Maternal
Newborn
Child
Health &
Nutrition

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Faith and Health: Engaging religious leaders to promote Reproductive, Maternal, Newborn Child and Adolescent Health

Country: Uganda
Budget: 48,280 USD

Partners:
Inter-Religious Council of Uganda (IRCU)

ABSTRACT

Uganda has seen a significant reduction in maternal and child deaths over the last two decades. However, reproductive, maternal, newborn, child and adolescent health (RMNCAH) outcomes in the country are still quite low overall, with 1 in 11 children dying before the age of five. According to the Ministry of Health (2013) data in Uganda, 15 districts out of a total of 111 account for 36% of child deaths, with the highest mortality rates in the rural areas of Karamoja, Southwest, West Nile and Western Region. In an effort to improve these statistics, UNICEF Uganda has built a partnership with the Inter-Religious Council of Uganda (IRCU) which brings together the top leadership of the country's 7 preeminent religious bodies.

So far, the partnership has focused on capacity building and system strengthening of district-level IRCU structures in Karamoja (North East) and Acholi (North) regions of Uganda. Using a communication for development (C4D) approach through the following components: capacity building of religious leaders, strengthening coordination mechanism between faith based structures and District Health Teams (DHTs) and community outreach - the intervention has sought to frame pressing RMNCAH issues for a religious narrative in order to gain traction with faith-based audiences.

The first round of this intervention has been rolled out across 15 districts, and 270 religious leaders have been directly trained in planning, implementing and promoting evidence based Key Family Care Practices (KFCPs). Preliminary data suggests that these trainings were highly effective, especially in creating a strong coordination mechanism between the IRCU and DHTs. 12 Interfaith Committees

BACKGROUND

Situation

Over the last two decades, Uganda has seen improvements in child and maternal health, with a 6.3% reduction in the number of under-five deaths during the period of 1990 to 2011. The estimated maternal mortality rates have also fallen from 527 deaths per 100,000 live births in 1995, to 438 deaths per 100,000 live births in 2011, a decline rate of 5.1% (MoH Uganda, 2013). However, in spite of such improvements, child and maternal mortality rates did not decline quickly enough to meet the country's Millennium Development Goal (MDG) targets for reducing child mortality and improving maternal health (MoH Uganda, 2015).

One in every 19 babies born in Uganda does not live to their first birthday, and one in 11 children will die before reaching the age of five — with 70% of child deaths caused by pneumonia, malaria, diarrhoea and other infections like HIV (MoH Uganda, 2013). In addition, an average of 18 women die every day. Pregnancy related complications are

the leading causes of death with 42% of deaths occurring due to haemorrhage, 36% caused by malaria, 22% due to obstructed or prolonged labour, 11% caused by unsafe abortion and anaemia, 7% of deaths due to HIV/AIDS (MoH Uganda, 2013). Moreover, many mothers do not receive any postnatal check-ups, yet over 60% of maternal deaths occur 23-48 hours after delivery (MoH Uganda, 2015). According to the Ministry of Health (2013) data in Uganda, 15 districts out of a total of 111 account for 36% of child deaths, with highest mortality rates in Karamoja, Southwest, West Nile and Western Region Rural areas and low income households presenting the poorer health outcomes. Furthermore, maternal mortality is highest in Western and Karamoja regions (MoH Uganda, 2013).

In addition to a lack of access to basic services, there are several demand side barriers impacting the utilization of existing RMNCAH services in Uganda. Women often lack both knowledge and decision making power to use such services before, during, and after delivery. In addition, religious and cultural practices in many parts of Uganda create barriers to maternal and neonatal survival, such as the ingestion of herbs to quicken labour, the rejection of caesarean sections and the culture of silence around birth pain.[1]

In order to respond to the slow progress of RMNCAH in Uganda, Ministry of Health (MoH) in collaboration with UNICEF developed an acceleration plan on reproductive, maternal, newborn and child health, "The Sharpened Plan on RMNCAH". The time-frame for this plan is 2013 – 2017. The plan's five defining strategies represented a paradigm shift for the MoH: focus geographically; target high- burden populations; scale high impact solutions; grow education, empowerment, economy and environment; and ensure mutual accountability.

