Improving Maternal and Newborn Child Health Outcomes among Apostolic Religious Groups in Zimbabwe

2015
The Apostolic Maternal Empowerment and Newborn Intervention (AMENI) Model

Improving Maternal and Newborn Child Health Outcomes among Apostolic Religious Groups in Zimbabwe

2015
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Prof. Geoffrey Feltoe, Legal Consultant

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Report by Brian Maguranyanga and Geoffrey Feltoe
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We are grateful to UNICEF Zimbabwe for the opportunity to design this package of interventions in areas of our interest – professionally and intellectually. We benefitted immensely from the technical input and reviews of UNICEF staff – Dr. Reza Hossaini, Dr. Janet Muita, Mr. Victor Chinyama, Dr. Mandi Chikombero, Ms. Shelly Chitsungo, Mr. Onesimo Maguwu, Mr. Godfrey Muchapireyi, and Dr. Monica Chizororo. Our special gratitude is extended to Dr. Mandi Chikombero, the project Focal Person, for her coordination, review and linking us up with relevant support structures and information to facilitate the smooth execution of this assignment.

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Team Leader,

Brian Maguranyanga, Ph.D.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>ASRHR</td>
<td>Adolescent Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>AtBA</td>
<td>Apostolic Traditional Birth Attendant</td>
</tr>
<tr>
<td>C4D</td>
<td>Communication for Development</td>
</tr>
<tr>
<td>DA</td>
<td>District Administrator</td>
</tr>
<tr>
<td>DMO</td>
<td>District Medical Officer</td>
</tr>
<tr>
<td>DNO</td>
<td>District Nursing Officer</td>
</tr>
<tr>
<td>EGPAF</td>
<td>Elizabeth Glaser Pediatric AIDS Foundation</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicators Cluster Survey</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal Newborn Child Health</td>
</tr>
<tr>
<td>MoHCC</td>
<td>Ministry of Health and Child Care</td>
</tr>
<tr>
<td>OPHID</td>
<td>Organization for Public Health Interventions and Development (OPHID)</td>
</tr>
<tr>
<td>PMD</td>
<td>Provincial Medical Director</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission of HIV</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal Care</td>
</tr>
<tr>
<td>SEM</td>
<td>Social Ecological Model</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZDHS</td>
<td>Zimbabwe Demographic and Health Survey</td>
</tr>
<tr>
<td>ZIMSTAT</td>
<td>Zimbabwe Statistics Agency</td>
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</tbody>
</table>
The Apostolic Maternal and Newborn Interventions (AMENI) package of interventions addresses poor maternal and newborn health outcomes among Apostolic religious groups in Zimbabwe, and identifies religious, socio-cultural and contextual (legal/policy) factors that drive these outcomes. It is an evidence-based intervention that emerged from evidence gathered from desk review and primary operations research. It focuses on nurturing Apostolic community transformation (ACT) in order to tackle religious doctrine, beliefs, practices and social/gender norms that promote poor healthcare seeking behaviors for women and children; poor uptake of modern maternal, newborn and child health (MNCH) services; rejection of modern sexual and reproductive health services including family planning; child/early marriages; limited educational opportunities for Apostolic children; gender inequalities and social inequity. Recognizing the multi-faceted challenges contributing to poor MNCH outcomes among Apostolic religious groups, AMENI offers a comprehensive package of complementary interventions to address these issues. In placing maternal and newborn health and survival within broader Apostolic religion system, AMENI highlights the drivers of poor MNCH outcomes, and maternal and neonatal morbidity and mortality due to religious objections, preventable conditions, and socio-cultural beliefs. Apostolic religious doctrine and socio-cultural norms continue to exert influence on behaviors of Apostolic women and female adolescents, and often inhibit them from using modern MNCH services, including sexual and reproductive health services. The emphasis on faith healing and use of ‘Apostolic healing systems’ increases the risks for poor maternal and newborn health outcomes including pregnancy, childbirth complications, pre-term birth, HIV transmission and infection, and lack of immunization for mother and newborn etc.

In view of these challenges, the Social Ecological Model (SEM) and Continuum of Care framework were adopted to explore the interactions of Apostolic religion and health of women and newborns as well as health seeking behaviours along the continuum of care. Therefore, drawing insights from both SEM and continuum of care, an eclectic analytical framework was applied, and if enabled situating the influencing factors within continuum of care and understanding them at the social ecological levels.

AMENI focuses essentially on increasing the uptake of MNCH services among Apostolic religious groups, particularly religious objectors in order to reduce maternal and neonatal morbidity and mortality in this target group; thus improving MNCH outcomes. It recognizes the importance of generating demand or uptake of modern health services among ultra-conservative and semi-conservative Apostolic groups, tackling religious objection through religious engagement and dialogue with key Apostolic stakeholders, and improving understanding of MNCH and key social issues in the Apostolic community. AMENI emphasizes on relationship building and nurturing respectful, meaningful engagement with the Apostolic sects. AMENI advances on multi-sectorial efforts to address the multi-faceted health and social challenges driven by Apostolic religion. Its success is predicated on appropriate engagement and mutually-beneficial relationship with key Apostolic groups, and carefully applying the “rule of law” and legal interventions to effect the necessary changes as well as galvanizing political will to confront the difficult issues. It is imperative that key social and political actors, Apostolic ecumenical bodies, religious leaders, Apostolic traditional birth attendants (AtBAs), and members of ultra-conservative groups including women
and female adolescents are sufficiently reached and engaged to enable them to accept AMENI. In addition, policy and advocacy strategies, and communication for development (C4D) should be designed, and social, behavioral and policy changes sustained to unlock and drive desired changes within the Apostolic community.

AMENI seeks to achieve the following objectives and outcomes within the identified six core components (see Table 1 below):

Objectives (O)

- Increase dialogue with Apostolic religious leaders and traditional birth attendants in order to nurture positive engagement and changes that support positive outcomes among Apostolic religious groups (O.1. Apostolic Engagement and Relationship Building)
- Increase awareness among Apostolic adolescents of ASRHR and opportunities to stay longer in school (primary, secondary to tertiary), and equip them with knowledge and skills to prevent early/child marriage and adolescent pregnancy (O.2. Adolescent Empowerment)
- Increase acceptability and uptake of modern MNCH services among Apostolic women (O.3. Maternal Empowerment)
- Increase religious acceptability of, and reduce barriers to, modern MNCH interventions and educational opportunities, and gender equality among the Apostolic community (O.4. Behavioral and Social Change)
- Increase skilled attendance at delivery among Apostolic women; timely referrals of pregnant women to health facilities by Apostolic traditional birth attendants (AtBAs); and effective links between Apostolic health systems and modern health facilities (O.5. Health Systems Strengthening)
- Facilitate enabling policy/legal environment for positive MNCH outcomes and rights of women and children (O.6. Policy and Advocacy)

Anticipated outcomes (AO)

- Reduced Apostolic maternal and neonatal morbidity and mortality due to preventable conditions and religious objection
  - Increased knowledge, awareness and acceptability of ASRHR and modern MNCH among Apostolic religious leaders and AtBAs (AO.1. Apostolic Penetration and Relationship-Building)
  - Empowered Apostolic adolescents with knowledge of ASRHR, other rights and advancing educational opportunities; and delayed sexual debut and marriage or increased age of marriage and first childbirth (AO.2. Adolescent Empowerment)
  - Increased uptake of ANC services due to improved self-efficacy: this enables improved SRH and use of MNCH services (including increased/early ANC uptake with
4+ ANC visits; skilled birth attendance; improved PNC for maternal and newborn care) among Apostolic women (AO.3. Maternal Empowerment)

- Increased acceptability of modern MNCH interventions, educational opportunities, and gender equality among members of the Apostolic community, particularly religious objectors (AO.4. Behavioral and Social Change)
- Increased referrals by AtBAs and Apostolic faith healers to, and improved links with, modern health facilities (AO.5. Health Systems Strengthening)
- Improved enabling environment for positive MNCH and rights of Apostolic women and children (AO.6. Policy and Advocacy)

The AMENI package of interventions offers the following possible benefits:

- For Apostolic religious community:
  - Reduced maternal and neonatal morbidity and mortality, and improved MNCH outcomes among Apostolic religious groups
  - Increased acceptability of modern MNCH services including sexual and reproductive health, ANC, HIV prevention and treatment, institutional delivery, PNC services
  - Improved awareness, knowledge and understanding of MNCH issues, rights of women and children, and challenges of child/early marriages among Apostolic religious leaders, AtBAs, Apostolic women and adolescents
  - Trained and sensitized Apostolic religious leaders and ecumenical bodies acting as agents for behavioral and social change, and addressing negative attitudes towards modern health services, medicines and gender equality
  - Enhanced self-efficacy / agency among empowered Apostolic women and female adolescents, which enables them to uptake MNCH and SRH services
  - Improved child protection and rights of women and children
  - Apostolic-sensitive service delivery meeting the needs of Apostolic members
  - Improved Apostolic referrals (AtBA referrals) of patients showing danger signs or complications to health facilities; improved links between AtBAs and health facilities

