive specific attention. In addition, technical experts, partners and NO decision makers can track trends in basic attitudes to determine other potential interventions. The change in attitudes over the course of the workshop can be notable. The questionnaire can also be used at later points in the life of the project with the same participants to show the sustainability of attitude changes over time.
Form 3: ***(CoH Facilitator's Workshop Report)*** **Purpose:** One form is completed for each CoH workshop conducted and the CoH facilitator captures the summary of data from Forms 1 and 2	Form 3 provides ADPs with demographic information to ensure that participation appropriately reflects the demographics and target group of the ADP and NO programming (including religious and denominational diversity, and gender equity). It also provides a snapshot of changes in attitude as well as the stated commitment/motivation of participants to take action on the CWB outcomes. Both show the effectiveness of particular workshops and facilitators.

Form 4 **(*CHAT Monitoring Form for Semi-annual (twice a year) meetings*)** **Purpose:** To monitor active CHATs (using consistent metrics).	Form 4 provides feedback on actions taken by partner faith communities after completion of *Faith Leader Catalysing* and *CHAT Strategising* workshops. They provide feedback on additional capacity building needs, help local and national actors to align future training and resources and advocacy, share opportunities and request additional support for any gaps.
CoH Semi-annual Report Workbook **Purpose:** Excel spreadsheet which summarises **all** CoH work done during the 6 month reporting period, including all demographic data (such as total participants and congregations) theological insights and motivation changes resulting from all CoH workshops conducted during the reporting period; demographic data from all CoH follow-up meetings; and monitoring data from active CHATs.	Summary information provides a snapshot of the above forms for management overview and partner view regarding which faith communities are engaged, as well as recording opportunities and challenges in engagement towards child well-being.

For copies of the CoH monitoring data collection forms and Microsoft Excel workbooks (*CoH Consolidated Semi-annual Reports)* contact the global CoH team channels_of_hope@wvi.org.

Note: At the time of publication a training and workshop database was under development to capture relevant data using existing forms. This database system will change some of the structures for reporting, simplifying the global roll up and data.

4. Management Considerations

4.1. Guidelines for staffing

The support staff structure for CoH depends on which curriculum will be implemented, the scope of the Technical Programme (TP) and an institutional mapping of the faith community. Based on the scope of implementation, the National Office (NO) will need three main roles to support CoH within any TP:

(1) **National Office CoH point person** (shared or full-time, depending on the size of the project)
(2) **Accredited CoH facilitators** (Best practice shows non-WV staff often make the best facilitators (See the *CoH Field Guide Addendum 6* for guidelines on selecting candidates).
(3) **CoH implementers** including NO sector leads (for example on health, gender, child protection and advocacy) and DFs or other local WV staff to assist with the coordinating and follow-up of implementing CoH.

The **NO CoH point person** is based at the NO (they may be the CC point person or sector leader of the CoH curriculum focus) and will implement and oversee CoH. The Regional or CoH Global team will engage with the NO CoH point person.

TPs that implement CoH need at least two (preferably three) accredited **CoH facilitators** in the relevant CoH curricula. However, this number could increase depending on the scale of implementation. In the case of WV staff, their tasks are embedded in their performance agreements and key performance indicators. Non-WV staff will sign an MoU outlining the number of workshops they will facilitate in return for their training and the rate of payment they will receive for facilitating later workshops. CoH facilitators can also conduct workshops throughout an entire NO or program area to overcome a shortage of facilitators.

The local **CoH implementers** (for example the local Development Facilitator, other WV staff or partner organisation community coordinator) who will support CoH at local level, need the capacity and sensitivity to establish relationships and work with local faith leaders. The skills and required time allocation to support the full CoH process should be included in the DF's job description and key performance indicators. Local CoH implementers also need to coordinate the logistics for all workshops; provide thorough and intentional follow-up, including semi-annual (twice a year) meetings; capture essential data for monitoring purposes; encourage and mentor progress among active CHATs; and help link them with local capacity building opportunities.

