Faith and Maternal Mortality – Consultation at the Berkley Center
June 15, 2011

Katherine Marshall opened the meeting with an introduction to the history and mission of the World Faiths Development Dialogue and the Berkley Center for Religion, Peace, and World Affairs and its work and current approach and priorities. Maternal mortality is among a series of explorations of development topics, focusing on the role that faith institutions and ideas do and could play. She noted that this topic of maternal mortality has attracted particular interest, suggesting that this is a moment that is ripe for action.

Anny Gaul, the principal author, introduced the report as an attempt to tackle both very broad issues—how do health, gender, and medicine overlap—as well as track very specific ways that faith-inspired organizations are working on maternal mortality. Gaul pointed out that during her research she was struck that not only is faith and maternal mortality underexplored, but maternal mortality is itself an underexplored issue in relation to child health.

Childbirth is an extremely personal and private issue, one that for many women has a spiritual aspect; for many women, religious organizations are the ones facilitating care. Sometimes this is because FIOs are the only facilities around; sometimes they are known for providing better care than government clinics; and sometimes there are specific religious values that might make them more attractive.

Amie Batson (USAID) offered the perspective from USAID, where they are giving high priority to maternal and neonatal child health within the budget. Why is it so important? There has been a real recognition led by the Secretary of State of the need to focus more sharply and purposefully on women and girls. This includes a maternal mortality component but goes far beyond that. There is also a strong moral dimension: women simply should not die giving birth to a child in this day and age.

Batson pointed towards the shift within USAID's strategy from focusing on the supply side-—medicine, hospital interventions—to focusing on the social, cultural, and economic factors that may prevent a woman from receiving the care she needs. And a major part of that is asking who are the trusted members of the community who can help support women in getting the medical attention they need, and that often points to religious leaders.

As a major example of momentum on maternal mortality, Batson pointed to USAID's Grand Challenges for Development initiative: the first one is called Saving Lives at Birth and has received around 690 proposals.

She suggested a few different roles for faith-based organizations within this space: a delivery function; reaching community leaders to spread messages about the care women need; and holding governments accountable. One final role, which is beginning to gain traction, is to engage women in the United States on the need to address maternal mortality, an issue that can truly resonate for many women and mothers.

The conversation turned to the problem of family planning's conflation with abortion, and the effect that has on funding and operations. Batson pointed out that any language employed around family planning is immediately interpreted by some as covering something up, whether the words used are

reproductive health, family planning, or healthy timing and spacing of birth. She suggested that often who is speaking can be more significant than the language used: when she discusses family planning and when a religious leader does, it's heard in very different ways. Faith-based organizations thus have a unique ability to use their voice to defuse radioactivity.

Azza Karam (UNFPA) noted that even though the UN Joint Action Plan on Maternal and Child Health, announced by Secretary-General Ban Ki-Moon in April 2010, has prompted astounding financial commitments from both the government and the private sector; however, commitments made to child health appear to outweigh commitments made to maternal health. Karam suggested that this is connected, at least in part, to family planning's association with abortion and women's ability to control their own bodies; she emphasized that this is a problem not only in the U.S. but globally.

Karam also noted UNFPA's Intercultural Approaches, particularly evidenced through the work of colleagues in Latin America, where dwelling on religious tensions is tackled in pragmatic fashion through culturally sensitive approaches, based on work with indigenous peoples within the human rights frameworks. These interventions are documented on UNFPA's website: www.unfpa.org.

Pauline Muchina (UNAIDS) emphasized that we need to take family planning out of the realm of controversy. As an African woman, when you think about reproductive health, the first thing you think of is safe pregnancy, non-painful periods—things not related to abortion. Jill Olivier (World Bank Development Dialogue on Values and Ethics, ARHAP) suggested that it might be useful at the beginning of the report to track the baggage that follows these terms, some of which cross over between continents and some of which do not. Tom Dannan (John Dau Foundation) drew from his own experience with medical clinics in South Sudan, where he said what is most needed is antenatal care and traditional birth attendants; abortion rarely comes up—not because it is a hot-button issue, but because it is not a priority issue there for women and families.

