

Spirituality as a conduit for social transformation?

Rethinking secular and religious
assumptions in development practice

**Report and Critical Research Reflection on
Channels of Hope HIV&AIDS and MNCH – Zimbabwe**

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Centre for
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Contents

- Abbreviations.....v
- Part 1. About This Report..... 1
 - 1.1 NWO-funded research project Channels of Hope..... 1
 - 1.2 Method and approach.....2
 - 1.3 Scope and limitations3
- Part 2. CoH Theory of Change6
 - 2.1 CoH and World Vision6
 - 2.2 Channels of Hope.....6
 - 2.3 Theory of Change.....7
- Part 3. Thematic Findings.....8
 - 3.1 Leadership8
 - 3.1.1 Overview of *faith leaders* in CoH methodology.....8
 - 3.1.2 Thematic findings: Leadership..... 10
 - 3.1.3 Who are faith leaders in CoH?..... 10
 - 3.2 Spiritual and religious content and change..... 12
 - 3.2.1 CoH methodology, spirituality and change..... 12
 - 3.2.2 Religion and spirituality in CoH: Trajectories for faith 13
 - 3.2.3 ‘Guiding Principles’ 14
 - 3.2.4 Spiritual and religious content and change..... 16
 - 3.2.5 Faith as narrative for change 19
 - 3.3 Gender, sexualities and intimacies..... 25
 - 3.3.1 Teenage pregnancy..... 26
 - 3.3.2 Gender-based violence and rape..... 27
 - 3.3.3 Reflections on gender and leadership 28
 - 3.4 Community change..... 30
- Part 4. CoH in Zimbabwe..... 36
 - 4.1 Introduction 36
 - 4.2 Women in Zimbabwe..... 36
 - 4.3 CoH in Zimbabwe 39
 - 4.4 Robert Sinyoka ADP 41
 - 4.4.1 Challenges in the past 41



4.4.2 Changes in the community	42
4.4.3 Changes in the churches	43
4.4.4 Ongoing challenges	44
4.5 Lupane ADP	45
4.5.1 Challenges in the past	45
4.5.2 Changes in the community	45
4.5.3 Changes in the churches	46
4.5.4 Ongoing challenges	47
Part 5. Conclusions and Recommendations	48



Abbreviations

ADP	area development programme
ARVs	antiretrovirals
CABSA	Christian AIDS Bureau of Southern Africa
CHAT	Church Hope Action Team
CoH	Channels of Hope
FGD	focus-group discussion
MCDWA	Ministry of Community Development and Women's Affairs
MNCH	maternal, newborn and child health
NGO	non-governmental organisation
NWO	Netherlands Organisation for Scientific Research
ToC	Theory of Change (model)
UN	United Nations
UNFPA	United Nations Population Fund
WV	World Vision
ZANU	Zimbabwe African National Union



Part I. About This Report

1.1 NWO-funded research project Channels of Hope

This report is part of broader research funded by the NWO (Netherlands Organisation for Scientific Research) that explores the place of faith and spirituality in processes of societal transformation. This research project developed out of an existing collaboration amongst three groups: the Centre for Religion, Conflict and the Public Domain at the Faculty of Theology and Religious Studies, University of Groningen; the Knowledge Centre Religion and Development in Utrecht; and World Vision. This collaboration has previously resulted in the establishment of a research cluster, a webinar series on issues related to religion and development, and the 2014 evaluation of World Vision's Channels of Hope (CoH) Gender programme in Malawi, South Africa, Kenya and Tanzania.

The CoH programme has had tremendous success in altering attitudes of local religious leaders and motivating them to take action to change the attitudes in their communities in project areas with varying religious, cultural and socioeconomic demographics. CoH provides education and training for faith leaders on issues traditionally associated with stigma and marginalisation in developing contexts, including HIV and AIDS, gender-based violence, child protection, and maternal, newborn and child health (MNCH).

Originally the research was to focus on Kenya and Zambia. Owing to time constraints and a variety of other factors, this was revised and the field research was conducted in Zimbabwe.

While the initial intention was to take a comparative perspective on CoH HIV&AIDS and CoH MNCH, the empirical research indicated that the two themes and methodologies were intertwined, with significant crossover, thereby making a comparison methodologically complicated. In 2011, the impact of HIV was less severe and there was more openness and care for people affected by HIV and AIDS as a result of new initiatives and improved community support structures. However, the health and well-being of mothers and children emerged as one of the more critical and comprehensive challenges that affected people and local communities. CoH MNCH was developed to address these issues, including a focus on people living with HIV and AIDS. For example, in Zimbabwe the second most common mode of transmission of HIV is from mothers to newborn babies; in our interviews in Robert Sinyoka area development programme (ADP), where we initially planned the evaluation of CoH HIV&AIDS, we found that people were referring to CoH HIV&AIDS and CoH MNCH simultaneously. CoH has now developed a model that is called MNCH+ that includes both HIV&AIDS and MNCH. As a result, this report focusses predominantly on CoH MNCH, though it also incorporates some reference to CoH HIV&AIDS.

The initial findings of the report were presented at a workshop held in The Hague from 25–26 June 2015. The workshop, titled 'The Spiritual Is Political: Exploring Transformations In Religion and Development', explored questions related to the themes of this research project: How and why do religion and spirituality matter in development? What are the interconnections between individual transformation and social transformation? What role does spirituality play in personal and social transformations? How can understanding of and reflection on individual, personal experiences of religious and spiritual transformation be incorporated in and contribute to the



development of more religious-sensitive policymaking and practice within traditionally secular development institutions and approaches?

Exactly how and why such dramatic shifts in attitudes occur, the effectiveness of engaging explicitly with faith, and the precise extent of the success of the CoH programme are largely unknown. The NWO-funded project worked to explore these dimensions with the aim of contributing to best practice in development as well as broader societal and academic understandings of the place of faith and spirituality in development. While there recently has been substantial increase in literature on the role of religion and faith-based organisations in development in religious studies and related disciplines, gaps still exist in knowledge of what difference engaging with faith makes in contrast to purely secular approaches and the precise processes through which faith-based attitudinal and behavioural change are achieved within programmes such as CoH. These are the meta-level analytical questions that sit behind the evaluation that is presented here.

1.2 Method and approach

Individual interviews

The research team operationalised these key outcomes by requesting interviews with key-informants and stakeholders on different levels in each ADP.¹ This included those not exposed directly to CoH (unless mentioned below):

- male church leaders/congregants
- female church leaders/congregants
- local leaders
- individual interviews with faith leaders exposed to CoH
- ADP staff.

Group interviews

Group interviews with congregants were conducted in men-only and women-only groups, recognising the possibility that women would potentially be more likely to discuss sensitive issues related to women's health in a female-only setting, and that men would be able to emphasise what was most important to them regarding MNCH and HIV and AIDS. Usually these men and women were married and of reproductive age, although occasionally some younger girls and boys were present as well. Because of its focus on MNCH issues, their distinctive perspectives were not necessarily very well captured within the chosen set-up.

Conversations with staff

In addition, we had many (informal) conversations with national office staff, including coordinators responsible for work related to health, church partnerships and faith and development.

¹ World Vision's programming model that defines a geographical area within which project activities would be implemented.



Categories of inquiry

Questions during interviews addressed the following in a semi-structured interview format:

1. personal introductions
2. experiences in MNCH and HIV-related issues in the community
3. changes observed in the past three years
4. perception of and/or experience with CoH
5. importance of MNCH through the Bible, involving religious leaders and churches
6. personal impact of CoH
7. changes in church following CoH
8. changes in community following CoH
9. key moments in the CoH workshop
10. what was not helpful, suggestions for changes
11. recommendations for follow up and support.

The questions allowed for interaction between researchers and interviewees as well as creating space for following up on issues that either researchers or interviewees brought forward as important in a specific session. The evaluation team also pursued certain lines of questioning on issues that were relevant for the report based on how they were brought up by the interviewees. Therefore, some interviews focussed more on scriptural and spiritual reflections on CoH MNCH and CoH HIV&AIDS, while others focussed more on the practical problems and solutions.

Other data sources

This report uses semi-structured interviews as the primary data source but also utilises background information on each ADP from its integrated programme design documents, which include information about the ADP's religious makeup. There are also reflections included from the research team's own observations in informal discussions with World Vision staff and community members, and increased insights into the CoH methodology and World Vision's approach.

1.3 Scope and limitations

The objective of the data collection, evaluation and report is twofold:

1. to provide direct and immediate feedback to World Vision on CoH MNCH and HIV&AIDS to strengthen and improve these programmes
2. to generate insights regarding the significance of religion and spirituality in addressing widespread societal problems and encouraging attitudinal and behavioural change.

This report focusses predominantly on the first of these objectives.

There were a number of important limitations on the research process that inevitably affected the outcomes detailed in this report. Research focussed on two ADPs in Zimbabwe: Lupane ADP and Robert Sinyoka ADP. The first limitation was that the evaluation took place in the absence of a baseline assessment in almost all the communities where CoH HIV&AIDS and CoH MNCH were implemented. For instance, in Lupane ADP a short evaluation of CoH MNCH had been done two years prior, which provided some insight into how CoH was



appreciated and appropriated by the community. Yet that evaluation was topical and only touched upon MNCH-related problems, whereas this study also considers how spirituality is intertwined with personal and social processes of transformation and change.

While our interlocutors have provided testimonies regarding positive changes related to different MNCH indicators (including changes in the uptake of services) these testimonies are necessarily limited to participants' own experiences and observations and cannot be used as definitive indications of change in the community as a whole. They have also been given in the very specific context of an interview related to the evaluation in the presence of World Vision staff, external consultants and local security officers. There is always the risk in such situations, and with interview methodology more generally, that interlocutors will tell the researchers what they think you want to hear. In interpreting the data, allowances must be made for this possibility.

Further, there is little statistical evidence available on change and, as such, the report relies on community members and professionals' *perceptions* of changes that have occurred regarding MNCH. That being said, the value of people's perceptions should not be underestimated. A programme may produce successful outcomes yet not be supported by the community, which undermines its long-term effectiveness. In the case of CoH, there is sufficient qualitative evidence outlined in the report below based on testimonies of participants to suggest that it is both perceived positively by the community and has had positive impacts on the health of women and children, rendering it more viable in the long term.

A second limitation on the process was time. The time constraints of the donor, the consultants and World Vision meant that the evaluation took place within only one week per ADP. It limited possibilities for follow-up interviews and affected rapport with the community members, which then also had an impact on the information gathered. Additional time would have enabled the researchers to observe community meetings and processes to see how the knowledge of MNCH is practiced in the community, not just receive testimonies from community members regarding how significant the impact has been. It is important to be able to hear how people themselves perceive the impact and also observe realities on the ground.

A third limitation of the research was language. Neither of the researchers spoke the local languages and thus had to rely on translation, which in itself was problematic to an extent. Additional problems arose because we had to rely either on World Vision staff or on members of the local community for translation assistance. In both cases the translators were not disinterested parties but had a vested interest in the ways in which both CoH and the community would be presented to the outside world. While we believe that on the whole the translations were provided with the utmost integrity and accuracy, we must nonetheless acknowledge these limitations.

A fourth limitation was the evaluation setting, in which foreign researchers are closely monitored. During our fieldwork we were, most of the time, accompanied by local security officers. This meant that in some of the individual interviews, aimed at discussing quite personal experiences and views, three local security officers were present. In some of the cases this may have directly hampered the possibility of engaging on a more personal level, while in other personal and group interviews this may have influenced more implicitly what was said and what remained unsaid. While none of the interviews contained or were intended to contain any reflections on politics – which was the main security concern – the chosen method of research



relies on rapport and trust between researcher and interviewee. In view of that, the presence of security officers was highly problematic and a serious limitation in the research.

As with all such research projects and evaluation reports, the information and data that we include here form a selection of the materials and insights we have collected. We encourage anyone who would like more information or additional stories and quotations relating to specific topics to contact us. We will be more than happy to provide them.



Part 2. CoH Theory of Change

2.1 CoH and World Vision

World Vision International is one of the largest non-governmental development organisations worldwide.² The organisation has its philosophical roots in American evangelicalism,³ yet now has links with many different Christian churches and denominations worldwide. It has built a successful child-sponsorship programme and attracted a large support base of individual donors, who are usually based in developed countries where World Vision funding offices are located.

World Vision has broadened its focus to community development in the past decades, and ADPs have become the basis for operation. This means that World Vision works with local communities regardless of faith or other identifications in that community. Earlier studies, including a widely acknowledged study by anthropologist Erica Bornstein, have suggested that this support base mainly operates along Christian lines.⁴ The organisation also attracts funding for its development programmes from larger (secular) development donors and foundations. Cooperation with national governments and local governance structures, leadership and other stakeholders is important. While World Vision maintains its links with Christian churches and communities worldwide – including through its church partnership and Christian witness programmes – it has incorporated a multiplicity of Christian (ecumenical), multi-faith and secular voices within its organisational practices.

World Vision's understanding of development is also referred to as transformational development. Transformational development seeks to restore and enable wholeness of life with dignity, justice, peace and hope for all girls, boys, women, men, households and their communities.

2.2 Channels of Hope

The Christian AIDS Bureau of Southern Africa (CABSA) initially developed Churches Channels of Hope in 2001 based on models developed by World Vision's Christo Greyling. CoH was designed to help churches respond to HIV and AIDS, building a network of faith leaders and churches providing accurate and full information in a faith-sensitive manner.

In 2004, World Vision International signed a license agreement with CABSA to adopt and implement the programme globally.⁵ CoH is therefore closely connected with World Vision, its worldwide network and its specific organisational approach to development. It has grown to mobilise faith communities for advocacy, care and prevention in HIV and AIDS, gender, maternal and child health, child protection and Ebola. CoH has expanded to serve Christian and Muslim communities in Africa, Asia, Latin America and the Middle East and Eastern Europe. In Zimbabwe the CoH model was implemented in its Christian-only version because of the Christian context.

² In 2014, the various entities of the World Vision Partnership employed more than 45,600 staff. See World Vision International, *Accountability Report 2014* (2015). World Vision is currently working in more than 85 offices worldwide. See 'Where We Work' on www.wvi.org.

³ Erica Bornstein, *The Spirit of Development: Protestant NGOs, Morality, and Economics in Zimbabwe* (Stanford, CA: Stanford University Press, 2005).

⁴ Ibid.

⁵ Christo Greyling, 'Channels of Hope: Partnering with the Local Faith Community for the Well-Being of Children' (2012).