An integrated RMNCAH Advocacy, Social Mobilization and Communication Strategy was also developed by MoH with support from UNICEF to roll out 'A Promise Renewed Sharpened Plan' to the community and household level - with the specific focus on shifting key religious and cultural norms contributing to poor RMNCAH outcomes.

The Need for Mobilization of Religious Leaders

The improvement[2] of RMNCAH care requires innovative approaches to service delivery and the establishment of strategic partnerships (Ampeire et al., 2016). In the past, several years, Ugandan health interventions have sought to involve religious leadership as key stakeholders, especially at the community level. So far the approach has proven highly effective. One of the well- recognized example being their active involvement in Uganda's HIV/AIDS education and prevention activities (Green et al., 2006). Such initiatives have been particularly successful at addressing gaps in key knowledge, attitudes and behaviours related to health — especially those perceived as religious.

According to the 2014 Census, 98% of Ugandans belong to one religion or another. Religion permeates every aspect of Ugandan life. This has implications for personal conduct, family life and organized communal activities. It also means that religious leaders are the most important and trusted opinion leaders in communities who have unmatched potential to shift social norms.

Allan Mugisha, Advocacy & Partnership Relationship Manager, IRCU

The Inter-Religious Council of Uganda (IRCU) is therefore an ideal candidate for the Ministry of Health and other partners to engage on the topic of addressing

1 Inter-Religious Council of Uganda's progress report, June 2016.

barriers to RMNCAH across the nation. The IRCU, is a multi-faith network that brings together religious leaders from Uganda's seven preeminent religions, for the purposes of formulating a common agenda and advancing social services through faith-based structures and approaches. The IRCU Council of Presidents is comprised of the highest ranking individuals in each of Uganda's major religious bodies:

- Roman Catholic Church
- Church of the Province of Uganda
- Uganda Orthodox Church
- Uganda Muslim Supreme Council
- Seventh-day Adventist Uganda Union
- Born Again Faith in Uganda
- National Alliance of Pentecostal and Evangelical Churches in Uganda

IRCU's day-to-day management and activities are conducted by a small Secretariat of full-time staff members.

THE PARTNERSHIP

The Current Partnership with IRCU builds on strong advocacy work undertaken last year. In July 2015, IRCU held a landmark conference, under the auspices of the Ministry of Health and UNICEF with President, Yoweri Kaguta Museveni, as the Chief Guest, to roll out the RMNCAH Advocacy, Social Mobilization and Communication Strategy in support of the 'A promise Renewed Sharpened Plan'. There was particular focus on explaining the continuum of care and the need to move beyond silos to integrated approaches.

Over 500 religious leaders travelled from across Uganda to attend a high level advocacy meeting to pledge their commitment to RMNCAH. This partnership between religious leaders, the Ministry of Health (MoH) and UNICEF resulted in the initiative to promote an evidence based package of high impact 'key family care practices' in Karamoja and Acholi.

The Partnership between UNICEF and the IRCU is deeply beneficial for the two institutions. Their mutual goal of furthering the National Health Ministry's RMNCAH objectives is echoed in the reflections of both parties on the partnership.

Uganda, is highly dependent on religious leaders for shifting some of the key religious and cultural norms related to RMNCAH. The respected voices on these norms are religious leaders. Therefore, building a partnership between the Inter-Religious Council of Uganda (IRCU) and the United Nations International Children's Emergency Fund (UNICEF) is a strategic choice that creates a sustainable mechanism with the potential to shift social norms in the long term by increasing the capacity of religious leaders to become change agents (S. Afghani, June 9, 2016).

In the picture; President of Uganda, Yoweri Kaguta Museveni, signing the declaration in support of RMNCAH. Minster and Director General of Health and UNICEF Deputy Representative accompanying him.

COMMUNICATION APPROACH

Purpose and objectives

The initiative "Engaging religious leaders to promote Reproductive, Maternal, Newborn Child and Adolescent Health in Uganda" is an ongoing joint effort between the Inter-Religious Council of Uganda (IRCU) and the United Nations Children Fund (UNICEF).

Following an evidence based strategic approach to communication planning and implementation, this initiative seeks to reduce morbidity and mortality among mothers and children in Uganda by mobilizing religious leaders to promote positive change in their respective constituencies' knowledge, attitudes and behaviours around a set of high impact Key Family Care Practices.