Marshall asked about the significance of the fact that over one in ten maternal deaths are attributed to botched abortions: what is the impact and approach? Muchina recommended working with health care workers to reduce the stigma that is a common reality: in many places, women needing treatment from botched abortions will receive worse care, and that many will choose not to go to the hospital because of insults they will receive. Karen Cavanaugh (USAID) noted that USAID has a program on post-abortion care, providing training to health workers on how to deal with botched abortions.

Pauline Muchina (UNAIDS) sounded a positive note: maternal mortality is preventable and we do know the causes, such as anemia, hypertension, and child marriage. But what we don't see is willingness of our communities—not only faith communities but government and development—to push for prevention. Child marriage is a major cause, and it is one where faith communities can play a huge role. Hypertension can be detected through simple screenings, which could even be administered at religious services. It is also important to look at gender and cultural norms—such as women carrying water on their backs or performing all the household chores when nine-months pregnant—that make women and girls vulnerable to maternal mortality; many of these norms are learned and maintained with at least the tacit support of religious structures.

On the topic of child marriage, Marshall pointed out that this is an issue the Elders group has chosen to address, both broadly and as an opening to more active engagement with faith

communities in their mission. The question is: What would be the most effective tactic in building on this important topic? How can they, and we, identify specific people and institutions to talk to? Is there merit in specific efforts to approach the Vatican? Who in India and Pakistan might they approach and influence?

Olivier emphasized the complexity of maternal mortality as a research question. Maternal mortality is an indicator of more complex problems, and this interdisciplinarity could be highlighted more in the report. Olivier suggested including in the report a visual mapping of the way multiple issues intersect with maternal mortality.

Several meeting participants brought up the difficulty of targeting the women who are at risk of maternal mortality, and emphasized that for this reason it is necessary to ensure that communities themselves know the danger signs.

Ray Martin (CCIH) brought up the widespread feeling in many countries that maternal death is simply the way the world is. He suggested trying to communicate that in the 21st-century maternal mortality is not inevitable, and in most cases represents some sort of failure. As one topic for further research, he suggested an anthropological scoping about perceptions in different societies towards maternal death, which might give clues towards how to prepare messages for religious leaders about how to reframe maternal death as something not inevitable. Karam noted that the recent report of the World Council of Churches, submitted to the Norwegian government, on how to engage religious leaders on maternal health addresses some of these points, and ought to be considered since messages for religious leaders and communities have already been developed and need to be built on.

Karam raised another challenge: there is often a disconnect—in messaging, language, and discourse—between religious leaders, religious institutions, faith-based organizations, and faith-based health service delivery institutions. Another challenge is one raised by some UN agencies, which is the difficulty of building alliances and relationships with certain religious leaders on certain issues—say, environment or climate change—but then risking the loss of the credibility of such allies, when some adopt positions related to more sensitive issues of sexuality, which could be seen as contradictory to international human rights norms.

Cavanaugh pointed to the remarkable strides made in reducing maternal mortality in Bangladesh, where USAID runs formal training institutes for imams, which include a curriculum on maternal health.

Farhana Ahmad (White Ribbon Alliance-Bangladesh) attributed the decline in maternal mortality in Bangladesh—where there hasn't been significant change in health facilities—to education and empowerment: due to increases in girls' education and increases in the female workforce in the garment industry, more women are delaying marriage and are more aware of proper antenatal care. She cited the USAID-funded Leaders of Influence program, providing leaders from multiple religions with curriculum for family planning and reproductive health. White Ribbon Alliance has been working with these imams to make Maternal Health Advocates. She also noted that activist organizations such as Care have worked with Leaders of Influence on child marriage.

Sonya Funna (ADRA) emphasized the importance of integration, linking health, agriculture, and other projects. Karam emphasized this further, noting that the Secretary General's and other

statements on maternal mortality focus on three forms of integration vital to making the campaign a success: 1) integration across the continuum of care 2) integration of different service delivery systems (campaigns, clinics, hospitals, etc.) 3) and integration of health related programs (nutrition, hygienic etc).

Katie Taylor (CIFA) suggested taking a multi-religious approach, finding spaces of synergy where different religions agree and creating program around that. Though there are many successful examples of single faith approaches at a local level, there can be scalable change when you engage more than one religion.

Olivier suggested researching theological discourses that touch on moral justice, where many of these advocacy questions around maternal mortality are being raised.