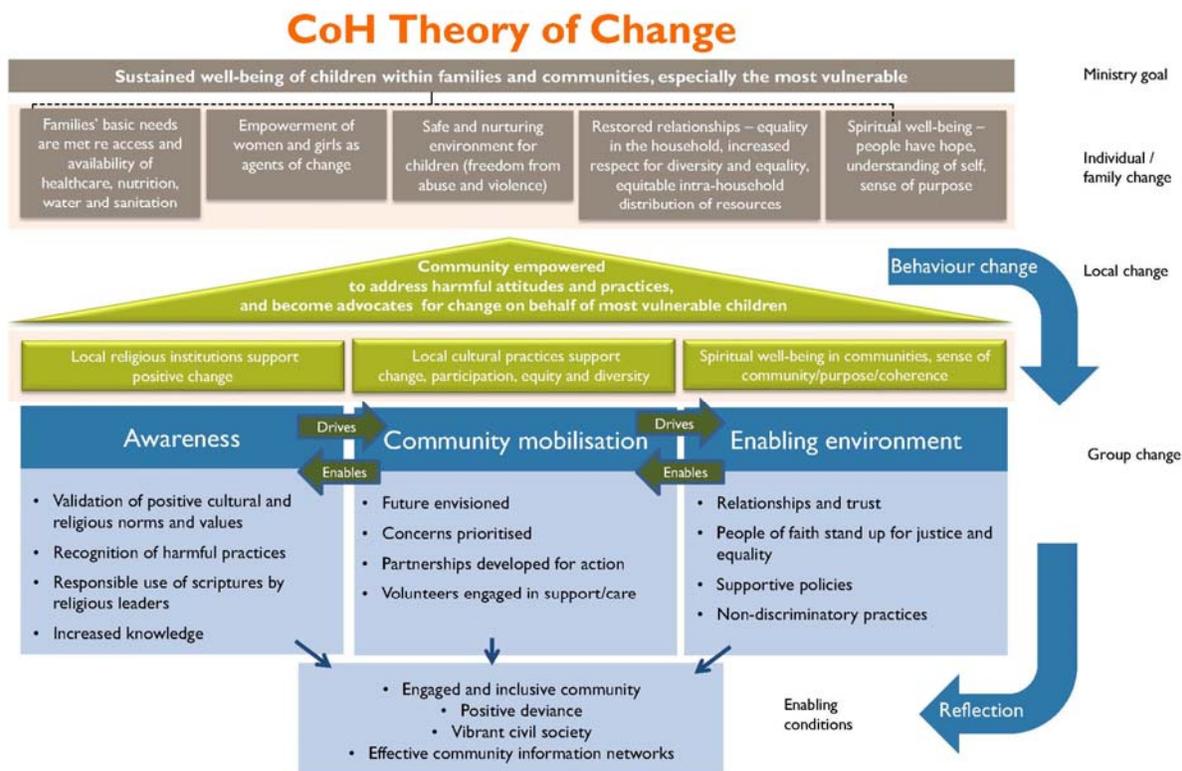
2.3 Theory of Change

The Theory of Change (ToC) model below illustrates how CoH catalyses change in local communities by engaging on an individual and family level, and then building towards group change (for example, in a local church congregation or faith group) and ultimately to community change.⁶ In this approach change is understood as interlinking the personal and the communal. Processes that raise awareness at the individual and faith-community levels positively support community mobilisation, and vice versa. Similarly, community mobilisation is supportive of an enabling environment (for example, one in which people living with HIV and AIDS are accepted and supported), while an enabling environment also ensures that more people in the community are mobilised into care for one another.

World Vision’s ministry goal is the sustained well-being of vulnerable children, families and communities. According to the ToC, CoH achieves this by:

1. sensitising (awareness, community mobilisation and enabling environment)
2. community engagement
3. creating an enabling environment for sustained well-being of children, families and communities, especially when they are vulnerable.

In all these phases faith plays a role, yet while faith and spirituality – and the move from blocking to enabling faith perspectives – are central in the first phase, the second and third phases have a more practical focus on what faith leaders, congregations, and the wider community can do to realise the well-being of children and families.



⁶ See World Vision International, *CoH Field Guide*, (2015).

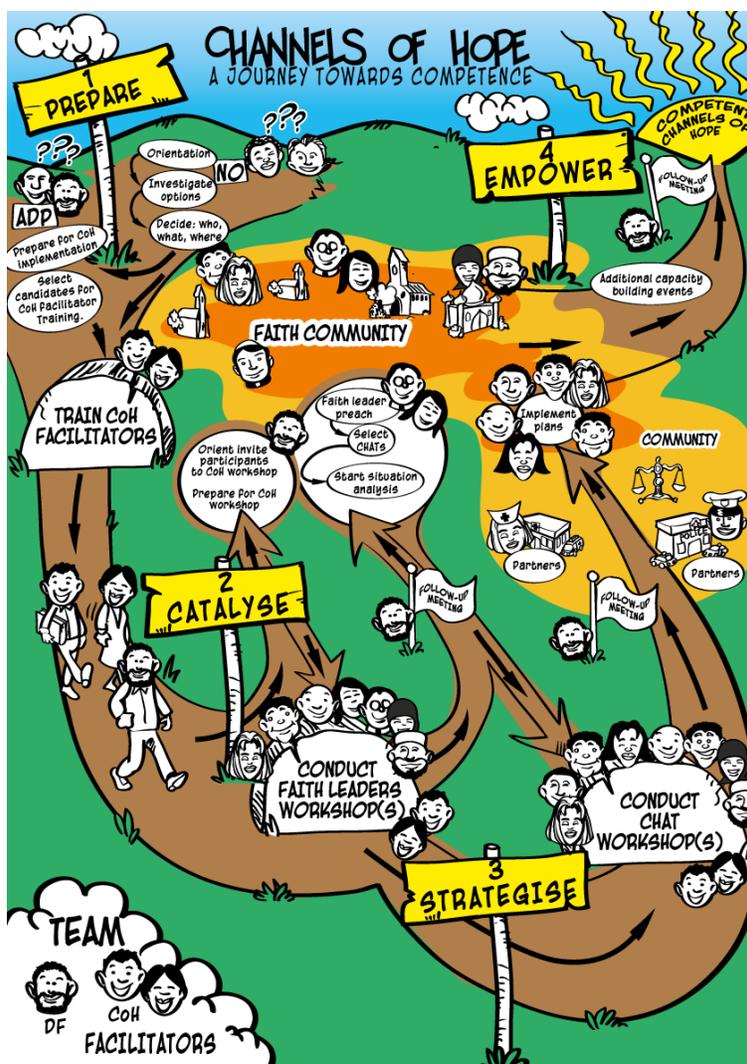


Part 3. Thematic Findings

3.1 Leadership

3.1.1 Overview of faith leaders in CoH methodology

The COH methodology is made up of four phases: prepare, catalyse, strategise, empower. Over four years the methodology builds towards community engagement; by that time the community and crucial stakeholders are supposed to have appropriated and integrated the method, the approach and the underlying principles. The figure below illustrates how these phases link to concrete steps and activities and how these serve to address strategically and include various groups and more formalised committees and institutions in the communities into the process.⁷



⁷ Christo Greyling, 'CoH – The Process and Training 2012' (2012).



There was good implementation on the prepare, catalyse and (to a lesser degree) strategise phases. However, the first phase – prepare – deals most explicitly and extensively with faith and spirituality. This phase of sensitisation is entirely focussed on faith leaders. This illustrates the CoH understanding of faith leaders as ‘door openers’ within the community, on which the CoH strategy for community engagement is built. The document outlining the Theory of Change of Channels of Hope⁸ explains the following:

Faith communities, faith leaders and community leaders play a crucial gate-keeping role in the community. They can either block or allow messages/approaches to be distributed within the communities. In some cases they might even obstruct messages when they feel the messages/approaches are in opposition to their faith and values. There may also exist cultural and religious practices, which contribute to or exasperate the issues that limit CWB [child well-being]. The combined effect of the gate-keepers blocking messages, together with the harmful cultural/religious practices, act as filters which limit the effectiveness of the efforts from the government and WV [World Vision] and other NGOs.

The understanding of faith leaders as door openers or blockers raises two sets of questions for further analysis, which are not explored in this study. The first set of questions relates to whether this construction echoes the dominant secular assumption that religion is either good or bad, and is generally seen as either a hindrance to or a carrier of development. While CoH tends to introduce alternative understanding of how faith and development are related, as we will illustrate in later sections of this report, this observation might be indicative of how faith-based models of development translate their (intrinsic) faith approaches and make them understandable and convincing for a secular donor audience.

The second set of questions deals with the understanding of leadership, and in particular of the role of religious leaders within CoH. Many development actors are interested in the role of religious leaders. Examples include The United Nations Population Fund (UNFPA) and broader United Nations (UN) institutions and the World Bank, which all have taken initiatives to cooperate with religious leaders on specific development themes, including sexual and reproductive health and rights. Some secular development donors have also expressed interest in engaging with religious leaders.⁹ Secular NGOs also increasingly express an interest in working with religious leaders, or at least building more constructive relationships.¹⁰ Faith-based development organisations often have long track records in engaging with faith communities and working with religious leaders. Studies in other fields, such as peacebuilding, give an ambivalent picture of faith leaders’ roles and impact on change. Hashemi states that ‘religious leaders are ideally suited to play a critical role in influencing norms and values, shaping political

⁸ World Vision *Channels of Hope Field Guide*, Addendum ‘CoH Theory of Change’. (2015). <https://app.box.com/s/aotks5of5ti3dqtibudak2u9z50y7d4i>

⁹ Examples include the Dutch government – see ‘Speech Development Minister Ploumen in the Netherlands’ on <http://www.rijksoverheid.nl/documenten-en-publicaties/toespraken/2014/03/08/speech-van-minister-lilianne-ploumen-bij-de-viering-van-internationale-vrouwendag-op-8-maart-2014.html> – and the UK government – see ‘Faith Partnership Principles and Dialogue with Faith Leaders’ on <http://blogs.fc.gov.uk/nigelbaker/2012/07/13/religion-against-poverty/>.

¹⁰ Various examples from the authors’ work with organisations include Hivos, Rutgers/World Population Foundation (WPF) in the Netherlands, and Oxfam International.



behaviour, regulating conflict, and promoting peace and reconciliation'.¹¹ Yet, Paffenholz questions the impact of religious leaders in comparison to other actors.¹²

3.1.2 Thematic findings: Leadership

The focus of the research project – next to producing a sound qualitative evaluation of the CoH MNCH and HIV&AIDS programmes – was to gain a better insight into how change occurs in faith leaders' perceptions, behaviours and messages around women's and newborn child health and HIV and AIDS. These topics address areas of life that are sensitive in many cultural contexts around the world, because they bring into question how societies and communities deal with difference regarding HIV status, the sensitive and vulnerable moments in which women give birth and how new children become part of the community, while tapping into broader issues that have to do with how sexuality and gender are lived and addressed socially.

The CoH methodology is based on the notion that faith leaders are crucial door openers in the community. They can motivate community members to rethink and change perceptions and practical approaches to these intimate personal and social issues. In addition, engaging these faith leaders is seen as a crucial way to address and 'solve' problems that people and the broader community face in relation to HIV and AIDS and MNCH issues. Thus, involving faith leaders in addressing MNCH and HIV and AIDS issues in the community should lead to concrete development outcomes such as an increased uptake of services related to pregnancy and delivery, reduction of maternal mortality, reduction of newborn and infant mortality and general increases in the health of mothers and children in the community. This section describes faith leaders' appreciation of CoH, the way they have experienced the CoH methodology and how this has influenced their leadership. In subsequent sections we explore how faith leaders understand and narrate transformation and what opportunities and challenges can be seen in how faith leaders address sensitive and intimate issues of gender and sexuality.

3.1.3 Who are faith leaders in CoH?

From a research perspective, determining who faith and religious leaders are in a given context is an essential aspect of CoH implementation. As outlined later in the report, CoH operates with a broad concept of faith leadership, including church leaders who do not hold formal leadership positions. Based on the research, we raise more specific questions on faith leadership and explore the need for developing alternative models of leadership, in particular in view of the gendered implications of the concept and its application in practice.

First of all, it is important to be aware that *faith leaders* is used as a very broad concept within CoH. The implementation of CoH starts with training a selection of official pastors or imams (usually together with their spouses). Yet in subsequent phases a wide range of people in leadership roles within their faith communities is involved. In the evaluation in Zimbabwe the

¹¹ N. Hashemi, 'Between Intolerance and Coexistence: The Vatican, Maronites, and the War in Lebanon' in *Between Terror and Tolerance: Religious Leaders, Conflict, and Peacemaking*, ed. T. Sisk (Washington, DC: Georgetown University Press, 2011): 49–68. For other reflections see R. Hackett, 'Nigeria's Religious Leaders in an Age of Radicalism and Neoliberalism' in *Between Terror and Tolerance*, ed. T. Sisk (2011): 123–44.

¹² T. Paffenholz, 'International Peacebuilding Goes Local: Analysing Lederach's Conflict Transformation Theory and Its Ambivalent Encounter with 20 Years of Practice' *Peacebuilding* 2/1 (2013): 11-27.



faith leaders selected for interviews were – more often than not – leaders of specific church groups (for example, worship, women, children, or youth groups) rather than the senior pastor of a church. In the group interviews, pastors, church members with leadership roles and general church members were mixed. In combination with the quite open and wide definition of faith leadership that can be observed in the CoH methodology, the observations in practice suggest that faith leadership should be seen as a continuum along which people have bigger and smaller, formal and informal, assigned and appropriated leadership roles. While sometimes clergy may play crucial roles with regard to taking leadership on MNCH and HIV and AIDS issues, in other settings lay leaders develop a crucial leadership within their (faith) communities.

Second, it must be noted that some of these leaders have been part of sensitisation workshops and, as a result, have been involved in church and/or community activities responding to MNCH or HIV challenges. Others have received additional training and are now CoH facilitators, conducting their own workshops or organising sensitisation meetings. The local CoH coordinator, usually a pastor, acts voluntarily in that role, cooperating closely with ADP staff. The type of leadership role, and how that role is perceived by faith leaders and the wider community, is also influenced by participation in the CoH programme.

Community perceptions of faith leaders as channels of change

In all the group interviews in Lupane ADP it was reported that pastors and churches had changed in their role in the community and how they addressed MNCH:

‘It used to be taboo in the church to discuss these things openly, it was never a topic allowed to be discussed in the church.’

‘It was a taboo, but now they are straightforward in discussing MNCH issues.’

In some churches this change led to discussions of MNCH-related issues with both women and men. However, on other occasions we had the impression that the focus was still on women; for example, quite a number of the lay church leaders were women’s group leaders who had limited possibilities of addressing the entire church congregation.

In Robert Sinyoka ADP our observations were slightly different. People still reported changes in roles and involvement of churches in issues related to HIV and AIDS (and to a lesser extent MNCH), yet these reports seemed to be more confined to people that actually also belonged to a church. People who did not regularly attend a church, or were less aware of what happened outside their specific church, reported general attitudinal change in the community but did not link it specifically to changes in churches.

Nevertheless, all interlocutors confirmed that faith leaders are important channels of community change. Again, in Lupane ADP, faith leaders’ roles were acknowledged in the whole community, while in Robert Sinyoka ADP, faith leaders were seen merely as door openers to the community like other leaders and professionals. The following words are illustrative here:

‘The majority of the people are Christian; there are very few people who do not go to church. Because [Channels of Hope participants] come from different settings and different stakeholders ... the impact is great.’ – a Robert Sinyoka ADP community leader



This community leader, who had been involved in various sensitisation meetings, was very appreciative of what he called the ‘open’ way of talking about sensitive issues. In an interview with two community leaders – a village head and a local councillor – in Lupane ADP, both reported significant change in how churches and faith leaders have opened up to cooperating with other stakeholders in the community. The councillor emphasised that he appreciated the CoH focus on faith leaders, because he realised that the pastors have an influence in the community and gain significant respect from the community. Both community leaders had heard about CoH, seen changes in the community with regard to MNCH, but were not very aware of what CoH actually entailed. They both expressed an interest in participating in CoH.