- For health providers and development partners
  - Multi-sectorial approach to tackling driver of Apostolic maternal and neonatal morbidity and mortality, and gender inequalities and social inequities in the community
  - Collaborative framework for implementation of strategies targeting the Apostolic community
    - Identification of priorities and implementation framework, including avoiding duplication of efforts and increasing efficiencies
    - Resourcing / funding mechanism for prioritized interventions and tasked responsibilities
    - Coherent, integrated programmatic responses to address Apostolic MNCH and social equity issues
    - Platform for shared Monitoring, Evaluation and Learning – assuming an collectively agreed AMENI implementation framework
<table>
<thead>
<tr>
<th>AMENI</th>
<th>Objective</th>
<th>Key Message</th>
<th>Targets</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement and Relationship Building</td>
<td>Increase dialogue with key Apostolic stakeholders - religious leaders, AtBAs &amp; women – to support positive MNCH outcomes</td>
<td>Healthy Women and Children: Church supporting MNCH services Overcome religious misconceptions that undermine health</td>
<td>AtBAs Apostolic leaders Apostolic ecumenical bodies</td>
<td>Increased awareness, knowledge &amp; acceptability of MNCH and social issues among key Apostolic stakeholders</td>
</tr>
<tr>
<td>Adolescent Empowerment</td>
<td>Increase awareness of ASRHR &amp; equip adolescents with knowledge &amp; skills to prevent early/child marriage and longer stay in school.</td>
<td>Adolescents with big dreams – no to child/early marriage, early sexual debut &amp; pregnancy</td>
<td>Adolescent Girls and Boys School Teachers Village Health Workers</td>
<td>Empowered adolescents with ASRHR knowledge, delayed sexual debut, &amp; increased age of marriage &amp; first childbirth</td>
</tr>
<tr>
<td>Maternal Empowerment</td>
<td>Increase acceptability and uptake of MNCH services</td>
<td>Education is your future No woman should die from preventable pregnancy/childbirth complications Seek MNCH and SRH services, Life Matters</td>
<td>Apostolic women AtBAs VHWs Health personnel</td>
<td>Increased uptake of ANC, SHR, institutional delivery &amp; PNC services by Apostolic women with improved self-efficacy</td>
</tr>
<tr>
<td>Social and Behavior Change</td>
<td>Increase religious acceptability of, and reduce barriers to, modern MNCH interventions, education and gender equality in the Apostolic community</td>
<td>No traditional practice or religious belief should cause deaths of women &amp; children Life should be protected; healthcare your right</td>
<td>Apostolic Leaders, AtBAs, Traditional Leaders, MoHCC, Apostolic women, men, boys &amp; girls, other community members</td>
<td>Increased acceptability of modern MNCH services, education and gender equality among Apostolic members, particularly religious objectors</td>
</tr>
<tr>
<td>Health Systems Strengthening</td>
<td>Increase AtBA referrals and skilled attendance at delivery among Apostolic women</td>
<td>Partnerships for safe motherhood No woman &amp; newborn should die from preventable complications / conditions</td>
<td>MoHCC (health providers), AtBAs, VHWs</td>
<td>Increased referrals by AtBAs &amp; faith healers of pregnant &amp; postpartum women to health facilities; and increased skilled birth attendance for Apostolic women</td>
</tr>
<tr>
<td>Policy &amp; Advocacy</td>
<td>Facilitate an enabling legal/policy environment for MNCH positive outcomes &amp; rights of women and children through legal interventions, persuasion and engagement with leaders</td>
<td>We can create a good enabling environment for MNCH “No child is like a brick”</td>
<td>Apostolic community, ZRP, Birth and Death Registration Office, Judiciary, Legal Drafters</td>
<td>Improved environment supportive to positive MNCH outcomes, rights of women and children, and child protection</td>
</tr>
</tbody>
</table>
Enabling environment for addressing challenges within the Apostolic community, and thus facilitating political, economic and institutional conditions for effective Apostolic engagement.

**AMENI Implementation**

A multi-faceted, multi-sectorial approach is needed in implementing the AMENI package of interventions given the diverse drivers and challenges of MNCH and social inequities among Apostolic religious groups in Zimbabwe. In addition, the sheer size of the Apostolic community population within Zimbabwe presents huge demand on efforts and resources to tackle the challenges. However, implementing AMENI at the local (village or ward), district, provincial and/or national levels requires consideration of the diversity of the Apostolic community based on the extent of religious objection to use of modern health services, the type of services, and available channels of engagement with the specific leadership of that Apostolic religious group. A “one-size-fits-all” approach to implementation of AMENI will undermine its success.

**Unique Features of AMENI**

- Recognizes the centrality of relationship-building and engagement in overcoming barriers to uptake of MNCH services
- Advances a demand generation approach to driving engagement and promoting uptake of MNCH services among Apostolic religious groups
- Recognizes the heterogeneity of Apostolic religion - various strands of doctrine, beliefs and practices among the different Apostolic religious groups (sects) – and therefore the need for sensitivity to the needs of the Apostolic groups without imposing a “one-size-fits-all” approach to programming
- Advances a multi-sectorial approach to tackle the drivers of poor MNCH outcomes, health and social inequities, and gender inequality in the Apostolic community; thus makes a case for concerted programmatic responses linked to a shared implementation framework to avoid duplication of efforts and promoted shared monitoring, evaluation and learning (MEL)
- Locates the tension/conflict between Apostolic religion (doctrine, beliefs and practices) and modernity (human rights, modern health services including use of MNCH services and medicines), and therefore the need to re-examine the institutional framework to ensure an enabling environment for the achievement of positive MNCH outcomes and other development goals in the country

**Keys to Implementation Success:**

- Relationship building through dialogue, consultation and trustful, meaningful engagement with key Apostolic community stakeholders will ensure sustained participation and ownership of the interventions
- Engage Apostolic leadership and religious structures at various levels to facilitate buy-in of the intervention and leverage the influence of the founding fathers and their immediate network/circle of leadership including family members with influential positions in the church
- Improve knowledge and awareness of MNCH and social issues within the Apostolic community, particularly religious leaders, AtBAs and women to motivate behavioral and social changes
- Invest in processes that nurture trust and confidence in the interventions, and overcome suspicion about AMENI’s key MNCH and social interventions by speaking also to the benefits of the interventions
- Identify influential role models (positive agents of change) within the Apostolic community and broader local community, and use them to facilitate relationship-building and dialogue on critical MNCH and social issues
- Emphasize practical, pragmatic benefits first and explore mutually beneficial interventions and dialogue on Apostolic religious and socio-cultural aspects, that were harmful to improving maternal and child outcomes
- Explore confluence of interests and build on collective, shared solutions to the MNCH and social challenges in the Apostolic community
- Avoid labeling and stereotyping the Apostolic community members, and appreciatively build on positive attributes of Apostolic religion and practices while exploring aspects that could be re-examined for improved MNCH and social outcomes
- Explore incentive frameworks (i.e., conditional cash transfers or vouchers) that facilitate uptake of modern MNCH services among targeted pregnant and post-partum women belonging to ultra-conservative Apostolic groups (religious objectors)

Barriers to AMENI Implementation:

The primary barriers or challenges to effective implementation of AMENI include religious objection to the interventions and resistance to desired social and behavioral changes among Apostolic religious leaders, key influencers and some members within the Apostolic community. The barriers and challenges to AMENI implementation may manifest as follows:

- Resistance by ultra-conservative Apostolic sects with radical religious beliefs towards health and education, and members’ strict commitment to doctrine of the founding fathers of the Apostolic sects or church
- Religious and socio-cultural beliefs and practices that militate against AMENI interventions
- Apostolic leaders and members’ attitudes towards modern health services, and continued emphasis on faith-healing on illnesses needing medical attention
- The “double-burden” of religion and tradition adds to the complex challenges faced by women and children in the Apostolic community
- Failure to engage Apostolic sect founders, leadership structures, and wives of Apostolic leaders
- Lack of Apostolic male involvement in the interventions
- AMENI primary beneficiaries (female adolescents and women of reproductive age, particularly from ultra-conservative Apostolic groups/religious objectors) may be difficult to openly recruit and retain longer in the interventions because of fear and/or sanctions imposed by Apostolic churches for participating in health-related initiatives supported by the secular world
Production and re-production of stereotypes of Apostolic religion may entrench prejudice, discrimination, and intolerance towards Apostolic religious groups/members.