Several participants brought up communications technology and religious media, as avenues with great potential for engaging communities on these issues. Muchina cited the extensive reach of religious television stations in Kenya as one example.

Olivier warned against focusing on religious leaders per se, to the neglect of working with other elements of faith communities, such as youth groups and women's groups. Dannan echoed this, pointing out that many imams and pastors are sensitive to their congregations' views and attitudes, and can't push for change that their congregations will reject. He said that we need to work with communities at the same time as we push for action among religious leaders. On the question of who we engage, Muchina emphasized the importance of working with the faith community and faith leaders to educate men on issues of maternal mortality.

Many participants echoed the need to understand culturally-specific practices that might affect the success of interventions. Olivier recalled a case study shared at the CCIH conference in Ghana: a hospital in northern Uganda had built a splendid new maternal ward, but few women attended. They spoke to the community and learned that the cultural practice was to give birth at home, focused on birthing holes dug in the floor. With the support of local religious leaders they set up traditional birthing holes within the ward.

Karam brought up the disconnect and suspicion between the secular and faith-inspired health worlds, which is even stronger in the context of gender issues and women's movements. Women of faith are a huge proportion of health service providers, but we have no documentation to demonstrate that that engagement of women of faith in the health sector gives any qualitative difference in services.

Ahmad responded that in Bangladesh the women's groups do not engage on maternal mortality because it is viewed as the prerogative of the health sector; White Ribbon Alliance is trying to work with women's groups to push that this is a central women's issue.

Kristin Savard (White Ribbon Alliance) commented that the alliance's member organizations are very interested in working with religious leaders, and cited a few ways that her organization and their national alliances have engaged religious leaders in maternal health, including a small grant in Pakistan to publicize a fatwa from four religious leaders.

Ron Mataya (Loma Linda University) addressed the need to better document what faith-based

facilities contribute to the overall improvement of maternal health, and cited a DFID-funded study he consulted for in Zimbabwe. He suggested looking at resources that mission hospitals have in each country, so we could use that as tool not to beat down government hospitals, but to improve funding of mission hospitals.

Ari Alexander (USAID) issued a call for better evidence gathering, data collection, and data-driven analysis among faith-based networks, at both the macro and micro level. One takeaway he had from the 2010 CCIH meeting in Ghana was that many faith-based health workers were confident that they were making an impact, but were aware that they had not invested enough in tracking that impact and presenting it to the world.

Gaul echoed that we need to find ways of scaling up the successful locally-specific interventions. Marshall asked for more feedback on which countries we should focus on as we continue. Karam mentioned that there are already several countries identified as high priority countries for interventions on maternal health as per a range of agreed upon indicators – these are noted in the SG Campaign and strategies.

Karam suggested that once the report is final we use the launch as an opportunity to go over the maternal mortality accountability indicators already developed by the international agencies working on the SG's Campaign, and find where there is a connection to the work of faith-based organizations in the same areas.

Next steps: *The meeting summary will be posted on the website after participants have a chance to comment. The draft report, with updates, will be posted on the Berkley Center website, seeking comments by August 15, 2011. It will then be finalized. A launch event, in collaboration with UNFPA and UNAIDS, will seek both to promulgate findings and encourage action and alliances.*

List of Participants

Farhana Ahmad
White Ribbon Alliance for Safe Motherhood- Bangladesh

Ari Alexander
USAID/ Director of the Center for Faith-based and Community Initiatives

Amie Batson
USAID/ Deputy Assistant Administrator for Global Health

Karen Cavanaugh
USAID

Tom Dannan
John Dau Foundation/ Executive Director

Sonya Funna
Adventist Development and Relief Association

Azza Karam
UNFPA

Anny Gaul
Berkley Center for Religion, Peace and World Affairs

Katherine Marshall
Berkley Center for Religion, Peace and World Affairs and WFDD

Ray Martin
Christian Connections for International Health/Executive Director

Ronald Mataya
Loma Linda University School of Public Health

Pauline Muchina
UNAIDS

Jill Olivier
World Bank Development Dialogue on Values and Ethics

Kristin Savard
White Ribbon Alliance for Safe Motherhood/ Program Development & Strategy Coordinator

Katie Taylor
Center for Interfaith Action/ Executive Director