3.2 Spiritual and religious content and change

3.2.1 CoH methodology, spirituality and change

In the CoH workshops religious leaders are motivated to address critical issues within their communities by:

1. touching the heart
2. touching the mind
3. touching the spirit
4. touching the hand.

The methodology structure recognises that various discourses and perspectives on these critical issues are intertwined in such a way that they are mutually supportive.

The ‘Faith Leaders Sensitising Workshop’ is one example of how the entire CoH methodology uses this approach (touching the heart), giving most attention to the spiritual and faith aspects of HIV and AIDS and MNCH. This particular workshop for HIV and AIDS consists of several steps.

1. The first step involves touching the heart by addressing the attitudes of religious leaders. During this step, potentially obstructive attitudes, such as the view that HIV and AIDS are linked to sexual promiscuity, are discussed.
2. The second step of the workshop focusses on touching the mind. This involves tackling myths.
3. The third step focusses on touching the heart by letting the religious leaders listen to the testimony from someone living with HIV or AIDS.
4. The fourth step is touching the heart and the spirit; it focusses on introducing principles from the Bible and discussing tough (ethical) questions. To remain with the example of CoH HIV&AIDS, this involves the discussion of prevention vis-à-vis biblical principles, including discussion of challenging questions such as condom use.
5. The fifth step focusses on touching the hand, that is, encouraging practical actions, by introducing religious leaders to various community stakeholders and actors around HIV and AIDS who provide specific opportunities for hands-on engagement.
6. The sixth step involves all four approaches and aims at envisioning a dream (also referred to as ‘God’s dream’) and an assessment of the participant’s own congregation with regards to HIV and AIDS. This final step involves developing a plan for the future, which allows each group to plan specific next steps and actions (touching the hand) in response to what they have learned and heard.



CoH MNCH follows the same structure.

1. The workshop starts with a section called 'MNCH and Me', which focusses on challenging personal attitudes and perceptions around MNCH.
2. It continues by giving scientifically grounded information about conception and pregnancy, childbirth, the newborn and the new mother, and the young child. The way this part of the workshop is introduced illustrates the earlier noted intertwining of scientific knowledge: 'There is a lot of persisting misinformation, including harmful cultural and religious practices which threaten the health and well-being of mothers and children. However, we can share from the wealth of correct scientific information in an effort to empower people and improve and change behaviour patterns.
3. The workshop then turns to touch the heart to look at the realities of MNCH in personal lives of people, inviting a woman from the community (or from a similar community or cultural setting) to share a personal story of challenges and loss around MNCH at this point.¹³
4. Subsequently, the workshop invites pastors to explore a Christian-focused faith response, which includes elaborate conversations, Bible study and exercises around the 'Guiding Principles', morning scripture reflections that engage with these same principles and a discussion on 'tough stuff'. Challenging issues and questions around MNCH are discussed with a Christian (or Muslim) perspective. We discuss this more extensively in the following sections.
5. The workshop continues with community interaction, which includes mapping important stakeholders in the community. With regard to MNCH this may include community health workers, a child protection committee, midwives and birth attendants, village heads, other faith leaders as well as other leaders or authoritative figures or institutions.
6. The workshop concludes by explaining how a community can become 'MNCH competent'. This draws on all the previous parts of the workshop, tying in scientific information, faith principles and motivation and (personal and community) actions that should be taken.

3.2.2 Religion and spirituality in CoH: Trajectories for faith

Advocates of the CoH model always stress that CoH does not aim to change participants' faith or introduce them to new theologies or faith perspectives. This quotation from the facilitator's manual for CoH HIV&AIDS underlines this point when introducing the 'Guiding Principles' to faith leaders who participate in the workshop:

This is not an HIV theology or an authoritative system ... The principles are practical pointers, 'signposts', direction indicators to assist us in an honest search for obedience to God's calling in the context of HIV and AIDS.¹⁴

¹³ In an earlier evaluation on CoH for gender we also observed that video material was shown in which a female church leader narrated her life history and experience with gender-based violence.

¹⁴ 'Introduction' in Christo Greyling and Logy Murray, *Channels of Hope Facilitator's Manual: Presenting Effective HIV and AIDS Workshops for Churches and Faith Communities* (January 2011), 2.



However, the following quotation indicates that it does propose a new way in which faith can be meaningful in community development:

*While sound information plays a central role in this [CoH] programme, it is specifically being developed and presented within the context of faith communities. ... It is a programme for Christians who want to serve as Christians in the midst of HIV and AIDS. The questions to grapple with are: 'What does it mean for us as Christians? What will an appropriate and effective Christian response be in practical terms?'*¹⁵

The CoH model thereby gives meaning to how social change can (and should) be realised and how it might be consequential for ways religion becomes public and is translated into social action in a given community. In addition, CoH suggests a certain unity or commonality within Christian contexts:

*It is so important for Christians to get involved in HIV and AIDS, and yet so many Christians struggle to understand the unique nature of our involvement. We will re-discover old truths we know, but then try to apply them within the context of HIV and AIDS.*¹⁶

Here we can observe again that rather than presenting a new theology or faith discourse, the emphasis within CoH is on 'old truths'. However, this also includes the assumption that these are indeed seen and accepted as 'old truths' amongst Christians from various denominations and theological contexts all over the world. In that sense it draws on a certain claim of universality within Christian faith. The question is how this is practically translated in connection with MNCH and HIV and AIDS.

3.2.3 'Guiding Principles'

The introduction to the personal workbook that faith leaders obtain at the start of the workshop indicates the most basic commonality that underlies CoH: 'To be together as Christians means that we have something in common: we are believers who follow Jesus Christ.'¹⁷ It explains what this means in terms of 'evaluating our conduct as well as our attitudes' with regards to HIV and AIDS and MNCH in view of the Bible. In narrating how Jesus Christ showed love and compassion, rather than obeyed rules and regulations, faith leaders are challenged to explore the Bible for the best way to approach HIV and AIDS, and MNCH.

The 'Guiding Principles' (also called faith principles by various CoH staff) vary a little across the HIV and AIDS and MNCH+ curricula but follow more or less the same structure. The 'Guiding Principles' have been developed based on the Bible, and they refer to different texts and passages. Some of these texts are quoted or referred to in the outline of the 'Guiding Principles'. *The Personal CoH Workbook* and the *Bible Study Book* contain exercises that relate to each of these principles.

¹⁵ World Vision International, *Health, Nutrition, and HIV CoP: Channels of Hope Interest Group Terms of Reference DRAFT* (July 2011).

¹⁶ Christo Greyling, 'A Word from the Authors' in Greyling and Murray, *Channels of Hope Facilitator's Manual*.

¹⁷ Christo Greyling, 'Work Book Page 1, Welcome' *Personal CoH Workbook MNCH+* (2011).



The 'Guiding Principles' of the CoH HIV&AIDS curriculum

- Our motivation** is to be compelled by the love of Christ
- Our service** is serving God in practical acts of love and compassion
- Our identity:** we are the body of Christ
- Our attitude towards people** is to accept as Christ accepted us
- Our compassion** is to uphold the dignity of every human being
- Our hope:** to believe is to have hope
- Our search for answers and solutions:** with wisdom of the Holy Spirit
- Our responsibility** is to break the silence by speaking the truth in love
- Our task** is to be Christ's ambassadors.

The biblical texts that are referred to stress the love of Christ and the responsibility Christians have to care for marginalised people (orphans, widows, the poor and the hungry are mentioned in texts such as James 1:27 and Matthew 25:34–40) as an expression of being ambassadors of Christ (2 Corinthians 5:20).

The 'Guiding Principles' of CoH MNCH

The *Bible Study Book* presents the 'Guiding Principles' in four groups:

1. biblical foundation
2. our vision
3. our response
4. advocacy.

CoH for MNCH explicitly taps into gender relations, focussing on the value of men and women, both created in the image of God.

- Our common source:** all people come from God and are created in God's image
- Our identity:** we are the body of Christ
- Our compassion:** to honour, uphold and restore the dignity and value of every human being
- Our celebration of hope:** together we promote life in all its fullness for mothers and children
- Our commitment:** to demonstrate God's love through practical acts of compassion
- Our duty:** together we welcome and celebrate every unborn and newborn baby
- Our attitude towards people:** to accept with Christ's amazing grace
- Our search for answers and solutions:** with wisdom from the Holy Spirit
- Our responsibility:** to break the silence by speaking the truth in love
- Our calling:** to stand up for justice.



3.2.4 Spiritual and religious content and change

Knowledge and scripture

The general uptake and appreciation of CoH for MNCH+ were positive. When asked about their reception of CoH, many of the faith leaders interviewed emphasised the kind of practical knowledge they had gained during the workshop.

'I learned a lot, for example, about the importance of exclusive breastfeeding. Before I taught that mothers should give their newborns mixed feeding including bottles with formula and water. Now we know we should [exclusively] breastfeed the child for six months.' – female church leader in Lupane ADP

In Robert Sinyoka ADP women who had participated in CoH for MNCH explained that the workshop brought new perspectives and insights on issues about which they had little understanding before. One woman referred to Luke 19:1-15, explaining that whatever the situation is in life, God gives us a second chance. This motivated her to learn more about MNCH and HIV and AIDS.

An elderly woman in Lupane ADP who had taken a leadership role in her own community around MNCH issues explained that the most important and impressive experience within the CoH workshop was the realisation that:

'[we should be] giving hope to women who may have been rejected by their partners during pregnancy, give them hope, even if the man has deserted you, your child is still welcome; there is hope for your child.' – an elderly woman in Lupane ADP

Other interlocutors also voiced the realisation that a church could be an example of inclusiveness as a result of CoH. It must be said, however, that this was most often emphasised when referring to the church's responsibility to care for people living with HIV and AIDS and most specifically for children in the community.

In addition to the emphasis on new knowledge, interviewees also emphasised that the synergy with scripture was important. Male church leaders, in particular, stressed this quite early in the interviews. The spiritual elements in the programmes seemed to convince them to change their views and behaviours. This may be related to another observation, that is, that some of the men were clergy or had more formal church leadership roles such as preacher and pastor. Women were more often lay leaders at church groups. The relevance and uptake of the spiritual elements in CoH, therefore, seem to have gendered meanings as well.

The appreciation of the spiritual elements in CoH was emphasised in two ways. First, the direct relations between MNCH issues and scripture enabled pastors to link MNCH to their ministries as preachers. The following quotation is an example:

'In the workshop there were so many scriptures, but the ones that touched me [were] the pregnancy of Mary, the birth of Jesus, the situation in which the Saviour was born. I use the scripture now to stress some points with regard to MNCH, for example, the importance of the father's involvement when his wife is pregnant. I tell them: "You need to assist, help in whatever."' – single interview, male faith leader, Lupane ADP



Second, faith leaders stressed that the scriptures referred to in CoH convinced them to put their faith into practice. When asked about the spiritual and scriptural aspect of the CoH workshop, one leader responded:

'I very much appreciate it. It taught me that God wants people to have a new life or to heal, because Jesus healed as well. The hospital is thus a place where God works. ... [This information was] not new as such, but one thing that is unique is the practicality, how to contextualise faith in real situations.' – a male pastor from Robert Sinyoka ADP

Another interviewee emphasised that the most important lesson learned during the CoH workshop was:

'In spiritual terms? That you cannot preach unless you put it into practice! It is more appreciated when you practice than when you just preach. Now to me, it's really something that touched my heart, it's something that is clear, that cannot be argued about.' – a faith leader in Lupane ADP

Tough stuff

Some clergy (faith leaders who preached and offered pastoral counselling) emphasised that tackling the 'tough stuff' in relation to scripture was crucial for them. This is the part of the CoH manual – in particular the version for pastors – in which statements are discussed on sensitive topics that are not easily addressed by faith leaders. These statements tap into the implicit assumptions and prejudice underlying the perceptions of faith leaders and communities with regard to MNCH and HIV and AIDS. Examples of issues that are discussed in the MNCH workshop for pastors are the spacing of births, illness, healing, pregnancy and children out of wedlock. Some pastors mentioned that this part of the workshop had been most enlightening and transforming.

'Some tough stuff issues were deliberated on, for example, what we thought of a child that is born out of wedlock. Some people thought it should be rejected or not treated with the same honour. The child is only born out of what the couple did but is not sinful. So, the child must even be accepted by the family and by the church as a religious institution. This statement was heavily discussed among the group.'
– church leader and CoH facilitator, Lupane ADP

During single and group interviews many faith leaders touched upon the theme of accepting and welcoming children. Many churches had started with dedication ceremonies in their church to pray for the newborn child, dedicate it to God, and ask a blessing for the child's life. In one of the villages we visited in Lupane ADP, we were shown pictures of such a ceremony in one of the local churches.

Finally, some of the faith leaders interviewed in the evaluation also referred to the good relations amongst them, the workshop leaders and World Vision staff as influential in their experience of change. The facilitators 'were so close to us, we learnt so quickly because of that,' said an interviewee. The opportunity to ask questions was another thing that was valued. More generally, faith leaders felt valued as faith leaders, as churches and faith communities, because World Vision endeavours to involve them in broader community change.



STORY OF TRANSFORMATION: CHRISTOPH DUBE'S EXPERIENCE

'WE NEED TO BRING WATER FROM THE GREEN AREAS TO THE DRY AREAS' CHURCH AND COMMUNITY

Christoph Dube is a church leader in the Southern Day Adventist church in Lupane and was trained as a facilitator in CoH after he attended his first workshop in 2012. 'My life is highly religious', he says. 'In everything that I do, I put God first. In my day-to-day activities, for example, I live according to Christian norms and values.' Christoph was motivated to attend the workshop because he believed that World Vision tries to empower rural communities so that rural people are not disadvantaged.

Christoph uses the metaphor of green and dry areas. Water from a green area can be taken to benefit a dry area. In such a way churches too can enable growth in a dry area. For him, the green land symbolises life, beautiful resources, and knowledge. Dry land reflects an area where people do not have the knowledge to do things right. He emphasises the importance of the new knowledge he has received: 'I did learn a lot of new things. What I realised is that the Bible is a MNCH manual. If you read the Gospel of Matthew, the birth of Jesus, it supports the CoH model'. When World Vision launched CoH in the community, Christoph and his fellow community members first realised that, as Christians they lacked the knowledge to understand what mother and newborn babies need. They discussed the consequences of some of their customs and were 'empowered with the right information'.

'It is the traditional thinking that a child born out of wedlock is the direct result of an evil activity. Yet, the child is only a product of a she and a he. The child knows nothing. The child needs protection.'

Christoph also mentioned other habits and customs, such as the absence of fathers in the labour room (this would jeopardise his love for his wife) and the tradition of placing burning herbs on the baby's head to protect against misfortune. He was highly motivated by the MNCH programme and wanted to acquire as much information as he could in order to change other people's 'mentality' as well.