As stated in IRCU progress reports, "the aim of this initiative is to strengthen the role of religious leaders to promote simple and proven family care practices, [and to] pass on accurate information on reproductive, maternal, newborn and child health to different segments of congregations and communities where the initiative is being implemented."

In line with the strategic priorities of the government's RMNCAH Sharpened Plan (A Promise Renewed, 2013), this intervention focuses on two of the regions with the highest levels of morbidity and mortality among mothers and children. The regions selected were Karamoja (North East) and Acholi (North)):

- The Districts in Acholi region (8) include; Amuru, Agago, Gulu, Lamwo, Kitgum, Oyam, Kole and Otuke.
- The districts in Karamoja region (7) include; Abim, Amudat, Kaabong, Kotido, Mororoto, Nakapiripirit and Napak.

- The following specific objectives underpin this intervention:

1. Cascade national resolutions of the top religious leaders to 15 high burden districts for RMNCAH to ensure religious leaders at sub national levels can be mobilized to roll out the resolutions at the community level.
2. Strengthen the district-level IRCU structures — called District Interfaith Committees (DICs) to improve coordination between religious structures and local governments.
3. Build the capacity of 300 religious leaders to communicate key family care practices effectively to their constituencies.
4. Mobilize congregations and communities through the trained religious leaders to popularize health messages and encourage behaviour change around key family care practices amongst the population.

FRAMING THE ISSUE

In all sessions with religious leaders, the evidence-based package of key family care practices and the respective benefits of reinforcing and practicing them were explained and referred to in carefully articulated religious terms. The key family care practices package was adapted in the light of the teachings of different faiths. This effort to have these words framed and spoken by religious leadership, has served to enhance a sense of ownership and commitment for this approach among religious communities.

THE PACKAGE –KEY FAMILY CARE PRACTICES

The Key family care have their origin in the Integrated Management of Childhood illnesses IMCI). In response to the global burden of challenge high child mortality, UNICEF and the World Health Organization (WHO) developed the Integrated Management of Childhood Illness (IMCI) strategy, which includes three main components:

1. Improvements in the case management skills of health workers through the provision of locally adapted guidelines on IMCI and through activities to promote their use.

2. Improvements in the health system that are required for the effective management of childhood illness.

3. Improvements in family and community practices.

The third component 'Improvement in family and community practices' is also called community IMCI (C-IMCI). It aims to reach families and communities where they live and is one way of impacting marginalized and hard-to-reach children.

Evidence based key family care practices for child health and development are at the core of the Primary Health Care (PHC) strategy, implemented in Uganda.

Family and community participation in health is one of the 7 elements of PHC. Optimizing child development requires a life-course approach with family care practices during pregnancy, childbirth, the new-born period and early childhood especially up to 3 years of age.

Inter-sectoral collaboration, across primary health care, social sectors, nutrition, education and environmental programmes, is crucial. IRCU as a key partner is rolling it out in support of MOH.

Key family care practices are currently being adapted to serve as the main parenting package for ECD in Uganda.

KEY FAMILY CARE PRACTICES:

1. Notify the birth of your child for registration as soon as possible after birth and obtain a birth certificate.

2: Exclusive Breast feeding for all infants up to six months.

3: Starting at about six months of age. Feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breast feed up to two years and longer.

4: Provide children under five, the old child and adolescents with adequate amounts of micro-nutrients either in their diet or supplementation and de-worming.

5: Protect mental and social development of children (0-8 years) by communicating and responding to children's needs for care (through talking, playing, affection and providing a stimulating, learning and safe environment).

6: Monitor growth and recognise children's developmental difficulties and disabilities for timely intervention and management.

7: Ensure wellness and proper development of adolescent by supporting and encouraging them to use adolescents and youth friendly services including getting information about STI/HIV/AIDS and Contraception.

8: Avoid unwanted pregnancy and ensure appropriate interval/spacing of your children by using appropriate conceptive methods.

9: Ensure that pregnant women and children sleep under insecticide treated nets.

10: Disposal of faeces, including children's and wash hands after defecation, before preparing meals and before preparing meals and before feeding children.

11: Protect children and women from neglect and abuse including exposing them to Female Genital Mutilation/ Cutting and Child Marriage and take appropriate timely action when abuse occurs.

12: Enroll and keep your children in school to the age of 18.