- Lack of understanding of the heterogeneity of Apostolic community contributes to banding together of all Apostolic members as “polygamists averse to western medicine, who (clean-)shaved their heads, wore white robes and that they all did not send their children to school” (Chari 2014:123)

- Strong assumptions about the homogeneity of the Apostolic community potentially weaken situational application of AMENI interventions to different Apostolic religious groups

- Failure to recognize positive shifts and transitions within specific Apostolic sects, leadership thinking, beliefs and teachings, and church’s practices

  This limits opportunities for re-interpreting original doctrine, beliefs and practices in the context of contemporary realities, challenges and new leadership. The new leadership provides opportunities for identifying new space for engagement and support

- Political expediency or the lack of political will to address MNCH and social issues within the Apostolic community

- Lack of resources committed to AMENI

Stakeholder Perspectives on Strengthening the AMENI Package of Interventions:

**What works?**

- Community-based intervention e.g., the use of village health workers (VHWs) affiliated to the Apostolic sect

- Engage the Apostolic leadership and ecumenical bodies (UDACIZA and ACCZ), and recognize the influence of Apostolic structures in facilitating access and modifying doctrine. Also identify local structures, and engage them in promoting health and development objectives in the area

  Engage Apostolic religious leaders in dialogue to facilitate modification or re-examination of doctrine based on emerging understanding of the needs of a modern Zimbabwe

- Empower women and female adolescents on SRH and ASRHR respectively; promote maternal health education and use specific channels focused on female adolescents and women to encourage optimal health-seeking behaviors (e.g., Channels of Hope program by World Vision)

- Use multiple approaches at different levels to engage Apostolic men, children and women; ensure Apostolic male involvement in some of the interventions as well as empower Apostolic men to promote MNCH. There are lessons to be learnt from male involvement in HIV/AIDS prevention
Promote youth / Apostolic adolescents' advocacy groups to address key issues facing them and raise awareness of ASRHR, education and health; engage peer educators within the Apostolic community to promote ASRHR and social objectives

Adopt community approaches in addressing MNCH and social issues in the Apostolic community; ensure integrated community services as well as address the challenges at household level; poverty at the household level has to be tackled

Respect the unique needs of Apostolic groups, especially members who want to access services but not publicly; understand their needs and promote inclusive programs that do not necessarily single-out Apostolic members in the local community; understand their “language”

Use of evidence to promote the need for behavioral and social changes, and improve MNCH outcomes among Apostolic religious groups;

Acknowledge strengths and limitations of both modern health and Apostolic health systems but also “praise the good” within the Apostolic community

Target influential people in Apostolic religious groups, and empower them to drive the behavioral and social changes as well as facilitate dialogue in the community (Shona proverb: Kutumbura munzwa nemumwe minzwa)

Integrate health into development programs

Incentives framework for nurturing AtBAs’ referrals to health facilities

Build and sustain relationships with key Apostolic stakeholders; listen more and speak less; do not impose solutions but co-create the solutions through meaningful participation of key Apostolic stakeholders – “nothing for us without us”

Policy advocacy is critical in ensuring that policymakers promote an enabling environment as well as regulate traditional birth attendants and religion in Zimbabwe

What does not work?

- Being confrontational with Apostolic religious groups in terms of health and social interventions
- Stigmatizing Apostolic members and leaders
- Ignoring the political leadership
- Inflexibility in the approach
- Approaching Apostolic members during church gatherings
- Forced participation in AMENI or health interventions
- Isolating Apostolic members in community engagements
- Expecting doctrinal changes rather than modification of Apostolic doctrine; modification of Apostolic doctrine is possible through dialogue and engagement as well as shedding compelling evidence on the social costs of the doctrine needing modification

This AMENI Report is structured according to the following sections/parts: (1) Introduction; (2) Theoretical Frameworks and (3) Legal Analysis of Apostolic Religion in relation to Maternal and Child Health; (4) Operations Research Findings; (5) AMENI Package of Interventions; and (6) Conclusion and Recommendations
Introduction

Apostolic Maternal Empowerment and Newborn Interventions (AMENI)
Improving Maternal and Newborn Child Health Outcomes among Apostolic Religious Groups in Zimbabwe
PART 1: INTRODUCTION

Objectives, Scope and Process of the Interventions Design

This report presents key findings from the operations research on Maternal and Neonatal Child Health (MNCH) among Apostolic religious groups in Zimbabwe conducted in Buhera District (Ward 22) in Manicaland Province from September – December 2014. This operations research emerged from the recognition of identified qualitative and quantitative gaps in Apostolic maternal and newborn child health in Zimbabwe, hence, UNICEF and the Ministry of Health and Child Care recognized the need for evidence-based model approaches/interventions to improve MNCH outcomes among Apostolic religious groups in Zimbabwe, focusing initially on a case study of Buhera District in Manicaland Province.

The specific objectives of the consultancy were to:

(i) Design a core package of immediate and long-term interventions to improve the care of women during pregnancy and birth among Apostolic religious groups in Zimbabwe

(ii) Review legal/policy and doctrinal frameworks and current Apostolic studies to inform the interventions model

(iii) Conduct a resource-mapping exercise of civil society organizations, including community-based organizations working in selected communities in Manicaland Province and document who is doing what, where and how, as well as capture lessons that inform the MNCH interventions model

(iv) Design an evidence-based interventions model, including an information and communication strategy to address MNCH challenges related to pregnancy and birth among Apostolic religious groups

Methodology

Based on primary research data (qualitative), complimented by quantitative data, published studies, grey literature and other secondary sources (documents, newspaper articles, policy/legislative documents, case law reports), this report provides detailed analysis of Apostolic religion and its influence on MNCH outcomes, health and social inequities among Apostolic religious groups in Zimbabwe.

The primary research process entailed extensive planning to ensure success, recognizing that ultra-conservative Apostolic religious groups were generally “hard-to-reach” and often suspicious of “outsiders”. The consultants devised an Apostolic Community Focused Operations Research Planning Methodology, which entailed:

(i) Five-day training of research assistants – covering various aspects of the study and relevant legal/policy issues

(ii) Obtaining permission to conduct the pre-test and operations study at Provincial and District levels

(iii) Engagement of UDACIZA and its local-level religious leaders to facilitate mobilization of Apostolic leaders and members to participate in the operations research in Buhera District conducting pre-testing of the data collection instruments in Seke Rural District in Mashonaland East Province and revising the instruments based on the pre-test

(iv) Several consultative meetings were held with UNICEF’s Reference Group (REG) to enable the consultants to share field experiences, preliminary and key findings as well as obtain guidance and feedback from UNICEF

The data collection process faced time and access constraints, which were quickly resolved through engaging key Ministry of Health and Child Care officials at provincial and district levels, and local-level religious and traditional leaders. The support of provincial, district and local-level leadership facilitated buy-in and the participation of the targeted study participants. The Buhera District Administrator’s Office and the Rural District Council facilitated access to various stakeholders in the district.

We conducted in-depth, individual face-to-face interviews with two religious leaders; 10 key informants, and 23 Apostolic traditional birth attendants using semi-structured interview guides. A total of 18 focus group discussions (FGDs) were conducted using an FGD guide with the following
groups: One FGD with first-time pregnant women; Two FGDs with Apostolic women who had two-or-more pregnancies, One FGD with village health workers (VHWs); Two FGDs with Apostolic men; One FGD with traditional leaders; Five FGDs with Apostolic traditional birth attendants (AtBAs) and three in-depth-interviews with the same; Five FGDs with female and male adolescents, and one FGD with six religious leaders (see Table in Chapter 3). The desk review entailed analysis of various documents covering Apostolic religion, health-seeking behavior, utilization of MNCH services, continuum of care, relevant policies and legislation, socio-cultural issues (e.g., child marriages, gender equality and empowerment), peer-reviewed publications, grey literature and newspaper articles on Apostolic religion, health and social issues in the Apostolic community (see list of documents reviewed).

Context: Apostolic Religion in Zimbabwe

African Independent Churches, primarily Apostolic religious groups, have the largest segment of Zimbabwe’s population (Maguranyanga 2011:4; UNICEF 2011), and the Apostolic religion is the fastest-growing religion in Zimbabwe (see Figure 1 below).

According to ZDHS (2010/11), Apostolic religion constitutes 33% of Zimbabwe’s women and men aged 15-49, and other religions – Traditional (2%), Roman Catholic (9%), Protestant (15%), Pentecostal (18%), Muslim (1%), other Christian (8%) none and other (14%). Based on the estimates of the population in the 15-24 and 25-54 age structures in Zimbabwe, the Apostolic members in these age groups accounted for approximately 2.5 million people of roughly 7.5 million people using the crude estimate of 33% of Apostolic religion population within the reproductive age (15-49).

This estimate of over 2.5 million does not account for children aged 0-14, whose huge majority could possibly be Apostolic children because of Apostolic religion’s emphasis on large families and rejection of modern family planning methods. The estimation of ultra-conservative Apostolic religion members is difficult given their heterogeneity, and lack of a universally acceptable methodology to disaggregate.
the Apostolic community. The ZDHS treats the Apostolic community as homogenous, and ignores diversity within the community which has implications for health and social inequities among Apostolic religious groups. We estimate the total population of the Apostolic community to be around 4.9 million of the total population of Zimbabwe. Within the Apostolic community, women and children constitute the majority, and largely reside in rural areas despite the growing presence of Apostolic members in urban and peri-urban areas. Therefore, the AMENI interventions target a significant segment of the population of Zimbabwe; with the Apostolic community being a large “population-at-risk” and “hard-to-reach”. It focuses on Apostolic women of reproductive age 15-49, newborns, and Apostolic religious leaders, Apostolic traditional birth attendants, adolescents and men who were key Apostolic stakeholders in effort to achieve positive MNCH outcomes and desirable behavioral and social changes.