When asked how CoH has affected his life, Christoph emphasises that CoH has made him a better Christian because now he understands the Bible better. 'It really makes me read the Bible more often', he explains. He continues stressing that CoH brought churches together:

'CoH is highly transformative. It is very difficult for us people to come together and to discuss about critical issues such as MNCH. Through COH we manage to come together, different churches with different views come together, and this was very new! We have an agenda together, we facilitate together. We share some Christian norms and values together. We were never like that before, now we are together, we share relevant knowledge together, we are friends now.'

It has also affected the community, because of the community activities that have been initiated. It has established support groups, sing songs and play dramas to 'convince people outside that this is the right thing'.



For Christoph, it has been important to become aware of healthy behaviours regarding women and newborn children by studying the Bible. Christoph's story indicates that increased cooperation amongst faith leaders who have attended CoH workshops has resulted in increased cooperation amongst churches and results in the strengthening of community systems.

3.2.5 Faith as narrative for change

Spirituality and social change

So far, we have discussed the accounts of participants in the CoH workshops and their appreciation of various elements. In addition, we have reviewed our interlocutors' perceptions about the roles of faith leaders in the community. As part of the research project underlying this evaluation, we are interested in exploring how and why faith and spirituality matter for development and social change. In various quotations in previous sections, references to scripture and the participants' appreciation of the use of scriptures in CoH appear first and foremost to build people's trust and convince them to review their understanding of MNCH issues. In this view, religion mainly has the purpose of bringing about behavioural change. This is a so-called instrumental view of religion, where religion is viewed primarily as a tool to achieve (secular) development goals.

On another level, references to faith and the scriptures are a 'language' or 'narrative' that people in faith communities use that is meaningful to them and has authority. A woman from Lupane ADP told us that the CoH programme had brought about 'spiritual growth and change of behaviour in the community'. Clearly the element of spiritual growth was important enough to be mentioned first in her account, going beyond faith being merely instrumental to it being central in bringing about change.

A male participant referred to the biblical figure of Joseph as his example. The story of Joseph according to Luke 2:1–7, as discussed in CoH, is that he rejected the pregnancy of Mary because he knew he could not be the father. Our interlocutor stressed the importance of role models, of inspiration:

'The Holy Spirit touched him, he was able to support Mary. ... Joseph was there, he was there through the birth processes and even accompanied them to Egypt. ... If Joseph can do it, why can't we?' – group interview, male participant, Lupane ADP

So, while the majority of interviewees focussed on the changes in the community and the practical knowledge they had gained, some of them – mainly men – emphasised the importance of spirituality and faith as a conduit for transformation. Being touched emotionally and spiritually appeared to be an important or even crucial element in broader processes of changes in these accounts. For a bigger research project it would be crucial to design a methodology that allows for assessing these processes of change, including its gendered components.



Narrating transformation

One of the ideas underlying the question of how the personal, spiritual and social are interlinked is that CoH as a methodology is successful because it *acknowledges* that personal and social processes of change are interlinked. In addition, it allows time and space for personal change to occur and feed into social change. Transformation is change in the developmental sense, but it also links to Christian discourses of conversion and spiritual transformation. While CoH does not aim for this type of Christian conversion to happen as it operates within faith (Christian, Muslim or other) contexts, it is interesting to explore how Christian notions of transformation feature in the narratives of Christian leaders interviewed for this study.

Therefore, we have included in the research questions about how faith leaders assess the change following their training in CoH in relation to other experiences of transformation in their lives. This was operationalised by including some single interviews with faith leaders in which we assessed their perceptions of CoH in relation to other moments of change in their lives. Due to limited influence on the selection process, as well as limited comprehension of our aims and requirements amongst the local staff that organised the programme, not every interview turned out to be an opportunity for exploring this research question; in two instances this was because the single interviewee had not been through the programme, and in other instances interviewees were general community members who had been exposed once and focussed on the practical knowledge gained rather than the change they had experienced. Our own roles, as white female researchers from the Netherlands, and the formal office setting in which we did the interviews, may also have limited the rapport we were able to build for this type of interview. That said, two interviews with faith leaders who were clergy (one male and one female) suggested that this more narrative and biographical approach to understanding transformation is an interesting one for a larger research project.

STORY OF TRANSFORMATION: PASTOR JAMES NDLOVU

‘SEE GOD IN ACTION’

TRANSLATING PERSONAL TRANSFORMATION INTO SOCIAL PRACTICE

Pastor James Ndlovu is a man in his fifties. He is a pastor in the Presbyterian Church in Southern Africa and is enrolled in an ecumenical Bible College in Harare. He has been assigned to minister in this ADP as part of his studies. ‘I never thought I would be one [a minister]; I had a career as a teacher in secondary school.’ He went back to college in 2012, being almost fifty then. ‘It was a huge change in my life’, he explains, but ‘if God calls you cannot refuse.’

His personal story is one in which experiences of spiritual transformation feature: ‘I am a convert; I am not born as a Christian. It happened at 40 years of age, and then I was baptised’. This started a process of transformation for James that is still not finished: ‘The transformation is still going on; it is the first thing that really changed me. I think I am still not complete, I am still transforming.’

James has a family of five children and a wife. Quitting his job as a teacher meant taking a risk. The school fees for the children are paid by the church, but the family had learn how to live on a much smaller income. His wife and kids accepted what he refers to as ‘my calling’. Yet his extended family did not accept his decision easily. He was raised in a family of teachers, and not



all of them attend a church. Yet his conversion and his decision to become a pastor late in life has had an impact on his family and friends as well: 'It is not only you who will be transformed, even your family, your clan, your friends, they have to adapt to the fact that you are converted.' Especially his friends have become more distant as a result. The process of transformation that James describes is influenced by a strong calling and firm decisions, but it also has come with material and social costs.

James' story with Channels of Hope

During the interview we tried to establish how James experienced CoH in relation to or as part of this broader transformation he described. He had been trained very recently in MNCH+, just two weeks before we interviewed him. It was his first time to be involved in community issues from the perspective of the church. The problems were not new to him, as he was aware of how women struggle with health issues related to reproduction. What was new was that it was connected to practice.

'Now, there is a link between the church and what is happening in the community. Preaching is a one-way direction, but when you get involved, when you participate in this action, you become more attached to the community than a mere Sunday preaching. Yes, you can provide first aid and take someone to the hospital [as a pastor, because] "God is everywhere".'

James explains how CoH helps him to use his teaching skills and connect his ministry to practical work in the community. This enables them to go into the community and teach about MNCH. As a pastor, he is better able to do that than others in the community, because he meets so many people through his work. He tells about a woman who died after giving birth. He suspects it was due to her late arrival in hospital that nothing could be done to help her. 'This is when I realised [that] if I had known, I could have given them information about health and natal care.'

Even though James had been introduced to CoH only recently, he already has organised a field day in which he informed people in the community about his intentions to serve them with information on MNCH and his desire to teach them.

'It is my hope that we could put this in practice and that the pastors will go to the community, to bring these people together, for example, pregnant women who need food. They can pray, but you can't eat through prayer.'

He feels he has a role to play in motivating men in particular, so they accompany their wives to hospital and become involved in caring for the baby. 'Men are arrogant; they don't want other men to be on top of them', says James. He therefore thinks it is a good idea to organise men's fellowships in which they talk about life, have something to eat, have drinks together as a way to introduce men to the issues. 'That's how you attract men!'

As a pastor he has authority, and he can reach out to other men. Yet, he has noticed that other men may also suspect his intentions: 'Why do you want to talk with my wife about contraceptives? You want to do something or you want her to do bad things?' He needs to establish relationships of trust with men in the community. And he thinks that his own



experience of transformation as an adult is important. In reaching out to men he can tell them: 'I know everything you're doing. I was one of you!'

Channels of Hope has not been transformational for him but has become part of the process of transformation he experienced and has given him the tools to put his faith into practice. It has helped him to 'see God in action. We will not just be preaching to people but [giving] them life, [showing them that] there is hope for a better future.'

STORY OF TRANSFORMATION: ELIZABETH MOYO

'GOD BEGAN TO USE ME' ON A DIVINE CALLING AND A PASSION FOR MNCH

Elizabeth Moyo had been a responsible child. While her older brother and sister would go out and drink alcohol, she used to tell them to stop when she was only eight years old. She was the head girl of her class in primary and high school. Her parents went to the Brethren in Christ Church. She accompanied them every now and then but was not very serious. In 2003, when she moved and attended a new church, she was elected to become youth chairperson.

Elizabeth indicates that she is about to share a more confidential and delicate part of her life history. We close the door of the room so nobody is able to hear what she tells us, and she continues her story. She was involved in a relationship with a guy and spent much time with him. 'Things went on and on and then it happened that he was going to marry me and then he found another girl. It broke my heart. I was so devastated and angry.' She just had obtained her driver's license and had thoughts of running him over with a car; she laughs a little when telling this. She continues her story by telling about a youth camp she attended to distract herself from the breakup.

'I heard people say that God speaks to people and thought maybe God will speak to me. But when I got in youth camp, God did not say anything and I was more devastated and then I stopped going to church.'

She met a new man, Robert, who was a doctor. She started going to church again and attended the youth camp once again a year later. She had started a business, and life was good for her. At the youth camp, while a pastor was preaching, she heard a voice:

"Get rid of Robert." Then I ran to the altar, and when I got there, I just fell down. Then I had a vision, the first vision in my life. In that vision I saw a scale. On the light side I saw myself being the chairperson for the youth but not going for the services; I saw myself in all of my vanity. On the heavy side I saw a man on the cross, a bloody man. He was crying, and he had blood all over, and then the voice came again and said, "Get rid of Robert".'

She was confused and did not know what to do. She went home and continued her relationship with Robert until she heard a sermon by a pastor who said:



“Some of you ladies, God tells you to leave your boyfriends ... but you continue in those relationships. You need to get out”, and I saw this was God speaking to me.’

Then she told Robert she wanted to break up. He was devastated, but Elizabeth did not change her mind. ‘Then God began to use me’, she explains. She began to focus on the ministry in the church, to attend the youth meetings and to reach out to other people. She started to attend a Bible School. She recalls that God spoke to her again a year later and told her to put her house in order. She is now married to another pastor, and they each own a business:

‘I love working with people and seeing them become better. When I go back to sleep at night I get satisfaction when I realise that I have been able to affect a life ... to change someone ... to be a better person.’

Elizabeth and Channels of Hope

World Vision invited her to join a training it had organised. She was very busy but managed to create some time to attend the training on MNCH+. ‘I was very excited, I was very happy. I went there and the lessons were so good and so eye opening. I realised so many things that I did not know, and I realised so much I could use.’ CoH helped her to realise that people hold ‘wrong beliefs’. They were used to disciplining unmarried girls who fell pregnant: ‘We make her stand in front of people, make her do all sort of things, and many times the girl even runs away from church.’ They realised they should take care of her rather than treat her as a sinner. That is bad for the girl and bad for the child, who is innocent, and who as a result grows up in a spirit of rejection.

Through the CoH workshop she realised that most of the time the people do not use the Bible relevantly and responsibly. She feels that she has a better understanding of the Bible now: ‘My eyes have been opened.’ In the way she narrates her story, the experiences where she heard God speaking to her have changed her life. CoH did not change her life, but it has changed her ministry and helped her to become a better pastor as well as become involved in the community much more than before.

She started to help pregnant mothers and mothers with newborn babies by organising her own trainings. She trained eight churches, together with her husband, who has not attended the CoH training but feels passionate about this as well: ‘I remember coming back home feeling so good that I had been able to share this information with others.’ As a pastor she feels she has something to offer because she is a good public speaker; she knows how to address people and motivate them. She has developed a passion for addressing MNCH issues in the community, and this has just naturally become part of her work with people. ‘It is my ministry,’ she explains, ‘I can do it without World Vision now.’ She explains that it is not about World Vision facilitating and paying for food during the workshops and meetings anymore. She has a passion and would find new and other ways to engage with the community on MNCH issues.

‘Most people go to church, so if the churches are equipped and all the members are trained, these various members can go to people’s homes and share the information; they can go there and have impact. It is no longer about food, it’s now about lives, it’s about saving those children, saving those women!’



The method of personal interviews was chosen to be able to get a better understanding of how faith leaders who have been through the CoH programme understand CoH-related changes against other moments of change in their lives. Two considerations were important in our choice for this:

1. our interest in exploring how spirituality is a conduit for change and how personal change is related to social change, as outlined in the research proposal
2. the emphasis of CoH staff at World Vision that CoH does not change people's faith or theology, but rather offers them ways to link it to practical problems and solutions.

Personal interviews allowed us to get a broader and better understanding of how faith leaders narrate important moments of change and, more specifically, spiritual change in their lives. We therefore chose to schedule six personal interviews per ADP. Due to our limited influence on how interviewees were selected, not all personal interviews turned out to be fruitful; only those faith leaders who were trained pastors and had been trained as facilitators turned out to be able to reflect on personal spiritual change in this way. Some of the people selected were too shy, too focussed on the practical results from CoH; on one occasion someone was selected who had not been participating in the programme. Only in the interviews with James and Elisabeth from Robert Sinyoka ADP were we able to build enough rapport within the hour scheduled for the interview to be able to ask them to narrate their life stories in relation to important moments of change in their lives. The fact that no security people were present in these interviews also may have been an influence.

Despite the limitations, these two interviews suggest that it is interesting and important to include a narrative, life-history approach when researching personal, spiritual and social change. First of all, both faith leaders report that significant spiritual change has occurred in their lives and that that spiritual change has affected their outlook on life. While referring to certain moments of change, both faith leaders also emphasised that changes have come gradually, that change is a process. CoH is one step or element in the broader process of change they describe. While quite a number of interviewees would use words like *transformative* and *enlightening* when narrating their experiences with CoH, in these stories CoH does not appear to be a key moment of change. Rather, James and Elisabeth emphasise how CoH has provided them with practical tools that match the spiritual transformation that is already taking place in their lives, a practical translation of faith and spirituality in communal life. This appears to confirm the prevailing idea that CoH does not change people's faith or theology.

Yet, we should also take into account the influence of CoH on how change is narrated generally, and more specifically on how meanings are attributed to past experiences. In addition, might providing practical tools and offering a model for action that gives faith leaders an avenue to perform and practice their faith leadership in different ways itself produce changed religious and theological meanings and relationships? Might an experience of spiritual change in the past be an important condition for a good uptake of the CoH model? If so, this might partially explain why the CoH model has good results in Pentecostal settings, which tend to be more comfortable with explicit spiritual dialogue, compared to other development models and programmes.

On a more conceptual level we wonder whether the success of the model can be explained by how it interlinks the personal and the social through its connection to the spiritual. These two stories, as well as the many more practical accounts of change, suggest that this attention to the



personal is crucial in working towards increased social engagement. They reflect what an approach such as CoH has to offer in terms of rethinking secular models for development and social change, and escaping the secular distinctions on which these models often rely.