13: Protect adolescents from early pregnancy (including abortions) and other risks by supporting and talking to them to delay sexual relations, avoid smoking, drinking alcohol and drugs.

14: Help keep the newborn warm, umbilical cord and skin care hygienic and recognise when newborns are low-weight (small) at birth, have illness and those born to an HIV infected mother and seek appropriate care.

15: Give children and pregnant women appropriate home treatment during sickness and recovery.

16: Continue to feed and offer more fluids including breast milk to a child when the child is sick

17: Follow the health worker's advice about taking medication and the treatment, follow-up visits and referral.

18: Ensure that every pregnant woman gets antenatal care. (This includes having at least four antenatal visits with an appropriate health care provider; receive recommended doses of Tetanus Toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery, and during postpartum / postnatal (within 6 days and 6 weeks) and lactation period and anti-malarial prophylaxis during pregnancy.

19: Ensure that men get involved in the process of offering care to women during pregnancy including preparing for birth, Childbirth, postpartum and postnatal period, when accessing family planning

20: Take children and adolescents as scheduled to complete a full course of immunisation (BCG, DPT, OPV, pneumonia HPV, and measles) before their first birthday.

21: Take appropriate actions to prevent and manage child injuries and accidents in the home and community.

22: Recognise when a sick child and pregnant woman needs treatment outside home and seek care early.

23: Recognise when an adolescent child needs psychosocial and medical care and seek timely and appropriate care.

IMPLEMENTATION

Popularizing Resolutions from the National Conference

Of the estimated 1, 070 communities of worship in the 15 target districts, 320 have had these conference resolutions disseminated to them through their local religious leaders. In addition, all 15 District Health Officers have been made aware of the conference outcomes, and have received a copy of its resolutions. The resolutions themselves have been used at the district level as an advocacy tool by IRCU representatives, in order to rally support from other local leaders of all faiths for the causes and commitments therein.

Strengthening District-Level Structures

This partnership-based approach is designed to map onto the IRCU's existing district-level structures. The IRCU is organized into District Interfaith Committees (DICs), which are organized much like the national structure in that they comprise appointed representatives from the leaders of each of the seven faiths. DICs exist throughout Uganda to facilitate dialogue between the religious bodies and government district administrators.

Prior to 2015, there were 45 DICs across Uganda, but none in the 15 districts of Karamoja and Acholi regions. Since the implementation began, UNICEF and the IRCU formed DICs in 12 of the 15 districts. In addition, they introduced the practice of encouraging DIC Chairs to participate in district planning meetings, in order to strengthen the link between religious and government leadership at the district level.

Building the Capacity of Religious Leaders

The IRCU, UNICEF and the Ministry of Health brought together groups of religious leaders from the target areas to train them on the 18 key family care practices. Ministry of Health trainers from each of the districts were also selected to carry out these trainings. A custom 56-page guide for religious leaders was developed for this purpose, which contains both the current situation in Uganda and the official key family care practices. The workshops lasted a total of two days, and focused on:

- Orienting religious leaders to key family care practices.
- Relating these practices directly to religious texts and passages from each of the 7 faiths.
- Working on concrete action plans for the district level.

270 religious leaders from 12 districts have been trained through these capacity building workshops. Oriented leaders came from the districts of Amuru, Agago, Gulu, Lamwo, Kitgum, Oyam, Kole, Otuke, Amudat, Mororoto, Nakapiripirit, and Napak.

Action Planning for Community-Based Activities

At the end of each workshop, the District Interfaith Committees (DICs) developed a 12-month Interfaith Committee Communication Action Plan detailing when and how each family care practice would be promoted throughout their district. Plans were also signed off by members of the district governments, in this case the health teams, in order to ensure mutual buy-in and responsibility. Ongoing mentorship is provided by IRCU and UNICEF to the DICs as these plans are operationalized.

According to the work plans, religious leaders in each district have committed to using multiple distinct platforms to disseminate this essential health information to their constituencies. They were encouraged to make use of moments when they would naturally be interacting with community members, such as during regular sermons and khutbahs (muslims), household prayer visits

and school sessions. Each group of religious leaders has also mapped other opportunities and entry points for groups within their spheres of influence, such as mother's unions, fathers' unions and youth wings.

According to the draft work plans, religious leaders have planned to integrate messages in other events as well, such as weddings, thanksgiving ceremonies, graduation ceremonies and funerals, amongst others.