Apostolic Religion, Health and Social Inequities

Health Inequities

Ha, Salama, Gwavuya and Kanjala (2012) highlight religion-driven inequities in maternal and child health among the different religious groups in Zimbabwe, and make a strong case for religion as a variable in health outcomes. They showed poor outcomes of Apostolic religion in ANC and skilled birth attendance (SBA) at delivery. The authors argued that “members of the apostolic faith were – less-likely to have at least one ANC visit; approximately nine percentage points less-likely to have at least one ANC; eight percentage points less-likely to have at least four ANC visits; 11 percentage points less likely to have skilled birth attendance (SBA) – compared to other Christian groups (Ha et al. 2012). In assessing the effects of association with Apostolic religion on skilled birth attendance, Ha et al (2012) observed “at least 43% of the wealth gradient between the richest 4th quintile and the poorest quintile”. Muchabaiwa et al. (2012:150), in a different study, show that “apostolic women were 19 percent less-likely to use this same service [ANC] than those from other religious affiliation at 5 percent level of significance, whilst women from the polygamous households were 31% less-likely to use the service compared to women from non-polygamous households at one percent level of significance”. Therefore, “members of the apostolic faith were the least-likely to use maternal health services even when compared to the least-educated females and poorest women” (Ha et al. 2012).

Ha et al. (2012) argue that affiliation with Apostolic religion is a significant risk factor in reducing the use of modern maternal and child health services. Using regression analysis on child immunization to assess the effect of Apostolic religion, the authors found that “apostolic religion is significant across markers of child immunization and retains significance even after controlling for other factors”. Therefore, Apostolic religion, statistically important for child immunization, and “children in apostolic faith affiliated households were almost six percent points less-likely to have BCG immunization, six percent points less-likely to have measles immunization and five percent points less likely to have polio vaccination when compared to children in households affiliated to other Christian groups”. In earlier studies, in Manicaland Province in Zimbabwe, Gregson et al. (1999) demonstrated that households affiliated to Apostolic faith in the Honde Valley area had high rates of infant mortality. Therefore, affiliation with Apostolic religion is likely to result in negative maternal and child health outcomes given the influence of Apostolic doctrine and beliefs on health-seeking behavior, practices and attitudes towards modern health services and medicines. Maguranyanga (2011) and Machingura (2014) discussed in detail the influence of Apostolic religious doctrine, beliefs and practices on health-seeking behaviors and utilization of modern MNCH services in Zimbabwe. Apostolic religious objection to modern MNCH services, sexual and reproductive health (SRH) services, and medicines, fundamentally
constrains choices and decisions to seek medical care (Jarvis & Northcott 1987; Hove et al 1999; Takyi 2003; Stephenson et al. 2006). Apostolic doctrine and beliefs on faith-healing and spiritualization of illnesses, diseases and health complications tended to have an overriding influence on the behaviors of Apostolic religious group members. OPHID (2014) also highlighted that Apostolic religion encouraged Apostolic women to seek care from religious leaders, faith healers and deliver largely at home or at Apostolic church facilities.

In addition, Apostolic faith demands strict adherence to church beliefs, social norms and practices, which reinforce individual and collective conformity to Apostolic doctrine, teachings and regulations (Maguranyanga 2011). In this fascinating article, “The Martyring of People over Radical Beliefs”, Machingura (2014:181) argues that the “Apostles’ / Vapostori sets themselves apart from their neighbors in many ways and have strict obligations to be followed”, and emphasize the “inspiration and revelation of the Holy Spirit” (hence, Bourdillon (1976) refers to them as the “spirit-type” churches). In emphasizing the operational power of the Holy Spirit / Mweya, Apostolic religious groups elevate individuals with spiritual gifts including the gift of prophecy, faith-healing and miracles, and leaders’ authority stems from the spiritual realm (Daneel 1970, Presler 1999). Healing plays a central role in the faith of Apostolic leaders and members of African Independent/Initiated/Indigenous Churches (AICs).

The spiritualization of illness, pregnancy and childbirth complications, and the emphasis on faith and evil spirits reinforce radical beliefs that shun medical care, which is viewed antithetical to God’s call for divine healing. In addition, the use of modern health services is seen to reflect Apostolic member’s lack of faith in God (Maguranyanga 2011), and neglects the spiritual aspects. Machingura (2014) located the radical beliefs toward modern health care, medicines and modern family planning methods in the original doctrine stated in the “divine commission” of each founding father of Apostolic sects.

Core Apostolic Doctrine

The core doctrine, beliefs and practices of AICs are associated with the divine commissions of the founding fathers of Apostolic religious groups. The leading founding fathers of dominant Apostolic sects in Zimbabwe include: (i) Muchabaya Momerume (1912-1963) of Johane Marange Apostolic Church; (ii) the late Samuel Mutendi of Zion Christian Church; (iii) Johane Masowe with the various strands of Johane Masowe sub-groups; (iv) Paul Mwazha of African Apostolic Church; and the Madhidha Apostolic sect in Gwanda District in Matebeleland South (see Table 2 below). In the key divine commissions of the founding fathers, the key theme is faith-healing – use of “holy water” and “anointed oil”, the laying of hands on the sick and the “healing” of all diseases and infirmities; prayer and centrality of the Holy Spirit in prophecy and healing (Marange 1981; Mwazha 1997; Ruzivo 2014; Ndlovu 2014; Chimininge 2014). In addition, some members of AICs carry a stick and/or a staff, which functions as weapon for fighting off harmful spirits and illness, and thus fortifying them against evil forces (Vengeyi & Mwandayi 2014). For example, members of Johane Marange and Johane Masowe carry the staff / Munondo, which they treat as spiritual weapon used in fighting spiritual wars; therefore they believe that the staff has spiritual power over evil forces (Vengeyi & Mwandayi 2014:213).

The review of the divine commissions and doctrine of the founding fathers of the dominant Apostolic sects revealed the foundational basis of reticence towards, and reluctance to the use of modern MNCH services and family planning. Modern family planning methods were deemed demonic (Maguranyanga 2011) or devilish (Machingura 2014), and “women who engage in any form of family planning are likened to be murderers and are put in the same rank as those who engage in witchcraft” (Machingura 2014:186).

Apostolic Diversity and Different Views on Modern MNCH Services

The Apostolic community is therefore heterogeneous, with varying religious doctrine, beliefs, practices and
degrees of acceptance or rejection of modern health services. Maguranyanga (2011) presents a simplified typology or classification of Apostolic religion in an attempt to disaggregate them; ultra-conservatives and semi-conservatives (including the relatively semi-conservative or ‘liberal’) Apostolic religious groups. The ultra-conservative religious objectors (e.g., Johane Marange; Madhidha; segments of Johane Masowe) were reticent towards the use of modern medicines and health services while semi-conservative Apostolic groups (e.g. Paul Mwazha; Nyenyedzi) and other less-conservative faith groups allowed the use of modern health services but emphasized that members first seek spiritual/prophetic counsel and support from the church before using these services (OPHID, 2014). In emphasizing spiritual counsel and faith-healing first, Apostolic religion contributes to the primary delays in making the decision to seek care from modern health providers.

The ultra-conservative Apostolic religious groups depended largely on their own ‘Apostolic health systems’—faith/divine healing through prophets, faith healers, Apostolic traditional birth attendants and birth camps, home deliveries and Zvitsidzo (places of faith/divine healing). Faith healers, prophets and members with spiritual gifts of healing, Zvitsidzo, Apostolic birth camps and birth attendants constituted the primary Apostolic health systems, and largely provided members of ultra-conservative, some semi-conservative Apostolic groups and non-Apostolic members with care during pregnancy, childbirth, and postnatal periods. Due to religious objections to the use of modern MNCH services or medical care, ultra-conservative Apostolic pregnant and post-partum women tended to use Apostolic makeshift or bush maternity centers for delivery and care (treatment) of newborns. They were assisted also by Apostolic birth attendants (‘midwives’) and other Apostolic women with ‘special gifts’ or ‘anointing’.

In contrast, semi-conservative Apostolic religious groups (e.g., The African Apostolic Church of Paul Mwazha; Zviratidzo zve Vapostori; Nyenyedzi; other variants of Johane Masowe, and a number of small Apostolic sects) allowed the use of modern health services and medicines in improving health outcomes but encouraged their members to seek spiritual counsel from the church leaders first before using modern health services as well as delivering at home. Largely, Apostolic religion emphasizes faith in God, and members perceived to have weak or questionable faith could seek medical care (Maguranyanga 2011). Consequently, seeking medical care reflects the weaknesses in, or lack of, one’s faith in divine healing powers.

Apostolic religious groups/sects (ultra-conservative and semi-conservative) encouraged AtBA-assisted deliveries at home or at Apostolic birth camps (Chitsidzo). Unfortunately, these non-institutional settings lacked basic medical equipment, medications, and other supplies to ensure safe delivery and hygiene, and hence, increased risks of maternal and newborn death, pregnancy and childbirth complications, HIV transmission, post-partum hemorrhage, and other health complications.

Religious Objection as a Factor in Maternal and Neonatal Mortality

The UN (2013) identifies post-partum hemorrhage, pregnancy-induced hypertension and puerperal sepsis as the leading direct causes of maternal mortality in Zimbabwe while the leading indirect causes include HIV and AIDS, accounting for approximately 26% of all maternal deaths. However, most of the causes of maternal deaths could be successfully mitigated by access to emergency obstetric care (EmOC), effective identification, screening, counseling and management of danger signs of pregnancy, and education on birth preparation etc.