Thus far in Part 3 of this report we have briefly introduced and analysed how religion and development are intertwined in CoH and pointed out how certain elements of Christian discourses are visible in the CoH methodology and approach. In relation to this, it is highly important to research further how faith leaders narrate personal spiritual change in relation to social change before and after CoH. Such interviews ideally should be part of an engagement with these faith leaders over a longer period of time, one which would allow for building the trust to share personal and intimate stories about one's life. In addition, such research should be done in different faith contexts in order better to understand how specific aspects of CoH may interact differently with the experiences of change of Christian, Muslim and other faith leaders.

3.3 Gender, sexualities and intimacies

This report is based on an evaluation of CoH for MNCH and (to a lesser extent) for HIV and AIDS. While these titles suggest that gender and sexuality are not explicitly addressed, for conceptual and empirical reasons we do think it is important to look at how gender and sexuality are understood and addressed by people who have been exposed to CoH. Gender and sexuality are contested social development issues. Amongst (secular) development actors many assumptions exist as to how religious actors hinder the implementation of rights around gender and sexuality. An earlier evaluation of CoH for gender in four countries demonstrated that there is a lot of prejudice around how secular actors have promoted gender activism in countries such as Kenya and that this has been influential in shaping religious actors' perceptions of gender. Secular development language around gender and sexuality, including that in international agreements, is often seen as reflecting foreign, top-down initiatives that conflict with religious moralities. However, approached differently – choosing alternative language, connecting to personal experiences, and offering space for spiritual and scriptural reflection – faith leaders can become promoters of gender equality. One recent example is the positive outcomes of the introduction of Channels of Hope for Gender. Another is the much longer influence of Christian (theological) networks and groups such as the Circle of Concerned African Women Theologians.

CoH for MNCH and HIV&AIDS address gender and sexuality issues that are often sensitive and sometimes contested within local and national contexts. Focussing on the health of women and newborn babies is strategic because it brings in questions of spacing children and family planning without flagging these explicitly as issues of reproduction and sexuality. This focus appears to be culturally sensitive and connect more effectively to local understandings and concerns. Yet, the interviews conducted for this study suggest that critical questions around gender and sexuality arise as a result of the implementation of CoH MNCH in local communities. While some of these issues arise, these are not necessarily addressed constructively within this specific model.

A first observation from the evaluation is that interviewees were more comfortable addressing certain issues than others. In Robert Sinyoka ADP, for example, male interviewees generally emphasised HIV and AIDS, problems of stigma and discrimination, and the necessity of being an inclusive church and community. MNCH-related problems were not always mentioned. Yet,



women referred to MNCH problems and stressed that men were often reluctant to support their wives during pregnancies and as new mothers. When we shared this observation with World Vision staff, one of them suggested that the personal impact might be one explanation. While HIV and AIDS also affects men, MNCH issues more directly affect women. The rather recent introduction of MNCH may be another explanation in this ADP. The observation does, however, indicate that a community that becomes more inclusive and caring towards people living with or affected by HIV and AIDS does not always naturally evolve into a community that is more inclusive when it comes to more challenging and contested issues related to gender and sexuality.

During the interviews we generally allowed time for people to bring up the challenges they experienced within their community around the health of women, girls, children and the involvement of men. We observed that during the interviews people did not always bring up contested issues such as teenage pregnancy or rape. This may have been due to our limited ability to build relationships of trust with our interviewees, due to the research circumstances and limitations we have described earlier. A few interlocutors in both ADPs raised their concerns around gender-based violence and sexual assault, and also about sexuality education and life skills for young people. In other interviews these were also raised in response to some probing questions in the last part of the interview. Referring to the kind of problems we have heard about in other communities, we would ask whether this was something our interlocutors had heard about happening in their community.

3.3.1 Teenage pregnancy

In a group interview with women in Lupane we asked about the challenges these women observed in their community. One woman raised the issue of teenage pregnancy and said: 'It is really worrying us. How can we bring this down?' Another woman stressed that they would like to have more knowledge about this, to maybe have another CoH workshop that talks about how to target young people, talk to them and give them skills to prevent getting pregnant at an early age. In the group interview with men who had been through CoH in Lupane it was emphasised that teenage pregnancy was an issue that was seen as diminishing. While youth used to hide it, they now come forward and get assistance from the church, shared one of the men. While this may be true for some churches, and desired by the men who had been through CoH, other interviews suggest there is still a lot of prejudice around teenage pregnancy in the churches and wider community. In the same group interview a man emphasised that his church would support and counsel an unmarried girl who was pregnant. The village head gave the following response:

'I experienced that these corrective measures are too harsh, mostly to the girl child – the partner is refusing to take responsibility and the girl is punished. It is a bit too harsh. Could there be a modified way of not harming more than already is done?'

The women who were interviewed said that the kind of disciplining measures that were taken differed from church to church; sometimes these girls were not allowed to wear church uniforms for three months, while in other places they were not allowed to perform a role in the church for a long time. In some churches there was also a cleansing ritual, in which the girls were rebaptised, for example.



Teenage pregnancy is a challenge that occurs in the community and that affects young girls tremendously if it happens to them. While never brought up in the group interviews, the village head and the local councillor shared their concern about girls dying or seriously damaging their health as a result of unsafe abortions. The reluctance to bring this up in the group interviews, and the eagerness to stress that this situation was improving while other interlocutors emphasised that this issue is far from solved, also hints at the sensitivity of the problem. The references to disciplinary measures in churches indicate that churches do not always deal with teenage pregnancy in a compassionate and inclusive way. Moreover, girls seem to be much more affected by such measures than boys or men.

3.3.2 Gender-based violence and rape

Another observation was related to how gender-based violence and rape were brought up during the interviews. While generally not raised by our interlocutors themselves, when we probed mixed responses were expressed. The women in Lupane who went through CoH stressed that it was an issue before CoH was introduced, but ‘now ... we have realised that it is slowly diminishing due to, for example, education and raising awareness’. However, other interviews suggest that it is still a challenge. The village head and local councillor in Lupane expressed their concern about child and women abuse, and they explicitly asked for programmes that addressed this. A nurse/teacher at a local hospital, who also acted as our interpreter for all the interviews, confirmed this. He had been working in a special clinic for girls who had been raped, and he explained how these girls are stigmatised by the way the procedures with the police and in the hospital are shaped. He stressed that there is a gap in addressing this and a need to create true support structures for these girls. An elderly woman, who had developed a leadership role after being trained in CoH, confirmed that rape was indeed a problem that she observed when talking to women in the community about MNCH issues. In Robert Sinyoka ADP there was little reference to gender-based violence or rape; in only a few instances was rape mentioned as a cause of teenage pregnancy. Yet interviews in Robert Sinyoka ADP were generally less explicit on issues that were more sensitive and tended to focus on problems and changes related to HIV and AIDS and safe delivery.

The challenges with regard to gender-based violence and rape need to be taken seriously. This was underlined also by a few of our interlocutors who had taken up leadership roles in the community, either as facilitators of CoH, as health workers or as pastors. They asked for follow-up with regard to educating young people. While some referred to MNCH issues for young people, one pastor was straightforward in stating that they need to improve their skills in talking about ‘reproduction and sex’. Based on the gendered consequences of teenage pregnancy and the challenges churches and communities experience in being inclusive and compassionate towards these girls, we also suggest a follow-up that more explicitly invites these churches to reflect on gender relations and on the gendered consequences of how they, as churches, deal with challenges around teenage pregnancy and gender-based violence. While a conversation with ADP staff showed that certain campaigns on gender-based violence and child protection had been introduced to the community in Lupane, these findings also suggest that this is not enough and that there is a need to build on MNCH and broaden and expand this to gender and sexuality education for youth.



3.3.3 Reflections on gender and leadership

While most faith leaders expressed the significance of CoH by stressing the practical impact of the programme in their communities, women, interestingly, tended to focus much more on the knowledge gained on MNCH issues and on the practical changes in their lives when sharing their experiences as a result of CoH MNCH. Men, on the other hand, tended to focus more on the scriptural aspects of CoH and spent much time during the interviews referring to the Bible stories and verses that had convinced them to become involved in addressing MNCH issues in the community. In one of the conversations we had with people from the community and ADP/World Vision staff, it was suggested that these findings reflected the roles of men and women as these are intended to be: the women as the loving and caring mother, and the father as spiritual leader and priest. We consider such an interpretation to be problematic.

First of all, there is a difference in how men and women are affected by health problems related to pregnancy, delivery, nursing and being a new mother. The observation in Robert Sinyoka ADP that men would focus more on HIV and AIDS and women on MNCH issues shows that the direct bodily and health consequences that people (may) experience shapes their understanding of the problem and the sense of urgency. In that sense it is understandable that women focus on MNCH, as they are most directly affected by the problems experienced and in many cases do not need to be convinced that these issues should be addressed in the community. This should not lead to hasty conclusions about their appreciation of the spiritual aspects, let alone about women's leadership roles. Rather, it throws up the question of how personal bodily and practical experiences are linked with and given meaning for women in relation to the spiritual and the social.

In addition, MNCH issues are sensitive, not only in these communities but also anywhere in the world. Matters of sexuality and reproduction belong to the most intimate spheres of people's lives, yet they have to be socially regulated. In every culture or community this is done through certain norms and values, and often religion plays a role in shaping and giving meaning to these norms and values.¹⁸ Taboos around sexuality and reproduction are not something religious per se; however, how these taboos are shaped and practiced in daily life is highly contextual. In view of women's proximity to MNCH issues, it is understandable that they are more inclined to support breaking taboos around sexuality and reproduction. They are the ones who are often more challenged by them. It does raise the question how women's bodily experiences are tied in with their spiritual lives, and how women embody spirituality. Men, on the other hand, relied on spiritual and scriptural arguments to support and account for their new (more open) attitudes towards women's MNCH needs. This may give them more authority and support for their changed lifestyles and attitudes towards their wife and children, for which they may be judged or ridiculed by other men in the community.

In addition, one should also be careful not to conclude that women are more open and pragmatic and men are more conservative. Teenage pregnancy and sexuality education appeared too challenging for both women and men. In particular in their roles as parents or church leaders, both women and men stressed the importance of being morally upright. This

¹⁸ See Brenda Bartelink and Erik Meinema, *A mapping on sexuality, human rights and the role of religious leaders: exploring the potential for dialogue* (Knowledge Centre Religion and Development, 2015), 6. <http://www.religion-and-development.nl/documents/publications/human%20rights%20sexuality%20and%20religious%20leaders.pdf>.



seemed to be a sensitive topic in both groups. In women's groups, when the disciplinary measures with regard to girls who get pregnant while unmarried were raised, some of the women also emphasised the importance of setting the right, moral example in church. On other occasions some women shared their concerns about girls behaving immorally and bearing responsibility for getting pregnant or being raped as a result of having older 'boyfriends' (transactional relationships).

Finally, another gendered dimension in our findings on CoH needs to be mentioned. While we have interviewed some female pastors and female church leaders, men predominantly hold the more formal church positions. Because CoH for MNCH starts with training pastors and church leaders, there is a certain bias towards men over women, given the traditional division of roles and tasks within churches. Practically, this meant that in our group interviews more of the men were pastors and therefore had theological training and were familiar with teaching scripture. Presumably, more of them had been involved in the initial training for pastors, in which the scriptural aspects are addressed extensively. Women, on the other hand, were less involved in teaching scriptures or preaching within their churches, and more likely to have been involved in subsequent workshops that had a slightly more practical focus. This also may have influenced men's emphasis on the scriptural aspects of CoH compared to women's focus on MNCH issues and the practical knowledge gained.

These reflections allow for a broader reflection on leadership as it is understood within CoH. Underlying CoH and its Theory of Change model is the view that faith leaders are indeed door openers to the community. While CoH is not a methodology that is focussed on bringing about change in the church, it sees faith leaders and faith communities as crucial intermediaries in realising community development. However, it is important to be aware of the gendered notions of leadership within these communities and the gender biases that exist within local communities, for example, ADP and national office staff (who are often also part of the cultural and faith contexts in which they work). Our interviews with people involved in CoH and general community members suggest that faith leaders are indeed important role models and authoritative figures in the community: 'Church people are shy of discussion, so if I lead the discussion people might get a positive view on issues such as HIV and AIDS', said a pastor in Robert Sinyoka ADP. He stressed that as a pastor he can support building confidence amongst his faith community so that people want to share the knowledge. Yet, our scope has been limited because the faith leaders who have not been willing to develop their leadership with regard to MNCH and HIV and AIDS in the church or community may not have been selected for an interview.

It is important to be realistic about what faith leaders' possibilities and limitations are, as we will also discuss in the following section. The evaluation study underlying this report indicates that CoH MNCH brings out questions regarding the (assumed or actual) gender roles and inequalities in the community, while the model itself seems to be limited in terms of giving people the tools and background needed to address the questions themselves. In our view it also shows that CoH catalyses a process that needs attention and follow-up rather than being a quick fix for changing problems in the community. In addition, we want to raise the question on gendered notions of leadership and existing gender biases than might be reproduced rather than challenged in the CoH model, and the need to create space for alternative forms of leadership to be supported and gender issues to be addressed within the communities.



3.4 Community change

The men and women interviewed in both communities were generally very positive about CoH and the impact of CoH in the community. In Robert Sinyoka ADP all interviewees, including those who did not go through CoH, described community changes with regard to people living with or affected by HIV and AIDS and sometimes also in MNCH. These changes started to occur around the time that CoH was introduced. While they also noticed changes in how the church was involved in the community with regard to these issues, people who had not been through the programme were generally unaware of a programme called CoH. When asked how these changes occurred, people would usually refer to the joint efforts of the government and organisations such as World Vision in the community.

In Lupane ADP everyone we spoke to pointed at CoH as a catalyser of change around MNCH issues in the community, whether CoH facilitators, pastors, village heads or health workers. One man described his experience in the following words:

‘I was so excited; I learnt some new things through CoH. We learnt that the father has to be involved. It was so fascinating. My wife is about to deliver now and I am excited to be there for the first time in my life. Prior to this knowledge we used to see the practice of women being assisted by elderly women while giving labour at home. Now we know that women need to be cared for during the pregnancy; men should support their women. These are some of the new things we have learnt.’
– male interviewee, Lupane ADP

A woman from Lupane ADP who is very active in reaching out to the community on MNCH issues since she was trained explained that CoH for MNCH has really helped them ‘to involve everyone in the community, to unifying everyone’.

The aspect of strengthening community cohesion and cooperation was visible in both ADPs. In Robert Sinyoka ADP, CoH stimulated church involvement in the community and their relationships with other stakeholders in particular. In Lupane ADP, where apparently fewer organisations were active and structures in place, CoH was seen as crucially important in creating structures of cooperation and care that were relevant beyond the specific MNCH and HIV and AIDS issues. Below we provide two examples of community strengthening as a result of the implementation of CoH.

