How and why does 'Channels of Hope' work?

These questions were examined by the Groningen University researchers in their studies on CoH for Health and Gender.

World Vision's faith-base and long-term relationship with communities has earned us the trust of faith leaders. As a result, they have allowed us to challenge and transform their often long held assumptions and attitudes that damage the wellbeing of children – an experience that can be deeply personal and emotive. Above all, CoH makes a connection with people's faith, intertwining deeply held beliefs and development: Our references to the spiritual and scriptural inspire. Hearts are touched when faith leaders and communities consider the harmful impact their attitudes and behaviour may have on others. The scientific evidence we present engages minds. And finally, the resources we provide enable people to take action, to use their hands, and change their communities for good. We also encourage faith leaders and groups to work with others to increase their expertise and capacity to break down the barriers hampering positive and transformative change.

Channels of Hope for Ebola

As a response to the recent devastating Ebola outbreaks in West Africa, we've developed CoH for Ebola. This programme works with faith leaders to help them dismantle the religious and social barriers that enabled the virus to spread by sharing accurate messages on protection against Ebola, to safely care for people with the virus and address the stigma they face. CoH for Ebola has proved to be a critical means for the uptake and support for the 'safe and dignified burial' protocol developed by the World Health Organisation. The success of CoH for Ebola has shown us that CoH can be a valuable tool in other emergency contexts – both in emergency preparedness and response.

Challenges and Conclusion

CoH works because it starts at the heart of a community, with its faith leaders – among the most influential people who can support, or block, initiatives that bring change and transform communities. We know that CoH is changing harmful attitudes and behaviour – from declining incidences of early marriage to more babies being vaccinated – but there is more for us to do.

We're currently working from a limited evidence base and need resources to invest in robust quantitative and comparative data to help inform our development plans for CoH. For example, recent qualitative data suggests our CoH programmes need to find places and ways to target and involve more men and boys, particularly on issues like GBV. CoH also faces the challenge of scaling up. We need to be ready and able to make a difference not just at local level, but at national and regional levels and also to work with other faith groups. And we also need to adapt CoH for different emergency responses. To achieve all this we will need expanded resources, networks and partnerships to work not only with local faith leaders and groups but with national and regional faith organisations and hierarchies too.

As we enter the new era of Sustainable Development Goals, we cannot ignore the fact that more than four fifths of people identify with a religious group, so working with faith leaders can no longer be a development 'add-on', particularly if we want to ensure that no-one is left behind. We need targeted, faith specific programmes for faith leaders and their communities and resources to fund them. This programming needs to include comprehensive information that bridges scientific and technical gaps, but crucially also speaks from religious scriptures to make the vital faith connection.

[3] Source: http://www.washingtontimes.com/blog/watercooler/2012/dec/23/84-percent-world-population-has-faith-third-are-ch/

World Vision is the world's largest international children's charity, working to bring real hope to millions of children in the world's hardest places.

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Children's choir, Chingale Presbyterian Church ©Janet Mbwadzulu, World Vision Malawi

'Channels of Hope' (CoH) is World Vision's signature programme for catalyzing faith leaders and their communities to transform children's lives in the world's hardest places. It was developed over a decade ago by the Christian AIDS Bureau for Southern Africa as a compassionate Christian response to the devastating effect of HIV & AIDS. Since then CoH has evolved to address other difficult and often taboo issues that affect the rights and wellbeing of children and has been used in over 30 developing countries.

Meeting faith leaders where they're at

Faith leaders are among the most influential members of the communities we serve. They are trusted, respected and listened to. And they are able to either inspire their communities to overcome traditional social norms and attitudes that harm the wellbeing of vulnerable children – or preserve the status quo. CoH programmes have been developed for Christian and Muslim communities. The Christian versions have been adapted for a wide variety of ecumenical contexts – from Pentecostal to Catholic and Orthodox. We have partnered with Islamic Relief and Islamic scholars to develop and roll out the Muslim adaptation which can be applied in mixed faith contexts (Christian-Muslim) and in Muslim only contexts.

One approach, many issues…

Currently there are five CoH programmes:

- CoH for HIV & AIDS
- CoH for Maternal and Newborn Child Health
- CoH for Gender (also available in a simpler format, specifically created to engage 8 to 15 year olds)
- CoH for Child Protection
- CoH for Ebola.

All CoH programmes share a common goal to empower faith communities to tackle behaviour and attitudes that harm children and deny them their rights. They also share a common framework that is adapted to address specific issues attached to each CoH theme. For example, Channels of Hope for Gender challenges traditional attitudes and practices that harm girls and women –such as keeping girls from school, female genital mutilation / cutting (FGM/C) and gender-based violence (GBV) – while Channels of Hope for HIV & AIDS helps to overcome issues like stigma and attitudes to condom use.

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The CoH process runs for a minimum of two years, taking in four phases:

PREPARE → CATALYSE → STRATEGISE → EMPOWER

Preparation happens at both national and community levels. During this phase we establish relationships with various faith groups and their leaders. We also build the capacity of staff and partners to plan for and implement the CoH methodology. The **catalysing** and **strategising** phases focus on motivating and equipping faith leaders and their wider congregations to engage with local issues in a meaningful way. The fourth phase empowers faith communities on a continual basis and integrates them with other community programming. In this way, the CoH process helps congregations to competently and sustainably address the numerous local development issues that CoH exposes them to.