However, the delays to seek medical care, failure to attend ANC, obtain skilled attendance at delivery, and the uptake of PNC services contributed to preventable maternal deaths. At higher risk of maternal deaths were Apostolic women, especially from poor households and rural areas (UN 2013:5) who experienced the triple burden of religion,
patriarchal traditions and gender norms that undermined women’s capacity to make decisions to seek medical care independently. When the Apostolic women fail to access services due to religion and socio-cultural factors (Machingura 2014), this increased their risks of pregnancy/childbirth complications and maternal and neonatal death. According to the UN (2013:4-5), “the risk of maternal death increased significantly by delivering outside institutions, operative delivery, delivery by non-skilled persons belonging to the Apostolic faith religious groups”.

In essence, the limited use of modern MNCH services by Apostolic women due to religious objection linked to Apostolic doctrine, teachings and regulations of the ultra-conservative groups posed challenges to the realization of positive MNCH outcomes in Zimbabwe (Ministry of Health & Child Care 2013).

### Apostolic Founding Fathers & Doctrine

<table>
<thead>
<tr>
<th>Apostolic sect leader</th>
<th>Divine Commission &amp; Apostolic Doctrine</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>- narrates the dreams and visions of Johane Marange</td>
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<td></td>
<td>- The Holy Spirit chooses Johane Marange to do God’s work</td>
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<td></td>
<td>- states that from his birth in 1912, Johane Marange was assigned by God to be the apostle to Africa</td>
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<td></td>
<td>- Johane Marange receives the holy Spirit in 1917</td>
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<td></td>
<td>- the spiritual experience of Johane Marange is authoritative and cannot be contested or put to argument by Marange sect members</td>
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<td></td>
<td>- Umboo utsva hwavaPostori remains the “theoretical reference and model upon which members of the sect base their accounts of spiritual experiences”</td>
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<td></td>
<td>- Marange sect’s charter, its rules and practices directly dictated by the Holy Spirit</td>
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<td></td>
<td>(Machingura 2014:177)</td>
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<td></td>
<td>- Divine healing and solutions to all health and social problems through revelations of the Holy Spirit / Mweya, the laying of hands and the use of holy water, oil and faith-healing concoctions by Apostolic prophets and faith-healers</td>
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<td></td>
<td>- Members use Zvitsidzo / Apostolic birth camps and healing centers as their health facilities</td>
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<td></td>
<td>- Expect full adherence / total commitment to Johane Marange doctrine, teachings and beliefs – including rejection of modern health interventions, family planning, medicines and immunization of children</td>
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<td></td>
<td>- Modern education not prioritized and shunned for being secular, and thus educational investment by parents is minimal</td>
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<td></td>
<td>- Promotes polygamy (Machingura 2011)</td>
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<td></td>
<td>- Johane Marange Apostolic Church / “JMAC encourages its followers to resiliently accept persecution that targets their beliefs and faith as a unique quality of purity and life” (Machingura 2014:180)</td>
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<tr>
<td></td>
<td>- Failure to commit-fully to church doctrine, beliefs and the vision of Johane Marange is viewed as betrayal, and sanctions/penalties are imposed on those members not committed (Mavunganidze 2008; Ruzivo 2014)</td>
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### Apostolic sect leader

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<tr>
<td>- Johane Masowe had a “similar call” to that of Johane Marange in 1932</td>
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<tr>
<td>- Johane Masowe was convinced that he was ‘John the Baptist of Africa’, sent by God specifically to preach to African people; hence John of the “wilderness” / masowe – worshipping in the open-air or bush</td>
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<tr>
<td>- Holy Spirit directs healing and solutions to all health and social problems, and through revelations of the Holy Spirit / Mweya, Apostolic prophets and faith-healers perform divine-healing, miracles and heal people of evil spirits and all illnesses and diseases</td>
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<tr>
<td>- Anti-Western / white-establishment; and emerged as a “reaction to colonial oppression and missionary paternalism” (Machingura 2014:179)</td>
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<tr>
<td>- Johane Masowe opposed Western/European things – “radically proclaimed the message of withdrawal from all European things, destruction of religious books… and shun all inventions of whites” (ibid.), including modern health services and medicines</td>
<td></td>
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<tr>
<td>- Modern education not prioritized and shunned for being secular, and Apostolic parents minimally invests in education of their children</td>
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<tr>
<td>- Such rejection forms the basis of qualitative separation from society, particularly through rejection of mainstream health, modern family planning and Western education – this establishes and reinforces the collective identity and markers of differentiation separating Apostolic groups from broader community and other religious groups (Machingura 2014; Vengeyi &amp; Mwandayi 2014)</td>
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<tr>
<td>- Johane Masowe’s followers encouraged to be economically self-reliant, and not seek formal employment with the white establishment – “not allowed to work for whites but to do their own trade as Korsten Basket makers” (ibid.)</td>
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<tr>
<td>- Expect full commitment to the Apostolic teachings and beliefs</td>
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### Paul Mwazha (1918 – present) of African Apostolic Church

<table>
<thead>
<tr>
<th>The Divine Commission of Paul Mwazha of Africa (Part 1 &amp; 2)</th>
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<tr>
<td>- narration of Paul Mwazha’s Divine Commission – including dreams and vision; provided divine assistance by the Holy Spirit</td>
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<tr>
<td>- Mwazha founded African Apostolic Church in 1959</td>
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<td>- ‘The Holy Spirit dictated that believers forsake the practices of witchcraft, wizardry and pagan sacrifices’ [and Mwazha actively called] “for a way of life that was in line with the gospel’s expectation of the behavior of those turned to Christ” (Part 1, page 35)</td>
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<tr>
<td>- members to desist from harking on and using magic portions in food and drink</td>
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<tr>
<td>- adherence to the command of the Holy Spirit in the laying of hands on all who have heathen materials; public confession of sin and asking for God’s forgiveness</td>
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<td>- Emphasizes faith healing</td>
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<tr>
<td>- Healing is a major factor in AAC, and church prophets exorcise evil spirits and guarantee protection to church members, “remedy to the clinical symptoms and the spiritual problems that have led to the manifestation of the disease” (Ndlovu 2014:59)</td>
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<tr>
<td>- people with evil and demonic spirits to be healed through the laying of hands on their heads</td>
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<tr>
<td>- believe in miraculous cure of illness (Part 1, page 36)</td>
</tr>
<tr>
<td>- healing the sick through the laying on of hands (page 68) – “Our hands were the conduits of the curative power of God who was never baffled by any disease” (page 69)</td>
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<tr>
<td>Apostolic sect leader</td>
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<tr>
<td>- Use water to heal the sick – place “index finger into water in the Name of my Lord Jesus to great healing effect. Worshippers drink it to allay pain, clean the blood stream or their intestines. Water has been the most effective Symbol of the fight against other diseases such as asthma, diabetes, rheumatism, anemia, anorexia, migraine, period pains and post-natal healing” (page 70).</td>
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<td>- “absolute conquest of all illness and evil spirits through the use of the water” and homes are protected when holy water is sprinkled sparingly in the home or yard as this guards against evil spirits (page 70)</td>
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<tr>
<td>- Pregnant women encouraged to deliver at home; assisted by Apostolic traditional birth attendants</td>
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<tr>
<td>- Polygamy is forbidden</td>
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<tr>
<td>- Secular life styles are forbidden, including attending to social, public or secular gatherings</td>
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**Rungano rwe Zion Christian Church**
- Samuel Mutendi received his first call in 1913, saw a vision of the angel Gabriel who commanded him to start a church in Zimbabwe and devote to prayer |
- Started church in 1922 |
- Church operates under the influence of the Holy Spirit and emphasizes faith healing |
- Established Dopota Mission at Defe |
- Samuel Mutendi performed signs and wonders using his Mapumhangozi rod, and also cast out demons |
- Samuel Mutendi was buried at Defe Dopota in Gokwe, the place of Zionist pilgrimage |
- Both the late Samuel Mutendi and Bishop Nehemiah Mutendi sought to eradicate illiteracy and combat poverty and diseases among their followers; supported education as a development tool (Chimininge 2014) |
- Bishop Nehemiah Mutendi, a trained teacher, recognizes the transformative power of the church and the imperative of changing the church – from “one that is mainly associated with the poor, uneducated blacks to one that has managing directors of multi-national companies, medical doctors and nurses, senior civil servants, bankers, business tycoons and university graduates” (Chimininge 2014:46) |
- Church’s theological teaching based on the Bible and the late Samuel Mutendi’s teachings |
- ZCC has a strong developmental thrust – “expansion of church-related projects such as mission in the Diaspora, building of schools, colleges, university, churches and conference centers” (Chimininge 2014:46) |
2
Theoretical Frameworks
PART 2: THEORETICAL FRAMEWORKS

This section provides the underlying theoretical frameworks that guided the evidence-generating process. The theoretical constructs provided lens for the desk review and primary operations research, and the different constructs were applied as part of an eclectic analytical framework combining insights from the Social Ecological Model (SEM) and Continuum of Care. It facilitated better understanding of health-seeking behaviors of Apostolic women in the lifecycle of care and within various levels of social influence. The objective was to explore the intersection of Apostolic religion, healthcare seeking and various social ecological influences.