STORY OF TRANSFORMATION: MWAZI COMMUNITY

‘MY PEOPLE ARE DYING THROUGH IGNORANCE’ FAITH AS AN INSPIRATION TO CARE IN MWAZI COMMUNITY

Mwazi Community is a village community on the outskirts of Bulawayo with small newly built houses scattered around a bushy and rather rural-like area. Mwazi Community is new. It was founded two years ago as a site for resettling people living in Terenace and Killarney slums in Bulawayo. This initiative by the city council with assistance from World Vision and the UN's Office for the Coordination of Humanitarian Affairs (OCHA) is new in its kind. It is a way to improve quality of life of people living in slums: ‘Slums are not only your environment, they are in your mind’, says Kilton Moyo, church partnerships officer at World Vision. ‘People live in



harsh situations and learn to think nothing of themselves, having no opportunities to a better life. So we wanted to give these people an opportunity to change their environment and see how that would empower them in their thinking.'

As we enter the site where Mwazi Community Church is currently located – the house and land of its pastor – Pastor Wilson Ngwenya comes out to welcome us. He takes us to the chicken farm that his church group has built and is still developing to generate income to assist the most needy in the community. The group currently breeds 150 chickens, that will be sold when mature. The pastor and his wife take turns sleeping next to the chicken run to make sure nothing happens overnight. Next to the chicken barn and the house of the pastor's family, there are two small new constructions covered with plastic. These places house 60 adults, and around 130 children gather on Sundays and various other times of the week for church service and Bible Study.



Today there is a small group of five people, the Church Hope Action Team (CHAT) that initiated the chicken project. They have gathered to share their experiences. They started less than a year ago inspired by the pastor, who wanted to go beyond preaching and support the community in a practical way. 'My husband was not feeling well', says one woman. 'The church supported me with money to take him to the clinic.' Now she wants to support others in the community. She is responsible for orphans and vulnerable children in the community; she ensures that children living with HIV take their medication on time, for example. She also assures them that God loves them; as members of CHAT, they want to show this to the people in the community. 'It has transformed us', comments a male member of the team. 'We help people who are sick by fetching their water and firewood and cook for their children.' The team shares that even though people were suspicious about this at first, thinking that they would only help fellow church members, the service now helps them to become a community regardless of people's faith or church membership.





Pastor Wilson Ngwenya and his wife, Anna, attended a CoH workshop in 2014 organised by other pastors in the area and supported by the local World Vision office. ‘It really opened my knowledge’, says Wilson. ‘I realised that as a pastor I am responsible for the church *and* the community.’ The workshop brought him to understand that it is important to care for people living with HIV and AIDS. ‘People should feel comforted and know that it is not the end of the road.’ It also inspired him to teach people about HIV and AIDS and not be shy about doing so. ‘We did not feel free [to talk about HIV and AIDS], but now we feel it is important to address this in the community and also teach in the church about sexuality.’ Anna adds, ‘As a children’s teacher I am glad to teach them that every child is the same, if you are HIV-positive, poor ... it doesn’t matter, we are the same.’ Their faith is an important inspiration. Through the CoH workshop, biblical texts got new meanings and implications. ‘My people are dying through ignorance’, Wilson quotes from the Book of Jeremiah, adding, ‘We don’t want to be ignorant but to care for people.’

The chicken project is the team’s first income-generating project. The profit generated from selling the chickens is dedicated towards paying school fees of orphans in the community. The plan is to increase profit by obtaining a place in the market where they can sell. If the team could access solar energy or another power source – currently there is no electricity in the new village – it would be able to slaughter and freeze the chickens, which would allow sales at a better price. Increasing the benefits from the chicken project would allow the team to help more children and people in the community. The group would even like to start a small health clinic to address the most immediate needs of community members, especially pregnant women, ill or elderly people who cannot walk the five kilometres to the nearest health clinic.

CHAT in Mwazi Community has dreams as well as plans for the near future, but it also reports challenges. The limited profit it makes from selling the chickens at a wholesale price rather than on the commercial market and the limited money to support people still need to be tackled. However, the dedication of Pastor Wilson, Anna, and CHAT members offers a different perspective on the interconnections between religion and development, especially with regard to sensitive issues of MNCH and HIV and AIDS. It suggests a complex, multi-layered relationship, one in which faith can be an avenue for enhancing care and raising awareness on these issues, not only, as is often assumed, an obstacle or a conservative worldview desirous of maintaining discriminatory and exclusive structures.

The story on Mwazi Community illustrates how CoH may catalyse change in community relations and involvement that may become embedded in community structures rather than in the actions of a couple of individuals. While the sustainability of CHAT over a longer run and its ability to create a broader and more sustainable base for community action should be reviewed in a couple of years, it is clear that in this case CHAT tools in the CoH model have helped to create new structures. It is also interesting that the activities of CHAT do not necessarily focus only on HIV and AIDS and MNCH issues, but also include farming, marketing and therefore broader economic-empowerment issues. In this case the impact of CoH must be seen as part of the broader change that occurred in this community – relocating from a slum to a semi-rural area. CoH seems to be a useful tool in creating community cohesion in this newly established community.



STORY OF TRANSFORMATION: DALUKA VILLAGE

‘WE DON’T ONLY PREACH THE GOSPEL, WE PRACTICE IT’ INTEGRATING AND APPROPRIATING DEVELOPMENT IN MSWELE GARDENS

In Lupane District, the homesteads are scattered around the bushy area. Women and children in the area struggled with challenges related to lack of prenatal care and home deliveries that frequently caused women and their newborns to die or experience serious complications. In addition, children that were born healthy suffered from malnutrition and diseases. Men, culturally regarding the care of women and children as ‘women’s work’, often lacked the ability to take care of their families’ material and other needs. Mswele is one of the villages that is engaged in the Lupane ADP. Together with communities, community leaders and local government representatives World Vision has introduced various development programmes focussed on improving health care and food security, contributing to improving education, children’s rights and so forth. In 2011, CoH MNCH was introduced into the community, first by training a selection of pastors from local villages in the area. From there it has trickled down into the community.

Now, four years later, people have gathered around the community garden and kitchen to share their experiences in setting up and running these projects in their community. After some of the members in their community and local churches had participated in the CoH MNCH workshop, they were motivated to start a practical project in their communities to tackle some of the challenges mentioned. A CoH facilitator from the community stated in an interview earlier that week that ‘I did learn a lot of new things’. Together with other people, including his wife, who is the community health worker, he started to engage other community members through a CHAT. In 2014, CHAT established two support groups, one for pregnant and lactating mothers, and one for elderly people who are looking after children. The support groups started to organise health sessions to tackle undernourishment of children.

The community decided to start a communal garden and a feeding programme. Women now work together to grow a variety of vegetables, such as various types of beans, greens and maize. While some of them are working in the garden, others tend to the children and stimulate them to socialise together. The produce of the garden and crops that are donated by the villagers are used to give each child in the village one extra nutritious meal a day. On the compound the community has constructed a small kitchen where this porridge, containing ingredients from every food group, is cooked. Children eat the meal together with their mothers, who make it a moment of fun and togetherness, motivating their children to eat in a playful way. Every week their weight is measured, and to their joy the community members have observed that the children’s weight improved in six weeks from undernourishment to a healthy weight. ‘Our children are now more intelligent, they develop their language skills at an earlier age and learn quicker; it is a great improvement’, said one community member.

‘Because of the CoH programme I was compelled to support the women in their project. I also started to support my own wife more than I used to. A lot of us [men] have now learned that we should accompany our wives to the clinic if they are pregnant’, shares Louis Signani. CHAT has shared its knowledge about the health of mothers and their babies with the community. It stressed how important it is for men to support their pregnant wives and accompany them to



screenings and health check-ups and to encourage them to deliver their babies in the hospital. The village head – who did not go through the programme but is a board member of the local hospital – now visits the neighbouring villages to discuss issues of MNCH with other village heads. Men are now much more involved than they used to be.

The Mswele garden project is a practical example of community change that integrates various developmental efforts such as health and nutrition and education with strengthening community relationships. Churches have started to work together; rather than emphasising the difference in their preaching and theology, they focus on the practical role they can fulfil in the community. ‘MNCH is a journey; in this journey you are never alone. You always partner with other fellowships’, says Mr Nyoni, the community CoH facilitator. Moreover, the community is now investing in working together based on a shared vision. It hopes to go beyond the garden project and establish an early child development centre. As Mr Nyoni affirms: ‘We were never like that before; now we are together, we share relevant knowledge together, we are friends now!’

The Mswele garden project illustrates how the initiatives of CHAT can actually lead to a community project with an even broader community support base. It demonstrates the potential of CoH to contribute to community strengthening and social cohesion. The Mswele garden project crosscuts health, education, nutrition and community issues. It also demonstrates that if a community starts owning the specific themes and concerns raised in relation to CoH, it tends to do so more holistically than official development projects are able to do.

With regard to these stories, it must be noted there we did not do a comprehensive analysis to determine when the introduction of CoH leads to practical and holistic community initiatives and when it does not. A better understanding of the circumstances under which CoH leads to structural community change and ownership can only be done through longitudinal studies with a strong ethnographic component.

Issues around the involvement of men have been mentioned with regard to MNCH in the community in both ADPs. In all of the single and group interviews this was raised as a concern. While women in Robert Sinyoka ADP tended to be quite negative over male involvement in general, women in Lupane ADP were slightly more positive but concerned with how to reach men who do not go to church. In Lupane, women also mentioned that men had been side lined in MNCH issues and health care more generally, because most health-care services focus on children and mothers. Specific measures to motivate men, such as being allowed to cut through the waiting line when a man accompanies his wife for pregnancy check-ups, have led to more men becoming involved. More attention for their reproductive roles and health concerns may be another way to involve them.

Occasionally, and somewhat more cynically, it was said that men only gathered in beer gardens and should be targeted there. In addition, funerals and weddings were mentioned as places where men as part of their families and communities gather to listen to speeches and discuss together. This example was also raised by interviewees in a previous evaluation on CoH Gender. While Western cultural norms would not consider a speech or discussion about an



issue such as MNCH appropriate at a wedding or funeral, in the context of many African communities weddings and funerals are public community activities and as such it is considered not only appropriate but important to discuss such critical issues as MNCH in these settings. This highlights the need to take into consideration differing cultural norms and expectations and how Western cultural assumptions may limit opportunities. Male CoH facilitators and pastors could take some time in these events to talk about MNCH issues and share information. At the same time, men and women all emphasised that involving more men is a real challenge and one that is not easily tackled.

Another related challenge is the need to involve community leaders. Community leaders were mentioned as influential, in particular with regard to getting male support in the community. In addition, some mentioned that community leadership sometimes still supports harmful practices such as early marriage, so involving community leaders is important in eradicating such practices. The need to involve community leadership more structurally seems to be quite urgent, as one of the participants stressed: 'it is important that we have workshops to target village heads; otherwise they become stumbling blocks.' Two questions arise that have to do with the potential and limitations of religious leaders as channels of change.

First, with regard to male involvement, is the question of whether religious leaders are the most appropriate and effective door openers. This question should not be misunderstood in terms of local resistance towards spiritual leadership, as many of our interviewees affirmed that generally all community members, including men, respect the Bible as a spiritual authority. Yet pastors or religious leaders are not the same kind of authoritative figure for everyone, and their ability to reach people beyond their own congregation may be limited. Second, as CoH aims at structural and sustainable community change, the question arises of whether the methodology should not explicitly involve other types of leaders, such as village heads, local councillors and wardens, in an earlier phase, perhaps by targeting them in special sensitising meetings. As one of our interviewees said: 'Village heads have authority over forty homesteads, which count over 200 people. They are supposed to be visionary leaders, so give them a vision!'



Part 4. CoH in Zimbabwe

4.1 Introduction

Zimbabwe is located in the south of the African continent. It is a landlocked country, neighbouring South Africa, Botswana, Namibia, Zambia, and Mozambique. The population of Zimbabwe is roughly 14.2 million.¹⁹ The Shona form the largest ethnic group of the country, followed by the Ndebele. Although English has remained the official language of Zimbabwe after independence, the Shona language is still predominantly spoken, followed by Ndebele and English.²⁰ A majority of the Zimbabwean population is religious, with 75.9 per cent of the population identifying as Protestant (including 38 per cent Apostolic and 21.1 per cent Pentecostal), 8.4 per cent Roman Catholic, and 8.4 per cent of the population following other forms of Christianity that can be syncretised with traditional religious beliefs.²¹



4.2 Women in Zimbabwe

When considering the position and roles of women in Zimbabwean society, three distinct legacies should be taken into account. First and foremost, traditions from Zimbabwe's precolonial society still have a strong impact on modern Zimbabwean culture and customs. One example is the lobola system of dowry, in which the husband pays bride wealth to his bride's parents. Although precolonial society was a patriarchal one, in which women's sexuality in particular was strongly controlled, women also had responsibilities. Both women and men were responsible for their families' maintenance. In addition, women had access to land if they were members of certain lineage groups. However, women had no authority and were considered to be minors under either their father or their husband.²²

Second, in colonial society the white European settlers imposed their own gender perspectives on Zimbabwean society. In their ideology women were appointed specific gender roles. Whereas in precolonial society Zimbabwean women were responsible for producing and maintaining the household, the settlers saw a more limited role for women. They were primarily mothers and ought to take care of their children while the men financially supported the family. This also implied that most of the black women did not go to school but were kept at home.

¹⁹ CIA, *The World Factbook*, <https://www.cia.gov/library/publications/resources/the-world-factbook/geos/zi.html>.

²⁰ Ibid.

²¹ Ibid.

²² Gay W. Seidman, 'Women in Zimbabwe: Post Independence Struggles' *Feminist Studies* 10 (Autumn, 1984): 420–421.



Third, one should consider how women's position became part of war for independence agenda. The war for independence was not prompted merely by racism, unequal power relations and unequal access to resources, but also by gender inequality. The Zimbabwe African National Union (ZANU) promised women that they would gain more freedom from oppressive gender relations, and that gender would be put on the postwar agenda.²³ About 10,000 women were recruited for the military faction of ZANU. In addition, in 1977, ZANU established a women's league that gave women a voice in the decision-making of the party. The women's league stated that there had to be emancipation of women in order for the revolution to 'triumph in its totality'.²⁴

After the war for independence, Mugabe's ZANU initially kept its promise by establishing the Ministry of Community Development and Women's Affairs (MCDWA) in 1981. The MCDWA particularly targeted child care, nutrition and domestic duties of women. Approximately 40,000 women have participated in courses offered by the MCDWA.²⁵ Furthermore, the ministry took over the government's literacy programme for adults and targeted women in particular.²⁶

However, the MCDWA faced financial problems and lacked structural organisation. In addition, the ministry faced many challenges that were deeply enrooted in the Zimbabwean traditional culture. This became particularly challenging when this traditional culture became celebrated as part of the new nationalist, anti-imperialist ideology. Women who spoke out against traditional values were called out by ZANU leaders as Western feminists who were propagating new forms of 'cultural imperialism'.²⁷ In the traditional system, independent women were undesirable. Thus, women became marginalised in Zimbabwean society after independence. This was disappointing for many women, particularly those who had fought alongside men during the war.²⁸ In 1999, the Zimbabwean Supreme Court ruled that Zimbabwean women are minors to men, and women lost the inheritance rights that they gained in the previous twenty years.²⁹ These traditionally informed gender imbalances also have led to an increased marginalisation of women. Women are expected for the most part to play their role in the domestic sphere.