4.2. Budget

Sample AP budget for full 4-year CoH implementation cycle:

Year 1					**US$6,000**
Item	**Details**	**Unit costs**	**# of people/ units**	**# of events**	**Cost**
Prepare Training of facilitators	Three people trained per AP or Technical Programme/grant.	US$2,000	3	1	US$6,000
Year 2-4					**US$18,800+***
CoH faith leaders workshops	Faith leader's workshops for Fiscale YearYear (number depends on target population and plan).	US$5,500*	1	2	US$11,000*
Follow-up meetings for faith leaders	Conduct follow-up meeting within one month after workshop and then every 6 months.	US$10	40	2	US$800
CoH Strategising (CHAT) workshop	Chat workshops planned for year (will vary)	US$3,200*	1	2	US$6,400*
Follow-up meetings after CHAT workshops	Conduct follow-up and 6-monthly meetings with participants of catalysing workshops.	US$10	50	2	US$1,000
Selected faith leaders included in CVA (or other capacity building) training	Send faith leaders who demonstrate capacity and passion for advocacy for CVA training.	US$300	4	1	US$1,200

Full Budget needs and a budget worksheet is available in the *Field Guide Addendum 4*.

5. Linkages and integration

5.1. Development Programme Approach

CoH addresses traditional, cultural or religious beliefs or practices that contribute to or prevent child well-being. It is a tool for sustained dialogue with faith partners, and a primary mechanism for strengthening partnership with the church (WV's indispensable partner) and other faith communities. Strengthening staff understanding and analysis skills as they use the Development Programme Approach (DPA) tools to identify and address underlying world views, including spiritual and cultural components, can provide information that will encourage the use of CoH to promote child well-being.

CoH is an ideal project model to use wherever faith leaders are influential community actors. If any DPA root cause analysis exposes underlying attitudes rooted in cultural or religious norms that serve either as barriers, or as contributing factors to effective child well-being, the CoH process can address and catalyse faith communities to become part of the response.

Whether faith leaders are seen as barriers to progress, or as allies who contribute to child well-being, CoH provides an effective model for engagement.

CoH also contributes towards key sustainability drivers: transformed relationships; local ownership; and local and national advocacy.

5.2. Integration and enabling project models – opportunities for integration with other CWBOs

Each CoH curriculum responds to specific strategic objectives and can be embedded in corresponding sector-specific programming. The CoH curricula mutually reinforce each other's outcomes and complement sectoral programming. They create an enabling environment for other interventions while strengthening faith communities to respond to important child well-being issues. Each CoH curriculum contributes to the relevant sector's child well-being objectives.

Some examples of CoH contributions include:

- CoH-Gender has contributed to an increase in girl children attending school as part of Zimbabwe's I-GATE project, which includes eight other project models including *Community Change for Social Action*.
- CoH-HIV in partnership with the *Home Visitors* project model training, has led to an increase in church-based volunteers supporting orphans and vulnerable children in multiple locations in Africa, according to operational research and Core HIV and AIDS Response Monitoring System's (CHARMS) data.
- CoH-CP is an integrated part of the *Child Protection Advocacy* project model and framework. In Malawi, CoH-CP was piloted alongside the *Citizen Voice and Action* project model, showing significant uptake in advocacy efforts on the part of faith leaders in the community. CoH-MNCH promotes prevention of mother-to-child transmission of HIV (PMTCT) and 7-11 messages to faith leaders and can be supported by follow up visits through *Timed and Targeted Counselling for Health and Nutrition*.

Part 3 – Detailed Field Guidance

This section is designed to provide practical, detailed descriptions of the methodology and supporting tools available to field staff as they implement the project model.

Resource Name	***Description***
Field Guide	This field guide assists CoH implementers (at AP or NO level) to understand the various steps and implement CoH successfully, including a visual roadmap.
CoH Facilitator's Manual and Package (Available for trained facilitators in each content area)	The CoH Facilitator's Manual provides clear instructions (content focuses on a specific technical theme, methodologies, and facilitation instructions) for trained CoH facilitators to conduct workshops. The full resources package also includes a Biblical Reflections Booklet, Reference Index, CHAT planning workbook, and Facilitator's DVD.
CoH Facilitator's Guide (Available for trained facilitators)	The Facilitator's Guide focuses on the planning and execution of workshops and is relevant for all content areas.
Pre-Implementation Road Map	Tool for NO leadership and CoH implementers to use before initial implementation to ensure they are fully prepared.
CoH DME Guide	An addendum in the Field Guide - the CoH Monitoring Guidance - outlines the full logframe, monitoring tools and other relevant DME guidance.
CoH Evidence and Evaluation Tracker/Evidence	A quick summary of past, ongoing and planned CoH evidence building work.

Contact CoH Sr. Technical Advisor Andrea Kaufmann at Andrea_Kaufmann@wvi.org for questions or additional needs.