Underlying Theoretical Frameworks

Social Ecological Model

The Social Ecological Model (SEM) recognizes that the individual is nested in the social, physical and institutional contexts; and influenced by family and peers, community, social environment, and institutions including laws/policies. Health outcomes were “shaped less by individual behavior and more by the wider-environment in which people live and make choices, influenced by family, peers, local peers and values, cultural norms and practices and political and economic circumstance” (Busza et al. 2012). Therefore, using the SEM, we can analytically examine the myriad of factors influencing health-seeking behaviors related to MNCH as well as appreciate the institutional context - legal, policy and political structures, institutional structures such as health systems, infrastructure, social welfare and insurance, and availability of services and drugs (the supply-side factors) – that influence other levels and contextual factors (see Figure 2 below: Social Ecological Framework). In addition, underlying causes of disease/illness can be located in the socio-cultural environment (Shefner-Rogers 2013), in which Apostolic religion, gender/social norms, and health beliefs and practices related family planning, pregnancy, delivery, post-partum care and breastfeeding operate. The social-cultural factors may constrain choices, and mediate decision-making related to utilization of MNCH services. This requires understanding the codes of Apostolic religious behavior - doctrine, beliefs and practices – governing Apostolic members, their influence on acceptance or rejection of modern MNCH services, and the sanctions imposed for violating the sect’s doctrine and regulations. In addition, we have to recognize how Apostolic religion provides a worldview in which Apostolic individuals perceive susceptibility or seriousness of disease, framing of the source and threat of disease/illness and pregnancy/childbirth complications, and the perceived benefits and barriers to uptake of modern health services and behavioral change.

Continuum of Care

Continuum-of-care is a core principle of programs for maternal, newborn, and child health. It highlights the continuity of care throughout the lifecycle – adolescence, pregnancy, childbirth/delivery, the postnatal period for mother and newborn, and childhood. Its application emphasizes that “all women should have access to reproductive health choices and care during pregnancy and childbirth, and all babies should be able to grow into children who survive and thrive” (Kerber et al. 2007). The continuum of care approach (see Figure 3 below) was adopted to examine the gaps in Apostolic maternal and newborn health care, and demonstrate how religious beliefs and practices influencing healthcare seeking behaviors within the different phases in the continuum of care. Therefore, religious objections to modern MNCH services at each phase effects Apostolic mothers and newborns’ health outcomes given the limitations imposed on benefits that could be derived from the services offered within each sequential stage. The continuum of care includes: (i) adolescence/pre-pregnancy stage includes empowerment for adolescent girls, education, and family planning services; (ii) pregnancy stages covers antenatal care aspects, identification and management of pregnancy complications as well as monitoring of the fetus; (iii) childbirth/delivery stage;
and (iv) post-partum maternal health and neonatal health and (iv) post-partum maternal health and neonatal post-natal, infant and childhood health. The post-partum care covers both the mother and newborn within the first six weeks of life. However, in this study, we focus on the newborn’s first 28 days of life. Notwithstanding, the importance of receiving care and services at each sequential stages and transition, the evidence also suggests that the majority of Apostolic women and newborns largely receive care from Apostolic faith healers, Zvitsdzo / healing centers, AtBAs, and other members of the Apostolic community with special anointing of the Holy Spirit/Mweya. Therefore, Apostolic members rely largely on ‘Apostolic healing/health system’, which is their primary source of MNCH care than the modern MNCH services. In some instance, the Apostolic members explore both services depending on their assessment of the service needed and perceived source of the health complication or illness (see Figure 4 below).
Figure 3: Continuum of Care

Linking across the times of caregiving

Adolescence pre-pregnancy > pregnancy > Post-partum > Maternal health

Neonatal Post-natal > Infancy > Childhood

Figure 4: Apostolic Health-Seeking Behavior Framework

Use Modern MNCH Services & Medicines

Chitsidzo or Birth Camp

Pray, sprinkle holy water and get anointing oil/holy stones/ holy water (faith healing)

AtBAS, faith healers, religious leaders

Apostolic individual (pregnant & post-partum woman)

Apostolic Health-Seeking Behaviors during Pregnancy, Delivery and Post-partum Period (Ultra-Conservative & Semi-Conservative Apostolic Sects)

End

Home Delivery with AtBA

Pray
3
Legal Analysis of Apostolic Religion
PART 3: LEGAL ANALYSIS OF APOSTOLIC RELIGION

This section examines the intersection of Apostolic religion and the law in relation to maternal and child health in Zimbabwe. It explores further the scope for and advisability of legal intervention in maternal and newborn health in Zimbabwe. It examines whether legal intervention can be effective in bringing about social change, and deals with the social challenges that can arise from using the law as an agency for social and behavior-modification among Apostolic religious groups in Zimbabwe.

Apostolic religion constitutes the largest religious community in Zimbabwe, and it continues to grow rapidly in size. The beliefs and practices of Apostolic religion deeply impact upon the lives of its many followers (Maguranyanga 2011, Muchingura 2014). Within the vast Apostolic community, there were variations in the way in which Apostolic religion was practiced. Some sects totally reject the use of modern medicine, whereas others allowed its use to some extent (Maguranyanga 2011). Within some sects, positive shifts and transitions were already taking place in relation to the use of modern medicine, and these shifts were encouraging and needed to be built upon.

Some Apostolic beliefs and practices are seriously harmful to maternal and newborn health care, and therefore have to be addressed to prevent such harm. The nagging question is whether law could be used in safeguarding maternal and child health among the Apostolic religious group, and what role legal intervention can play in improving maternal and newborn health outcomes among Apostolic religious groups.

The religious beliefs of the Apostolic faith are deeply-ingrained and inter-mingled with norms derived from the culture and practices of traditional African society. Within the Apostolic community, women are subjected to male domination and control, and gender equality was not recognized. As pointed out by Maguranyanga (2011) and Muchingura (2014), Apostolic religious doctrine and socio-cultural norms continue to exert influence on the behavior of Apostolic women and female adolescents. Apostolic doctrine often inhibit women and young girls from using modern services, including sexual and reproductive health services.

Ultra-conservative Apostolic sects totally prohibit the use of modern medicine to treat illness. These sects view any form of modern medical treatment as disobeying God’s will; heathen practices and the devil’s work. They strongly believe that illness results from evil spirits and witchcraft, and the only accepted way to deal with illness was through faith-healing carried out by persons with spiritual powers to perform such healing. Thus members of these sects may not seek modern medical treatment; if they did, they face severe sanctions, the “wrath of God”, public humiliation and confession and sometimes asked not to wear the Apostolic religious garments.

The total prohibition of modern health services and medicines amongst ultra-conservative sects means that none of the following medical interventions are allowed:

- The use of modern drugs
- Immunization against dangerous diseases
- Surgery and blood transfusion
- The use of contraception by women for birth control purposes
- The use of drugs to treat sexually transmitted infections and HIV
- The use of medicines to prevent mother-to-child transmission of HIV
- Medical care for pregnant women before, during and after childbirth and medical care for newborn babies
- Medical termination of pregnancy on lawfully-permissible grounds under the Termination of Pregnancy Act [Chapter 15:10] by a pregnant adolescent/woman, such as a termination to save the mother’s life or to prevent a serious threat of permanent impairment of her physical health or where the pregnancy resulted from rape.

Pregnant women belonging to ultra-conservative sects may only receive assistance from traditional birth attendants at home or in Apostolic birth camps or Zvitsidzo. Most of the Apostolic birth attendants...
(AtBAs) are not trained in medical aspects because their sects reject medical treatment. Spiritual guidance and faith-healing are used to deal with complications during and after birth, even with life-threatening complications. There are no referrals for medical treatment where faith healing is preferred for the existing complications, and the end-result is that women with serious birth complications may die when medical intervention before, during and after childbirth could have prevented such deaths. For instance, maternal and neonatal deaths may have been avoided through effective medical identification and management of problems in pregnancy as well as access to emergency obstetric care to deal with birth complications.

In contrast, less-conservative Apostolic sects may allow pregnant women with birth complications to go for medical treatment but only after faith-healing techniques have been employed. The requirement of seeking spiritual counsel and applying faith-healing first could delay the obtaining of medical treatment. Sometimes, medical treatment is only accessed too late to save the lives of women and babies concerned or to avert serious harm to them. Some Apostolic sects may allow women to receive antenatal care and postnatal care, and also permit immunisation of babies. However, they tended to emphasize home delivery and the utilization of PNC services. In general, Apostolic religious groups object to the use of modern family planning methods.

Child marriages are common within the ultra-conservative Apostolic sects, and girls often are being forced to enter into these marriages. After such marriage, the girl will be under pressure to become pregnant. Pregnancy at a young age carries considerable health risks. The pregnant adolescent is at increased risk of pregnancy complications such as eclampsia, premature labor, prolonged labor, obstructed labor, fistula, anemia and death. For the pregnant adolescent under 15 years, these risks increase substantially. The younger the mother is, the greater the risk to her and her baby. The pregnant adolescent or Apostolic ‘child bride’ faces a high-risk of “immature uterine muscles and mucous membranes that pose serious danger and a high-risk of a ruptured uterus in the case of prolonged labor.” [UNFPA quoted by Machingura (2011:202)]. There is also a greater risk of premature birth, low-birth-weight, health problems and infant death.

The Law relating to Medical Treatment for Women and Children

There exist various constitutional and criminal laws that could be applied in this area and further laws could be created to prevent Apostolic leaders, husbands and parents from stopping women and children from obtaining maternal and child health care services.