Primary education is free for both boys and girls in Zimbabwe. However, although 82.4 per cent of girls attended primary school between 2008 and 2012, only 48.6 per cent of girls attended secondary school.³⁰ In addition, according to staff members of World Vision Zimbabwe and interviewees, the rate of teenage pregnancies remains high and results in high rates of school dropout amongst teenage girls. According to a 2012 census from the Zimbabwe Statistical Agency, 49 per cent of women have missed out on formal education. In addition, health issues during pregnancy form a serious challenge for many Zimbabwean women.

²³ Sanne Schotting, 'Women and Democratization in Zimbabwe: A Gendered Analysis of Transition Politics in Zimbabwe', bachelor's thesis (2013), 2.

²⁴ Seidman, 'Women in Zimbabwe' 419.

²⁵ Ibid., 434.

²⁶ Ibid.

²⁷ Ibid., 432.

²⁸ Schotting, 'Women and Democratization in Zimbabwe', 6.

²⁹ Saliwe M. Kawewe, in K. Shillington, *Encyclopedia of African History*, Volumes 1–3 (New York: Taylor and Francis Group, 2005), 1736.

³⁰ UNICEF, 'Statistics' http://www.unicef.org/infobycountry/zimbabwe_statistics.html#120.



According to a 2010 census there are 570 maternal deaths per 100,000 live births. Furthermore, official WHO statistics of 2012 have shown that rates of stillbirth and neonatal death in Zimbabwe are still high, with prematurity (12.6 per 1,000 live births) and birth asphyxia and birth trauma (11.8 per 1,000 births between 0 and 27 days) being the highest causes of death.³¹ This is often a result of giving birth at home instead of in hospital, which increases the risk of complication for both mother and child.

HIV and AIDS

Around 1.6 million Zimbabweans are infected with HIV.³² By 2011, over 900,000 children were orphaned as a result of HIV and AIDS.³³ On a national level it has been challenging for the government to respond adequately to the disease. Zimbabwe deals with a dysfunctional public health system due to the economic crisis, high rates of unemployment, corruption and political violence.³⁴ Although the government has invested in prevention schemes, many of them lacked long-term financial funding. The government has emphasised the importance of screening and testing for HIV since 1999. This has had positive results, as 1.65 million people tested for HIV in 2010 and 1.83 million people in 2011.³⁵ Nevertheless, according to our informants, many people are reluctant to be tested for HIV due to stigmatisation and discrimination. In addition, public health institutions charge consultation fees, which cannot be afforded by everyone. This can have a negative impact on the decision-making of people to go for testing.³⁶

Over time antiretrovirals (ARVs) have become more available in Zimbabwe. A WHO report shows that about 79 per cent of HIV-infected people in Zimbabwe received antiretroviral treatment in 2013.³⁷ However, the costs of ARVs have increased drastically. In addition, it remains difficult to obtain ARVs, particularly for those who live in the rural areas, due to low incomes, lack of infrastructure and a shortage of health-care workers. Both the government and NGOs have distributed free condoms. In addition, the private purchase of condoms has increased immensely. This suggests that the use of condoms has become more accepted.³⁸

In addition to the government's efforts to reduce HIV and AIDS, the Zimbabwean population and NGOs have also made efforts. Most campaigns target young people, as almost 50 per cent of the people living with HIV have become infected during their young adulthood. Hence, HIV and AIDS prevention has become a part of the curriculum in primary and secondary schools.

³¹ See WHO Global Health Observatory Data Repository, 'Mortality and global health estimates > Child mortality > Causes of child death > Proportion of deaths by cause > By country [Zimbabwe]' <http://apps.who.int/gho/data/view.main.ghe200-ZWE?lang=en> (2012 figures for Zimbabwe).

³² UNAIDS, 'AIDS info' <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>.

³³ UNAIDS, *Global AIDS Response Progress Report 2012: Zimbabwe Country Report (2010-2011)* (2012) 2 http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_ZW_Narrative_Report.pdf.

³⁴ AVERT, 'HIV and AIDS in Zimbabwe' <http://www.avert.org/hiv-aids-zimbabwe.htm#>.

³⁵ UNAIDS, *Global AIDS Response Progress Report 2012: Zimbabwe Country Report (2010-2011)* (2012) 24.

³⁶ AVERT, 'HIV and AIDS in Zimbabwe'.

³⁷ WHO, UNICEF, UNAIDS, *Global Update on HIV Treatment 2013* (2013) <http://www.who.int/hiv/pub/progressreports/update2013/en/>.

³⁸ AVERT, 'HIV and AIDS in Zimbabwe'.



UNICEF and the Ministry of Education, Sport and Culture have trained schoolteachers to educate on this issue.³⁹

Although there is a positive trend in Zimbabwe with regard to HIV and AIDS prevention, numerous challenges remain. Due to a higher rate of poverty and lower education, it can be challenging for women to access information and treatment. Access to information and treatment remains a challenge in general. In 2012, only 45 per cent of children infected with HIV and AIDS had access to ARVs.⁴⁰ Poverty and malnutrition contribute to a higher risk of death amongst those who are infected with HIV and AIDS. In addition, due to Zimbabwe's tense political and social climate, it is challenging for NGOs to offer consistent aid to those in need. As mentioned earlier in this section, the Zimbabwean government has become suspicious of international NGOs, often accusing them of having an imperialist or political agenda. In conclusion, mother-to-child transmission of HIV and AIDS remains high. Mother-to-child transmission is the highest risk of infection after heterosexual intercourse.⁴¹ Women who give birth at home are particularly at risk due to higher risk of complications. Children born to HIV-positive mothers at home are at higher risk for HIV infection as well.

4.3 CoH in Zimbabwe

CoH was introduced in Zimbabwe in 2010. Since 2010, 2,268 congregations have been involved in various CoH programmes, mostly in CoH HIV&AIDS. According to CoH monitoring data from 2013, 517 faith leaders have been trained. In addition, over 1,055 people have participated in organised CoH workshops, and 302 CHATs have been founded within the existing 27 ADPs. Furthermore, CoH has provided assistance for 3,364 children across the country.⁴²

CoH 2014 monitoring data shows that 25 ADPs have implemented CoH HIV&AIDS. In total, 64 individual congregations were represented at the catalysing workshops on HIV for faith leaders nationwide. Ninety-eight participants have taken part in the HIV catalysing workshops, 48 men and 50 women. Sixty-two participants have taken part in the HIV strategising workshops for congregations, in which 30 different congregations have been represented.⁴³ Furthermore, 1,210 people have participated in the HIV CHAT workshops (551 men and 659 women). Over 300 (324) volunteers have been mobilised from the participating congregations and participate in all HIV-related activities.⁴⁴ In addition, 160 volunteers from the HIV CHATS have been trained as home visitors. World Vision has trained 29 of its employees as facilitators and has also trained 63 non-staff members as facilitators. A majority of 59 facilitators are Protestant Christian (including Apostolic and Pentecostal).⁴⁵

³⁹ Ibid.

⁴⁰ WHO, UNICEF, UNAIDS, *Global Update on HIV Treatment 2013*
<http://www.who.int/hiv/pub/progressreports/update2013/en/>.

⁴¹ AVERT, 'HIV and AIDS in Zimbabwe'.

⁴² Zimbabwe National CoH monitoring data 2013.

⁴³ Zimbabwe National CoH monitoring data 2014.

⁴⁴ Ibid.

⁴⁵ Ibid.



Robert Sinyoka ADP is located on the outskirts of Bulawayo, the second largest city in Zimbabwe. In Robert Sinyoka ADP, 34 congregations have been involved in the CoH workshops. This includes congregations outside the ADP. Robert Sinyoka ADP trained 12 facilitators between 2010 and 2011, of whom 11 are pastors (7 males and 4 females); one is a health officer. Four pastors are from mainline churches, the other seven from Pentecostal churches. Nine of the pastors are now responsible for community trainings. Church leaders (such as church elders and deacons) and church members joined the CoH workshops. We were told that more women than men participated in the workshops. Churches sent mixed groups of youth and elders to the workshops to ensure sustainability of interventions in the churches and communities.

Since 2010, Robert Sinyoka ADP has organised four sensitisation meetings. With these meetings, Robert Sinyoka ADP aimed to implement the CoH programmes within the churches and faith-based organisations in the ADP. In addition, 12 CHATs have been founded since 2010; they help with action-oriented plans on HIV and MNCH that are implemented in the church and the community.⁴⁶

Lupane District is located in Matabele North Province on the road from Bulawayo to Hwange. The district comprises 28 wards and 156 villages. CoH MNCH has covered two wards and 20 villages in four different areas: Gwampa, Jibajiba, Daluka and Lake Alice. Each village has an average of five churches.⁴⁷ The ADP started in October 2012 and will phase out in September 2019. Lupane ADP covers a population of 31,675 people, including 3,600 children.⁴⁸ In 2013, Lupane reached 83 congregations. In addition, 27 faith leaders have been trained in two faith-leaders workshops, and 87 participants took part in three organised CoH MNCH workshops. Two CHATs have been founded and are active in Lupane ADP.⁴⁹



In 2012, there was a mid-term evaluation of the CoH MNCH programme in Lupane ADP by independent evaluators. These evaluators stated that the CoH programme has led to a 'silent revolution' in Lupane.⁵⁰ They claim that churches have undergone noteworthy changes in their embrace of MNCH issues, even those that are considered to be more conservative. Not only is there attention and education in the churches, but it was also reported that churches are involved in women's health issues, encourage men to be involved during pregnancies, and organise child celebrations. Men were reported to be more involved with regard to women's health issues. Particularly during pregnancy and after pregnancy, men helped their wives with domestic duties and accompanied their wives to the clinic. Overall, the evaluation report of 2012 is highly positive about the results of the CoH MNCH programme in Lupane ADP.⁵¹

⁴⁶ All information from the Robert Sinyoka ADP office.

⁴⁷ *Evaluation Report CoH MNCH*, WV Zimbabwe Lupane (2012).

⁴⁸ Information from the Lupane ADP office.

⁴⁹ Zimbabwe National CoH monitoring data 2013.

⁵⁰ *Evaluation Report CoH MNCH*, WV Zimbabwe Lupane (2012).

⁵¹ *Ibid.*



4.4 Robert Sinyoka ADP

This section provides an overview of the data gathered during the evaluation.

4.4.1 Challenges in the past

Both men and women reported that there were several challenges with regard to HIV and AIDS in the past. First and foremost, there was limited knowledge about HIV and AIDS. People could not explain where the disease came from ('Why does this happen?'). In addition, medicines were scarce, which led to a high death rate amongst those infected with the virus. People thus became afraid of the disease (focus-group discussion [FGD] CoH Men) The women in the FGD explained that the disease became associated with promiscuity (FGD CoH+ Women). The men stated that HIV used to be considered a 'spell from the invisible world' (FGD CoH+ Men).

Because of these views, the community stigmatised people who were infected with HIV and AIDS. Those who were infected were advised to visit a witch doctor, because it was the common belief that HIV and AIDS could only be treated by traditional medicines (FGD CoH+ Men). Discussing HIV and AIDS – which also leads to discussing sex and sexual reproduction – was not merely taboo in the community, but also in the churches. Some church sects even forbade their members to visit hospitals (FGD CoH Men). Two female health workers reported that it used to be difficult to engage churches and church leaders in general. Faith leaders stigmatised HIV-positive people because they also connected the virus to promiscuity (interview with community health workers). During our interview with the community health workers, one woman shared a personal experience with us. She told us that during one workshop she told the group of a person who was HIV-positive but could still do everything in life. When the group did not believe her, she told them that it was her own story she had just shared with them. 'I was presenting about my own experience with HIV; then people were surprised and asked questions. It opened other people's minds.'

Likewise, there were challenges with regard to MNCH in the community. The women expressed to us that their family and the community often did not support young girls who became pregnant. Some women had birth complications resulting in a high maternal and neonatal death rates. In general, the women who went through the programme described to us that there used to be a lack of neonatal care for women and children (FGD CoH+ Women). The men also expressed their concerns about teenage pregnancies. They explained that young people often have no future due to poverty, low education and unemployment. According to them, this leads to early sexual activity, with early pregnancies as a result (FGD CoH Men).

Another challenge that was mentioned by both men and women was the lack of male involvement with regard to pregnancies and health issues. Men expressed that fathers were often reluctant to go for HIV screening (FGD CoH Men) and stated that women used to not get tested as well. The female health workers also stated that most women would give birth at home instead of going to the hospital, which resulted in higher risk of birth complications and deaths (community health workers' interview). If women did go to the clinic, their husbands often stayed at home (FGD CoH Men). In addition, the health workers shared that sexual education used to be taboo. When they would go to people's homes to educate their children



about sexual reproduction, they would be told 'it's not for us' or 'you are such a child, what do you know about these issues', referring to the young age of the health workers.

4.4.2 Changes in the community

All groups and individuals reported that they witnessed changes in the community. Most of them stated that changes started to occur four to five years ago. However, the men who went through the CoH programme said that the changes started to occur in 2012, after CoH had first been implemented. With regards to HIV and AIDS our interviewees told us that the community has gained knowledge about HIV as a disease. People have started to realise that HIV and AIDS is not a punishment from the transcendental world for promiscuity, but a virus that can also infect and affect everyone, regardless of religion, lifestyle or marital status. One of the health workers shared with us that, in the beginning, many people found it difficult to comprehend that there was the possibility of a hopeful future for HIV-positive people due to the stigmatisation and fear for the disease. However, now that people have become aware of which medication to use and medication has become more available, people are realising that HIV does not necessarily result in a quick death. The health workers described this as a change of people's mindset: 'They changed their attitudes, and they see that HIV-positive people can do things that people without HIV can do as well.' The FGD women (CoH+) shared this thought, stating that people would now advise HIV-positive people to go for check-ups and medication.

Our interviewees reported that people who attended the training started to realise that HIV could happen to anyone and find creative ways of bringing the message to different people in the community, including men and youth. The health workers shared with us that they would compare HIV to sports while educating people during sports events: 'The way you attack, HIV attacks you.' The group of men who went through the programme also made a similar statement: 'It is only a matter of time before you could be infected yourself.' This personal awareness motivated them to share knowledge about HIV and AIDS in the community. In addition, both men and women (CoH+) mentioned that hygiene with regard to circumcision had improved, and people now use different blades or knives instead of one. Finally, it was mentioned that sensitisation, through CoH, led to more unity amongst people and the acceptance of people infected with HIV now that people share the idea of how the disease can be treated: 'We should not stigmatise but love each other' (FGD CoH Men, FGD CoH+ Men, CoH+ Women, CoH Women, quotation from single interview with two women).