STORY OF A SHEIK

Sheik Mohamad Obalim, one of the early district-level religious leaders to be trained through this initiative, started integrating key family care practices in his khutbahs and preaching activities. He has rolled out some advocacy actions in his district, Lamwo. As part of these activities he conducted visits to three schools to address issues related to teenage pregnancy, early marriage and school dropouts. After the session was finalized in one of the schools, an adolescent girl approached him to share her story. In the words of the Sheik:

"One girl only happened to follow us after we had talked to her class, and she told us that when she was in senior one, she actually got pregnant. Due to pressure from the parents, she chose to abort, so she aborted and she was now asking us if there would be an effect after it. I told her to go and meet the medical personnel to do some kind of testing to be aware of whether there was some damage during the abortion or not. She was also telling me that during that pregnancy she got HIV virus and she is also HIV positive."

Moreover, the Sheikh said that after speaking to the girls he really appreciated the relevance of the training he received for his congregations. The training has equipped him with the necessary knowledge to sensitize and help people in his community with confidence. He pledged to continue follow up and mobilization around the key family care practices in his community.

PROGRESS AND RESULTS

The major focus of this phase of the programming was on system strengthening, introducing coordination mechanisms between the DICs and district administrators, and capacity building (S. Afghani, June 9, 2016). As of July 2016, the following aims were accomplished through close collaboration between UNICEF Uganda and the IRCU Secretariat members.

System strengthening efforts have been formalized throughout this phase: As part of this aim, linkages between the DICs and district administrators were formalized through district-level meeting participation. 12 new District Interfaith Committees (DICs) have been formed.

As Sheeba Afghani, Development Specialist for Unicef Uganda Country office, explains:

> *"As a part of this program we picked the coordination mechanisms, interfaith coordination committee where representatives for all these 7 faiths sit together and plan whatever their activities are going to be quarterly in a specific district. So the additional element that we strengthened was to make sure that the district has its own focal people sitting in these meetings, so the planning has some reflection in the district plans as well."*

Capacity building trainings have been highly effective: 270 religious leaders from Karamoja and Acholi have been trained in key family care practices. From the feedback received, there is also reason to believe that the workshop allowed not only to train religious leaders to reliably relay health information, but also to motivate religious leaders to take ownership of shifting the high morbidity and mortality rates among women and children in their individual constituencies (though this has not yet been systematically evaluated). As Sheik Mohamad Obalim, one of the early district- level religious leaders to be trained through this initiative puts it:

"The knowledge that I have now [through the training] is very, very, very important to me, to make sure that I am able to sensitize and help people in my community (…) I am able now to explain myself and I'm – I'm very able to stand even before a thousand people and tell them about their health, I am able now to even train other messengers (…) And before I was not able to integrate [health messages in preaching activities], that is what I got from the training."

Religious leaders at the training sessions on Key Family Care Practices

Action plans have started to be executed at the community level: Action plans were created and co-signed by DICs and District Health Educators (DHEs). And, though this phase of the programming did not yet focus on the implementation of such plans, some religious leaders have reported success and initial positive response in their efforts to share health messaging with their communities.
The IRCU Secretariat has begun receiving preliminary progress reports and anecdotal accounts from the religious leaders who attended the workshops on their initial attempts to make use of their health training. As of July 2016, some religious leaders had already begun to find religious passages that bolster and legitimize health messaging to include in sermons and khutbahs (muslims), and have started to deliver those and initiate conversations within their routine activities in their communities. For instance, in the districts of Kole, Lamwo and Kitgum, trained DICs have been able to arrange cross-faith visits to different churches and mosques to deliver 20-45 minute khutbahs on the key family care practices.

In cases where religious leaders are members of school management communities, the IRCU has noted that they have begun to take initiative to talk to the children and adolescents on issues related to early pregnancy and school dropouts. One such leader is the DIC Chairperson of the Lamwo district, Sheik Obalim Muhammed. He has reported an initial visit to three secondary schools Padibe, Lolung and Parabek SS to speak to 230 students about pregnancy and school dropouts and felt well-equipped by the information he gained from his training to answer difficult questions on teenage pregnancy and sexual health.