Relevant Constitutional Provisions

The Constitution of Zimbabwe affords various fundamental rights to persons. The most relevant rights in regard to the well-being and health of persons are the following:

- The right to life [section 48(1)]
- The right to bodily and psychological integrity; [section 52]
- The right not to be subjected to inhuman or degrading treatment [section 53]
- The right to human dignity [section 51]
- The right to make decisions concerning reproduction. [section 52(b)]
- The requirement that there be an Act of Parliament protecting the lives of unborn children [section 48(3)]
- The right of women to equality and non-discrimination and to be treated with dignity and equality with men and the obligation of the State to take measures to promote equality and protect against unfair discrimination [sections 56 and 80]
- The rights of children under 18 include the right to be protected from sexual exploitation, maltreatment and abuse and the right to education and health care services [section 81]
- The right to education [section 73]
- The right to have access to basic health-care
services, including reproductive health-care services and the obligation of the State to take measures within the limits of resources available to it to achieve the progressive realization of the right to health care [section 76].

The goal of advancing the right to health services is reflected in the aim of the Medical Services Act [Chapter 15:13] to provide and maintain comprehensive hospital services in Zimbabwe. Under the Public Health Act [Chapter 15:09] it is the function of the Ministry of Health and Child Welfare to promote the public health, and prevent, limit or suppress infectious and contagious diseases within Zimbabwe. The right to healthcare is also incorporated into the various health policies formulated and implemented by the Government of Zimbabwe to advance the health-rights of Zimbabweans.

Relevant International Conventions

Zimbabwe is also a State Party to various United Nations Conventions set out below:

The Convention on Economic, Social and Cultural Rights provides in Article 12 that people have the right to the highest attainable standard of physical and mental health and that State Parties must take steps to fully-realize this right, which steps must include making provision for the reduction of the still-birth rate and for the healthy development of the child.

The African Charter on the Rights and Welfare of the Child Article 4 provides that the best interests of the child will be the primary consideration in all actions concerning the child undertaken by any person or authority. Article 14 states that children have the right to enjoy the best attainable state of physical and mental health and State Parties must fully-protect this right and must reduce infant and child mortality. Article 11 provides that children have the right to education. Article 1(3) provides that any custom, tradition, cultural or religious practice that is inconsistent with these rights must be discouraged.

The Convention on the Elimination of All Forms of Discrimination against Women provides in Article 14(2) that State Parties are obliged to take all appropriate measures to eliminate discrimination against women in rural areas and must ensure that such women have the right to access adequate health care facilities, including information, counseling and services in family planning. Article 16 obliges State Parties to take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations. In particular they must ensure that marriage only be entered into with the full-consent of the parties and that the spouses will be equally responsible for matters relating to their children but, in all cases, the interests of the children will be paramount. The spouses will have the same rights to decide freely and responsibly on the number and spacing of their children and must have access to information, education and the means to enable them to exercise these rights.

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Article 6 of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa provides that State Parties must ensure that women and men enjoy equal rights and were
regarded as equal partners in marriage. State Parties should enact appropriate national legislative measures to guarantee that no marriage will take place without the free-and-full consent of both parties and that the minimum age for marriage for women will be 18 years. Article 12 stresses that women must have equal opportunities with men in respect of education and it obliges State Parties to take specific positive action to promote the enrolment and retention of girls in schools and other training institutions and the organization of programs for women who leave school prematurely. Article 14 provides that States Parties must ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. This includes women’s right to control their fertility, the right to decide whether to have children, the number of children, the spacing of children, and the right to choose any method of contraception.

Although these Conventions do not form part of the domestic law of Zimbabwe because they have not been made part of domestic law through an Act of Parliament, the courts are obliged to interpret all legislation in a manner which is consistent with this Convention (See section 327 of the Constitution). Having ratified all these Conventions, the Government of Zimbabwe should seriously consider the obligations it has assumed under them.

Scope for Constitutional Challenges to Prejudicial Apostolic Practices

Section 44 of the Constitution of Zimbabwe provides that not only the State but every person must respect, protect, promote and fulfill these fundamental rights set out in the Constitution. Section 80 provides that all laws, customs, traditions and cultural practices that infringe on the constitutional rights of women were void to the extent of the infringement. Section 63 further provides that, although people may participate in their chosen cultural life, they may not do so in a manner that is inconsistent with the fundamental rights of others, such as the right to life.

Using these provisions, it would be possible for women’s rights organizations or children’s rights organizations acting in the public interest, to bring a case before the Constitutional Court challenging the constitutionality of certain Apostolic practices. In such litigation, an organization could seek a declaratory order that a particular practice of the ultra-conservative Apostolic sects that violate the fundamental rights of women and children should be declared void to the extent of the violation and that members of the sects engaging in these practices were in breach of the duty of every person to respect these rights.

Those opposing this sort of application might seek to argue that the members of these sects were merely exercising their constitutionally-guaranteed right to freedom of religion or belief set out in section 60 of the Constitution. This argument would fail. Section 60 makes it clear that although a person may exercise the right to freedom of religion, that person may not rely upon this right to violate the fundamental rights of another person. Section 60 thus provides that parents and guardians of minor children have the right to determine the moral and religious upbringing of their children according to their religious beliefs, but they must not do this in a manner that prejudices the constitutional rights of their children, including the right to health, safety and welfare. Thus a parent may not violate the child’s right to life or physical well-being by causing its death or serious harm to its health. This is underscored by section 81(2) of the Constitution which provides that the best interests of child are paramount in every matter concerning the child and this principle supersedes any religious values to the contrary. It is also underscored by the provisions of the human rights Conventions to which Zimbabwe is a State Party.

Constitutional litigation, as a mechanism to put a stop to detrimental practices, has various limitations. Firstly, it is dependent upon persons or organizations bringing appropriate cases before the Constitutional Court. Secondly, these cases often take long time to process through the court and obtain judgments. Finally, even after the court declares a practice to be unconstitutional, it will usually be necessary for Parliament to pass legislation to outlaw the
practice or to amend existing legislation to make it constitutional.

Nonetheless, constitutional litigation can be an important tool to attack unacceptable practices. A good example of this is the case presently before the Constitutional Court on the constitutionality of child marriages, namely **Loveness Mudzuru and Anor v The Minister of Justice, Legal and Parliament Affairs & Ors Constitutional Court of Zimbabwe Case Number 7 of 2014**. A ruling in this case is eagerly-awaited. Hopefully, the Constitutional Court will rule it unconstitutional to enter into a marriage with a child. Such a judgment would oblige the Government to amend the Customary Marriages Act [Chapter 5:07], which does not set a minimum age for a customary marriage; it would have to be amended to set the minimum age for such a marriage at 18. If that happened, a customary marriage of a girl below the minimum age would become a criminal offence.

In a Constitutional challenge, the arguments can be fortified by reference to the provisions in human rights Conventions to which Zimbabwe is a State Party.

**The Right to Refuse Medical Treatment**

Every sane adult person has the right to refuse to receive medical treatment even if such refusal will lead to that person’s death. Any forced medical treatment without the consent of a sane adult amounts to an assault. The only exception is the compulsory treatment of a person with a dangerous infectious disease and the treatment of a mentally incompetent person unable to understand the need for treatment.

What this means is that an Apostolic adult has the right to refuse medical treatment based upon deeply-held beliefs that medical treatment is evil. So too a pregnant Apostolic woman who holds this belief is legally-entitled to refuse to obtain medical care before and during pregnancy; although this refusal may not only endanger herself but also the unborn child. However, as will be seen below, the law imposes a legal duty upon parents to obtain necessary medical treatment for their minor children and they may not refuse it because they believe that all medical treatment is evil and contrary to God’s will. Parents who do not seek medical attention for their sick children violate the child’s right to life or physical well-being. This also means that it is illegal for a father or mother to refuse to allow a newly-born child to be immunized against a “killer” disease.

**Applicable Current Criminal Laws**

a) **Protection of Physical Health**

It is important to emphasize that in general terms, the criminal law focuses on protection of the physical health and well-being of persons, and is concerned to protect people against activities that cause physical harm to them.Negligently causing the death of another person thus constitutes the crime of culpable homicide. Physical and sexual assaults upon women and children are criminalized. The law seeks to protect children under the age of 16 against sexual exploitation by making it an offence for a man to have consensual sexual intercourse with a girl under the age of 16. One of the reasons for protecting the girl against sexual exploitation is to protect the girl child against the adverse health consequences that can result from early sexuality, including the risk of sexually transmitted infections and pregnancy.
b) Legal Liability of Persons with Protective Duty towards Others

Section 10 of the Criminal Law (Codification and Reform) Act [Chapter 9:23] imposes a legal obligation on family members and those with a protective duty to others to protect the life and safety of their family members and the persons to whom they owe a protective duty. Thus, parents and guardians have a duty to protect the life and safety of their children; if they failed to fulfill this duty, they can be held criminally liable. For example, if the father of a child knew that his five-year-old son was seriously ill and failed to obtain medical treatment for the child where he could easily have done so and the child died, the father could be convicted of culpable homicide if it can be proved that the child would have survived had the father obtained medical treatment when it became evident that the child needed such treatment.