Impact case study – Maternal and Newborn Child Health

Two communities – Lupane and Robert Sinyoka – in southern Zimbabwe have recently completed our CoH for Maternal and Newborn Child Health. The urban Robert Sinyoka community had also previously run our CoH for HIV & AIDS programme. To help us assess the impact of CoH, several people who took part in the programme as well as non-participants and health workers were interviewed by researchers from the University of Groningen and the Knowledge Centre for Religion and Development .

In both communities, prior to the programme, attitudes towards maternal and child health were having harmful effects on the wellbeing of pregnant women, mothers and babies. For example, rather than visiting health centres for screenings, check-ups and to deliver their babies, women took advice and treatment from older community women and gave birth at home. Family planning was also frowned upon, breastfeeding not considered important and pregnancy outside of wedlock heavily stigmatised. Men were not encouraged to get involved or support their partners during pregnancy, birth and early motherhood.

The research found that since communities have been involved with CoH many former harmful attitudes have changed and as a result the health and wellbeing of babies, children and their mothers is improving. Positive changes in Lupane and Robert Sinyoka include the following:

- Pregnant women are now using the health facilities and are being screened and having check-ups
- Fewer women are giving birth at home
- More babies are being vaccinated against life threatening diseases
- More babies are being breastfed exclusively for their first six months
- Some men support their partners before and after their child's birth and have a better understanding of her needs during this time
- Newborns are celebrated in church services and harmful traditional practices, such as holding babies over smoking herbs, no longer happens
- Churches are more involved – encouraging women to use health centres and passing on helpful and accurate information regarding child nutrition, family planning and other sexual matters. A garden has been created to provide nutritious food for vulnerable children

In Robert Sinyoka, the research also found that:

- Attitudes and behaviour around HIV & AIDS shifted significantly
- People living with HIV were treated with greater care and compassion, were no longer ostracised and experienced better quality of life
- The attitudes of people not involved in the programme also changed to be more supportive of people affected by HIV & AIDS

[1] Dr Erin Wilson (Centre for Religion, Conflict and the Public Domain, University of Groningen), Brenda Bartelink (Knowledge Centre for Religion and Development, NL) and Nikki Haze (Centre for Religion, Conflict and the Public Domain, University of Groningen).

Impact Case Study - Child Protection

In 2014, two communities, Chingale and Namachete, in the south of Malawi, took part in our Channels of Hope for Child Protection pilot training, supported by DFID UK aid. In these areas the protection and wellbeing of children had not been a priority. Many children were not in school and were working instead, or had married at a young age. Harsh physical punishment of children was also commonplace. Traditional values and practices did not encourage valuing children or recognising their rights. However, after the CoH sensitisation workshops, researchers from Queen Margaret University found the attitudes of faith leaders and their congregations towards children changed significantly .

During sermons and in church groups, community members came to understand that the safety and wellbeing of children in their community was extremely important: As adults, it was the community's responsibility - not just the parents'- to ensure that all children went to school and were protected from abuse, such as forced labour, early marriage and corporal punishment. To help make this a reality, many faith leaders explored innovative ways to protect their community's children; either within existing women's and youth groups or by setting up new action groups. Others forged new links and worked together with government bodies and related agencies, including child protection committees, the police, social workers and teachers. For example, one community, working with relevant legal bodies, established a by-law that made early marriage illegal, protecting more girls and enabling them to stay in school.

"I knew that some people hit their children but I didn't realise that this is child abuse… I can never be the same again. There was me before the workshop and me after the workshop. I am changed and I can never go back to how I was before," Pastor K from Chingale

"This training has been very helpful - looking at the communities a man can do anything with a girl - you can just do what you like and nobody can speak. I used to thank God that I was not a girl! Now we can intervene. It has empowered us. Even politically things are changing. We need to respect each other, biblically. We have to spread that to the community," Male pastor from Ixopo, South Africa

Impact case study - Gender

After World Vision ran CoH for Gender in communities in Kenya (Riruta and Wema), Malawi (Chitundu and Mposa), South Africa (Ixopo and Umzimkulu) and Tanzania (Muklat and Nakombo), researchers from the University of Groningen and the Knowledge Centre for Religion and Development carried out research to assess the impact of the programmes.

Before communities were involved with CoH for Gender, women and girls were affected by traditional patriarchal attitudes, including the beliefs that men are superior to women, women should obey men, work only in the home and that girls are not as important as boys.

After taking part in the programme, researchers found that most communities experienced some positive changes in attitudes towards women and girls:

- Faith leaders now set examples of gender equality by sharing domestic roles and chores and appointing women in leadership roles
- Church sermons regularly and specifically addressed gender issues, including preventing and reporting gender-based violence
- More girls are now registered for and attending school
- Some looked at alternative safe 'rites of passage' to replace FGM.

[2] Blessings Kachale, Carola Eyber and Alastair Ager from the Institute for International Heath and Development, Queen Margaret University, Edinburgh