This preliminary feedback on community-level interventions will be expanded through a tailored systematic monitoring and evaluation strategy that has not yet been initiated; however, it does provide a solid proof-of-concept for the capacity building components of the initiative. The reported eagerness and level of engagement of those religious leaders who have already begun working with their communities is encouraging in that their localized

2 Regions:
Karamoja (North East)
and Acholi (North)

District Interfaith
Committees (DICs)
strengthened

Religious leaders
trained on Key Family
Care Practices

interventions, which are in many ways self-motivated actions, lend credibility to the impression derived from workshop feedback that the sessions served to successfully motivate religious leaders to take concrete action on maternal and child health issues.

Partnership with religious leaders has thus far proven to be a powerful, low-cost and appropriate channel through which to build

CHALLENGES

Implementing a comprehensive Monitoring & Evaluation plan: Within the current structure of the initiative, the data collected has largely focused on outputs. In addition, anecdotal evidence has suggested programmatic impact. However, in order to systematically measure the effects of the intervention on target populations, a more robust plan will be put in place, including baseline and endline surveys and SMS monitoring tools.

Financial sustainability: District- and community-level implementation, and even the operational costs of the newly formed DICs, are not fully within the scope of this intervention's budget. Though some leaders have proven motivated and willing to operationalize their plans, incidental costs have been flagged as prohibiting factors for the implementation of certain activities —for example, travel costs to conduct school visits and DIC meetings.

Sustainability of motivation levels: At this point, religious leaders seem to be motivated and enthusiastic about the premise of educating their communities on key family care practices. The challenge will be to sustain that level of engagement and interest beyond the scope of this initiative. A strong monitoring and evaluation plan where results are communicated regularly and transparently might support this challenge.

"It all starts with having the space to discuss some very sensitive issues and empowering religious leaders that they are the champions for change. (…) The fact that there is space now to talk about teenage pregnancy and the consequences not only on the child development but [in] society as a whole, dropout from school (…) So if their discourse is shifting and they are trying to make the connection between teenage pregnancy to school dropout to nutrition and early pregnancy and maternal mortality, we have half the work done (…) As soon as you start speaking it, you are committing [and] to me that's how change begins. And if the religious leaders themselves are convinced, there is no way you can prevent change, because they are the custodians of social norms." (S. Afghani, June 9, 2016)

NEXT STEPS

This support in 15 districts led to the following outputs:

- Enhanced the capacity of 270 religious leaders on Key Family Care Practices in Acholi and Karamoja regions.
- Strengthening of coordination mechanisms through the interfaith committees and District health teams.
- Adaptation of the KFCPs manual in light of the teachings from different faiths.
- Development of interfaith committee communication plans for KFCPs.

As a result of the above mentioned support, a pool of 270 trained religious leaders is now available at district level in 15 districts supported by UNICEF. These districts also have revitalized Interfaith Committee (IFCs) and communication plans for community level roll out.

The need now is to roll out these communication plans for behaviour change at the household level. This initiative requires engagement with religious leaders at the Parish level, using the district level pool. The Parish level leaders will then mobilize key community based structures like mothers' unions, fathers' unions and youth groups for promotion and uptake of KFCPs.

IRCU therefore intends to continue collaborating with UNICEF while building and consolidating on its achievements and lessons learnt to further expand the previous initiative by undertaking the following activities:

- Continued capacity building of parish level Religious Leaders in key family care practices and communication skills (Inter Personal Communication, communication planning and monitoring).
- Supporting the district interfaith committees as centres for advocacy for health and community based services.
- Building capacity of parish level religious leaders.
- Rolling out the district interfaith committee communication plans for key family care practices.
- Ensuring the delivery of sermons on key family care practices at places of worship.
- Supporting community mobilization for the uptake and practice of key family care practices through mothers' unions, fathers' unions and youth groups
- Adapting and using IEC materials on RMNCAH in local languages.
- Improving coordination and planning between districts and religious leaders/ faith based organizations.
- Improving referrals between health centres and communities with religious leaders as key points of contact.
- Reaching out to adolescents through school based structures.
- Conducting quarterly review meetings with partners and stakeholders.
- Monitoring and evaluation to ensure efficiency and effectiveness.
- Selection of certain religious leaders as RMNCAH "champions", to build religious leaders' advocacy skills, and to consider developing a referral system between religious leaders and health facilities.

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