With regards to MNCH our interviewees also witnessed some changes in the community, although this was not mentioned often in comparison to HIV and AIDS. Both men and women reported that they were more aware of the unity of the family, particularly with regard to male involvement. We were told that men were encouraged to join their spouses at the hospital, to go as a family (FGD CoH Men). The CoH+ women told us that the community became more aware of the importance of postnatal care; they gave organising homecoming parties for mother and newborn child as an example. In addition, these women emphasised the new knowledge with regard to the mother's responsibility for the child (single interview) and issues such as exclusive breastfeeding (FGD). Furthermore, the CoH women told us that most women now get tested for HIV and AIDS. Men also underlined the importance of using facilities to prevent mother-to-child transmission of HIV and AIDS. They also recognised that openly discussing these issues has become more important, as 'talking about HIV and AIDS and reproduction is important to keep the newborn baby safe' (FGD CoH+ Men). The men who had been through



the CoH programme also shared with us that they have managed to form special programmes for men that promote gender equality. The men now organise community meetings or invite men to stay after sermons to talk about these issues. Furthermore, sport events are used to share information and promote equality and friendship.

Some of the interviewees referred to the Bible as an inspirational source for their own responsibility with regards to all these changes in the community. All of them had been through the CoH programme. With regards to HIV and AIDS, one of the men referred to the Book of Romans when discussing equal treatment of all people. With regard to MNCH, the women in the FGD referred to Biblical principles when discussing exclusive breastfeeding for newborns. A young woman also referred to the calling to be 'the salt and the light' (Matthew 5:13–16) that is discussed during the workshop as an encouragement for her to participate actively in the community on these issues. She told us that during the workshop the facilitators explained that salt heals wounds, which she interpreted as that she should be the salt for wounded people in the community and bring light to their lives (interview single mother and younger woman).

4.4.3 Changes in the churches

'If people listen and respect the church leaders, it can have a positive impact in the community', one of the men stated (FGD CoH Men). In general, all interviewees saw the potential of including religious institutions and faith leaders. First, the churches are linked to the local leadership. Therefore, faith leaders can request audiences in the community to talk about their experiences. Second, church members are often shy and prefer not to start a discussion about HIV and AIDS or sexual reproduction. If church leaders start, they might follow (FGD CoH+ Men). The men who went through the CoH programme stated that they were becoming more confident about sharing knowledge with others in the church.

It was reported that churches were becoming more open to people from the community, helping them with problems and encouraging those with HIV to go to the hospital. Some churches have started to offer HIV programmes as well; Seventh Day Adventist church was mentioned here (FGD CoH Men). With regard to HIV, some churches act as a mediator between spouses who were infected with HIV by their partner. The church guides them and shows them they have to leave the 'blame game' and forgive (FGD CoH Women). It was noteworthy that the women who did not go through the CoH programme referred to workshops of World Vision that had trained pastors. Another interviewee who went through the programme stated that 'the church reached out to the community because of Channels of Hope' (single interview with single mother and younger woman). The churches now train their congregants. With regard to tackling stigma and discrimination around HIV and AIDS, it was also mentioned that it was important that the community be sensitised in various ways, including through government programming, yet there also needed to be specific programmes focussed on engaging churches and faith leaders. CoH was seen as crucial in this, although Catholic Relief Services was also mentioned.

In the case of MNCH, examples were a bit more limited. It is quite early in the process to evaluate change, yet it was mentioned that the churches advise women to go to the clinic. In addition, they also encourage men to accompany their spouses to the clinic, to go as a family. Some churches offer lessons and education during special weeks for women and families. Before, such topics were not discussed in the churches. Interviewees emphasised that churches have become more open to these issues, yet there is still a way to go, especially when it comes



to the involvement of men. The observation that men were more inclined to focus on HIV and AIDS related topics, while women brought up MNCH issues more spontaneously in the interviews is a case in point. The health workers also acknowledged this, reporting that the level of open communication has increased. They also stated that when pastors leave the CoH programme, they incorporate their new knowledge in their teachings and preaching.

4.4.4 Ongoing challenges

Although all interviewees reported improvements and changes in the community and churches, they also pointed out that there were many challenges still ahead, particularly with regard to MNCH. One important concern was early pregnancy. Men explained to us that young people who believe they do not have a future become more active sexually, resulting in a high pregnancy rate (FGD CoH Men). We also heard that peer pressure amongst teens plays a crucial role; girls are pressured to engage in sexual activities that they might regret later (single interview, single woman and younger woman). Our translator from World Vision added that poverty is also a contributing factor because girls will have sex in exchange for gifts (a bag of chips or other products that the girl wants but cannot afford).

A second concern was the participation of men, which was pointed out by both men and women. According to the women, some men have become more involved in MNCH but other men still do not accompany their spouse to the clinic. In some families women still could not talk about their health with men (FGD CoH+ Women). The men reported that men did accompany women to the clinic, but they acknowledged that there were still challenges in involving men, particularly in involving those men who do not attend church on a regular basis. The women suggested it might be better to organise meetings for men alone (FGD CoH Women). They referred to the men's forum as a possible option. Men saw possibilities in including sports, as many men drink in the bars and watch soccer. They also expressed that men-to-men teachings might be more constructive than mixed dialogue (FGD CoH+ Men).

A third challenge that was mentioned was the inclusion of young people in the programme. One interviewee commented:

'I think the programme must be implemented among young people. At times you can see sixteen-year-old children having a child. ... We also have to educate their parents and others who stay with them.'

Other interviewees suggested including children in the programme to educate them about sexual reproduction and HIV and AIDS before they get to puberty. A special module for children would also be welcome, though this has to be balanced with the risk of introducing children to such topics too early and potentially contributing to sexualising them at a young age. In conclusion, the health workers emphasised that the mindset of adults needs to change as well: people must know the realities.



4.5 Lupane ADP

This section provides an overview of the data gathered in Lupane ADP during the evaluation.

4.5.1 Challenges in the past

During the single interviews and FGDs members of the communities told us that they had faced many challenges with regard to MNCH in the past. Women usually did not go for prenatal care or plan to have their babies in a health facility, nor did many men and women go to be screened for HIV and AIDS, which led to higher risk of mother-to-child transmission of HIV. Women delivered at home due to absence of nearby clinics, or because they didn't book for the clinic. Both men and women expressed to us that the home deliveries caused complications, resulting in high infant mortality rates as well as risks of maternal death due to excessive bleeding.

The lack of male participation was mentioned by both men and women in the single interviews and the FGDs, even by those men who did not go through the CoH programme. Men showed little interest in pregnancy and postnatal care. They did not accompany their spouses to the clinic, nor did they witness the birth of their children. One man expressed to us that men tended to see pregnancy as stressful or difficult and that men did not understand women's specific needs (FGD CoH+ Men).

Other issues that were addressed were lack of immunisation and lack of knowledge about nutrition. Children did not get immunised during their first six months. Nor did mothers exclusively breastfeed their babies during their first six months. Both men and women expressed that it is common to feed babies water and even other food. (This was referred to as 'mixed feeding'.) Several groups and single interviews mentioned the ritual of child smoking as a common practice in the area. During this ritual a newborn child is held in smoke caused by burning herbs on hot coals to protect the child from misfortune and evil forces. This tradition caused serious health risks for the child.

4.5.2 Changes in the community

All interviewees reported significant positive changes in the communities. They also considered the CoH programme to be a crucial factor in these changes, even those who did not go through the programme. They told us they had heard about the programme through their church or were told about it by other community members. Those who did go through the programme mentioned new knowledge on MNCH issues led to practical health improvements.

We noticed that the practical aspects and changes following the introduction of CoH were particularly emphasised by women (FGD CoH+ Women; single interview 2, 3, 4). They reported that more women planned to give birth in the clinic and left on time for hospital. They stated that this reduced the maternal and child death rates. In addition, the new knowledge on nutrition and exclusive breastfeeding was also mentioned as beneficial, and more than one woman referred to specific verses in the Bible that they felt support breastfeeding. One woman reported that it became obvious that exclusive breastfeeding improved the health of her granddaughter (single interview 2). The men also stated that children who now get the right nutrition even seem to develop better than children did before (FGD CoH+ Men). Also, the child-smoking ritual has been abandoned by many because they have become aware of the health risks.



Another crucial impact that the interviewees reported was synergy with scripture. The ward councillor of Daluka states: ‘CoH makes me a better Christian, because I never realised that MNCH issues are also inside the Bible. When I prepare the workshops, the more I read the Bible, the more I can provide relevant scriptures’ (single interview 1). Others also reported that they never had thought about a connection between issues such as MNCH and the scripture. It was noteworthy that it was mostly the men who focussed on the relation between MNCH and the scripture in the CoH workshop. In particular, they emphasised how enlightening and transforming this realisation was, both in their private lives and in the community. One of the men who went through the CoH MNCH programme (and has become a World Vision facilitator) shared with us that he already had two children but never had been involved during his wife’s pregnancy or the labour. Now that he was aware of the importance of his support, he is supporting his pregnant spouse and wants to witness her giving birth to his third child (single interview 5). One male interviewee summarised the changes:

‘The community has transformed because the provisions are there. The involvement of men has improved. A new mother was never my business. It is my mother who would take care of her and the newborn baby. But now it is a different story. I am with my wife during the labour; I play a pivotal role in the family. Our marriage is now stronger than before. It was a taboo for the man to watch the process of delivery. Now we stay together as a family.’ – male interviewee, single interview 1

The men gave the birth of Christ as an example of how the Bible served as motivation for them to support their wives during pregnancy and labour. Although Joseph was not Christ’s biological father, he cared for his pregnant wife and helped her when she gave birth under harsh circumstances. In addition, clinics now have adopted a policy by which couples receive priority and do not have to wait in the queue. These factors have led to an increased number of men accompanying their wives to the clinic.

4.5.3 Changes in the churches

Almost all interviewees mentioned that they witnessed changes within their own church. Themes such as pregnancy and sexuality often had been considered taboo or difficult to discuss within the church. Such topics are discussed more openly since pastors were trained in the CoH programme. Knowledge about MNCH is now shared in the church. Some churches even touch upon MNCH in their services (single interview 5). There already had been services for pregnant women, but these services increased after the CoH programme.

Also, preachers now emphasise the importance of taking pregnant women to register their babies and to go for check-ups before and after the child is born. The church warns the mothers about danger signs that could point to health complications for mother or child. Lectures inform women what they should eat during and after the pregnancy and teach women about exclusive breastfeeding. It was reported that in the beginning it could be challenging to convince women about health risks and high maternal deaths. Showing them statistics was reported to be a real eye-opener (single interview 6). Churches were also reported to support women who experienced any inconveniences or lack of support from their spouse (during the pregnancy).

Furthermore, the church contributed to acceptance of *all* children, including those born out of wedlock, and whether they were boys or girls. The churches organised child celebrations for all



children, although it was reported that some churches would take disciplinary measures (for the parents) in case of early pregnancy or adultery (FGD CoH+ Men). In addition, the churches have opened up to other churches and even to other denominations by inviting other church leaders to join discussions and workshops. This has decreased the sharp boundaries between different denominations that existed in the past.

4.5.4 Ongoing challenges

One of the most important ongoing challenges reported in both single interviews and the FGDs is teenage pregnancy. Although it was reported that in most churches these girls were supported, they were not always accepted by the community. Different interviewees suggested different solutions, which varied from strengthening support for abstinence to establishing awareness programmes (peer to peer) for the youth. Education on reproduction and sex for young teens was mentioned by more than one person. A CoH programme that specifically targets youth was mentioned as well.

Another reported challenge was with regard to finance. At times the community had financial constraints that made it difficult to organise workshops. Furthermore, due to distance and lack of transportation, women often do not reach the clinic to give birth when they have to travel from their village. Giving birth on their way to the clinic can cause birth complications.

Another challenge that was raised was the involvement of men. According to some interviewees, some men were still not involved. Just as in Robert Sinyoka ADP, sports were mentioned as a way to involve men who do not go to church. Furthermore, it was recommended that all authoritative figures of the community be involved in the programme, particularly village heads and leaders (single interview 4). We spoke to the ward councillors and village head of Daluka, and they stated that they were keen on participating in the CoH programme.

Several interviewees expressed their concern about sexual abuse (especially sexual abuse of orphans). There were even some concerns raised about sexual abuse taking place in churches. However, other interviewees disputed this (after we raised this issue), stating that 'abuse is at its lowest level'. These interviewees generally stressed that rape was a slowly diminishing phenomenon. It was noteworthy that the interviewees distinguished between domestic sexual abuse and sexual violence that happens outside the household (this was referred to as rape). Yet some interviewees who had taken leading roles in addressing MNCH issues in the community stated the contrary, sharing their concern that these topics remain taboo, which could potentially lead to cases going unreported and unnoticed.



Part 5. Conclusions and Recommendations

Based on these findings, we make the following recommendations for the strengthening of existing CoH MNHC and CoH HIV programmes in Robert Sinyoka and Lupane ADPs:

- Bring together a combination of religious leaders, village heads and ward councillors rather than focussing solely on religious leaders in the initial introduction of CoH in a community. This will meet a dual need by involving village heads and ward councillors in raising awareness on these issues, increasing possibilities for influencing men in the community, and building relationships for future cooperation amongst religious leaders, village heads and ward councillors.
- Combine CoH with activities that are explicitly designed to attract men, such as sports events, men's forums or financial training (an example from Kenya) as a way to expose more men in the communities to issues surrounding MNCH.
- Run 'men only' CoH trainings (or have part of the CoH trainings gender exclusive) to create safe spaces for men to ask questions about these issues without feeling uncomfortable in front of women.
- Accompany the implementation of CoH MNCH by simultaneous implementation of CoH Gender to address issues of stigma and gender inequalities that also affect MNCH issues.
- Introduce advocacy and citizenship training following the introduction of CoH to provide CoH participants with skills to address wider social and political structures that inhibit improvements on MNCH, such as lack of access to clinics, insufficient education on breastfeeding and so forth.
- Increase cooperation across CoH and other programmes offered by other service providers that seek to raise awareness on MNCH issues, such as Catholic Relief Services.
- Adopt a broader understanding of faith leaders in CoH rather than initially focussing solely or primarily on people who hold formal positions of leadership within hierarchical church structures and who, for a variety of reasons, are predominantly men. CoH should include informal faith leaders from the very beginning.
- Provide a secondary influence by contributing to the improvement of women's literacy, through, for example, education in scripture.



- Long term: Improve monitoring and evaluation systems that enable measurement of change through, for example, gathering of baseline statistics on issues such as:
 - maternal and newborn infant mortality rates
 - child mortality rates
 - rates of breastfeeding
 - home births vs hospital births.
- Undertake surveys for similar statistics at the mid-point and end-point of CoH implementation; this would provide a more comprehensive overview of the changes that occur during the period of CoH implementation.

In addition, we recommend selecting individuals and communities to focus on during the entire phase of CoH implementation. These individuals and communities would be followed from pre-exposure to post-exposure to CoH in order to determine the extent to which participation in CoH results in lasting attitudinal and behavioural change as well as the types of changes that occur. At present, while there is substantial testimony from individuals interviewed that participation in CoH has resulted in changes in their lives, we have only their word for this. Their responses may be influenced by what they think the researchers want to hear. We suggest training World Vision staff in participant-observation techniques in order to observe for themselves what changes are occurring. There is also a need to follow individuals who do not become active on MNCH issues and for whom CoH produces little to no discernible change. Why do we make these recommendations? Incorporating longer-term evaluation processes such as these will enable greater knowledge on the reasons why change does or does not occur.



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