Under section 7 of the Children's Act, a parent or guardian of a child (a person under the age of 16) is guilty of a criminal offence for neglecting the child by failing to provide or pay for medical, surgical, dental treatment or other effective remedial care necessary for the child's health or well-being. Any person convicted of this offence is liable to a fine not exceeding $300, or to imprisonment for a period not exceeding two years, or to both such fine and imprisonment. The only defense to this charge is that the person with this obligation lacked the financial means to pay for the treatment, but this would not apply for failure to obtain free treatment for the child in a Government hospital or clinic. Section 76(3) of the Constitution specifically provides that no person may be refused emergency medical treatment in any health-institution.

The fact that the law is concerned to protect the physical well-being of children is further underscored by the provisions in section 76 of the Children's Act. Essentially, where a doctor is faced with a situation where a young child needs to be medically treated but the parent or guardian refuses such treatment for religious reasons, the doctor can obtain authorization from a magistrate to go ahead and treat the child despite the objections by the parent or guardian.

To put all of this in the context of an Apostolic parent whose religion prohibits the obtaining of medical treatment for the child, the parent could potentially be charged with culpable homicide or contravening section 7 of the Children's Act [Chapter 5:06] if the child dies for lack of medical treatment. Similarly, if a pregnant wife of an Apostolic man demands to be taken to a nearby hospital because she has serious pregnancy complications, and the husband refuses to do this because of his religious beliefs and his wife dies for lack of medical treatment, the husband could potentially be charged with culpable homicide.

The defense that the father or husband would obviously seek to make would be that his religious beliefs precluded him from seeking medical treatment for his child. As seen previously, this defense would not succeed as the Constitution does not allow a person to rely upon his religious beliefs when he has a legal duty to protect the physical well-being of another.

This is evidenced by the decision in the case of S v Machaya 2980/14 where a father was charged with contravening section 7 (b) of the Children's Act. It was alleged that the accused ill-treated or neglected 12 year old son by refusing to obtain medical treatment for him when he sustained a wound on his left thigh. The accused’s defense was that he was following his religious belief that it was wrong to obtain medical treatment and only the Holy Spirit could heal his son. The court convicted him of this offence and sentenced him to four months imprisonment.

c) Child Marriages and Forced Marriages

Some Apostolic men in ultra-conservative Apostolic sects often marry very young girls, and impregnate them. The young girl is often forced to enter into the union due to socio-economic and religious factors. After marriage, the girl is not permitted to use modern family planning methods or birth control, and is encouraged to have as many children as divinely possible.

**Forced marriages**

A person forcing a girl-child to marry commits a criminal offense. Section 94 of the Criminal Law
(Codification and Reform) Act makes it a criminal offense for a lawful custodian to enter into an arrangement promising in marriage to a man, a girl under 18; the same section makes it an offense, by force or intimidation, to compel a female person to enter into a marriage against her will. Section 4, read with Section 3 of the Domestic Violence Act, also makes it a criminal offense to use cultural or customary rites or practices that discriminate against or degrade women, including forcing a woman to marry. A forced marriage is therefore an invalid marriage.

Child marriages
As already stated, there is presently before the Constitutional Court, an application challenging the constitutionality of child marriages; if a decision was handed down declaring such marriages unconstitutional, the Government would have to amend the Customary Marriages Act [Chapter 5:07], which does not set a minimum age for a customary marriage. The Customary Marriage Act would have to be amended to set the minimum age for such a marriage at 18. If this happened, a customary marriage of a girl below the minimum age would become a criminal offense.

However, even presently, there are provisions in the Domestic Violence Act criminalizing child marriages. In terms of Section 4 read with Section 3 of the Domestic Violence Act [Chapter 5:16], certain listed cultural or customary rites or practices that discriminate against or degrade women are criminalized, and one of these is child marriage; that is, marriage to a child under 16 years. Although it might be argued that this provision is directed at cultural practices and not religious practices as stated previously; however, child marriages in the Apostolic faith often derive from both religion and culture.

Sexual intercourse after marriage
In Zimbabwe, it is a criminal offense for a husband to rape his wife (Section 65 read with section 68(a) of the Criminal Law (Codification and Reform) Act.) Thus the fact that a man is legally married to the female is no defense to a charge of rape; even more so, if the marriage is illegal because it was a forced marriage or it was a child marriage. The man cannot defend himself against a criminal charge of rape on the basis that he was married to the girl. If he forced the girl to have sexual intercourse without her consent, he is guilty of rape. If the girl was under 12 years at the time of the sexual intercourse, the man would be guilty of rape because a girl under 12 is deemed to be legally incapable of consenting to sexual intercourse. In terms of section 70 of the Criminal Law (Codification and Reform) Act it is a serious criminal offense for a man to have sexual relations with a girl between the ages of 12 and 16, and even with the girl’s consent. This provision only applies to extra-marital sexual relations, but this only covers a legal marriage and not an illegal marriage.

d) Undertaking Treatment When Not Competent to Do So
In terms of the Traditional Medical Practitioners Act [Chapter 27:14], a person may practice traditional medicine and may also practice as a spirit medium. However, it is implicit in this legislation that a traditional healer must not attempt to treat serious medical conditions that obviously require immediate surgery or medical treatment. In such cases, a healer should hand over the patient for surgical intervention. If the healer failed to do so and the patient dies when surgery would have saved the patient, the traditional medical practitioner faces possible criminal charges for culpable homicide. On a similar basis, it can be argued that Apostolic faith healers and traditional birth attendants are not legally permitted to try to ‘heal’ girls and women where it is clear that modern medical treatment is required. The law would oblige them to hand over the persons concerned for modern medical treatment. It will not be an excuse that religious beliefs prohibited referral for modern medical treatment.

e) Legal Regulation of Apostolic Traditional Birth Attendants
The Ministry of Health and Child Care is responsible for regulations related to the health sector and
therefore, can regulate the practices and services of Apostolic traditional birth attendants. These regulations could at least require Apostolic traditional birth attendants to carry out their practices and care services in hygienic conditions. However, birth attendants from ultra-conservative sects are completely opposed to any form of medical treatment, and would possibly refuse to comply with regulations that required them to undergo some form of training emphasizing modern medical treatment and care. They would also refuse to comply with regulations that would require pregnancy, childbirth and maternal and child care cases to be referred to proper medical facilities. Thus, the enforcement of such regulations would be problematic among ultra-conservative sects, while such regulations may be acceptable to sects that allowed some form of medical intervention.

Interestingly, the Medical Services Act [Chapter 27:19] established the Nurses’ Council, has the power to regulate, control and supervise all matters affecting the training of persons in, and the manner of the exercise of, the nursing professions. Those falling under this council include maternity/Midwifery nurses and State certified maternity nurses. Unfortunately, the Apostolic traditional birth attendants continue to provide ‘birth attendance’ and ‘nursing’ services without the prerequisite training and licensing. Therefore, they provide ‘nursing’ and ‘midwifery’ services to pregnant women, post-partum women as well as ‘care’ for the health of children without the license to offer such services.

g) Registration of Births and Deaths

The Birth and Death Registration Act [Chapter 5:02] requires that all births and deaths be registered, and failure to do this is a criminal offence in terms of Section 27 of the Act. An adult relative of the deceased person is supposed to give notice of the death to the registration authorities within 30 days; the notice is supposed to be accompanied by a certificate from a medical practitioner confirming the cause of death. The AMENI study documents evidence of non-compliance with this obligation, with deceased women and babies often being buried in secret using Apostolic burial rites. It is also unlikely that many ultra-conservative Apostolic adherents comply with the obligation to notify a birth especially when babies are not delivered at a health facility. District registrars have the authority to summon before them, the responsible person who has not registered a birth, still-birth or death as prescribed by the Act, to explain the reasons for their default and to rectify that default.

It would probably help the process of inducing behavioral change to oblige the Apostolic community to comply with these requirements. However, although the requirement of a doctor’s certificate for a death may be problematic. Greater compliance with these requirements would provide more data on the numbers of deaths occurring as well as the number of birth deliveries in birth camps and by traditional birth attendants.

h) Use of Open Space Without the Requisite Water and Sanitation Facilities

The regulations about sanitary conditions at open air gatherings in urban spaces are reflected in the Salisbury (Open-air) Events By laws 1974 (RGN 463 of 1974). These by-laws only impose a duty upon the owner of the site to apply for a license to hold the event. The license will only be granted if the owner has provided a supply of pure water and separate toilet facilities for the use by males and females to the satisfaction of the Medical Officer of Health. Therefore, it is an offence to hold the event without

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complying with these regulations. Despite the existing by-laws regulating the use of public spaces for holding of open air events, most Apostolic sects have mass gatherings and conduct religious ceremonies without complying with the regulations. In addition, the local government authorities and law enforcement agencies hardly enforce the by-laws and regulations.

Advisability and Consequences of Legal Intervention: Carrot or Stick?

What has been dealt with above are the possible ways in which the law could be brought to bear in the context of Apostolic maternal and child health in Zimbabwe. However, before invoking the law, various questions need to be asked. Is it appropriate to use the law in this context as an instrument to try to bring about desired social and behavioral change? Will such law be effective? Will the Apostolic religion adherents vehemently resist such law, considering it to be grossly unfair and a complete denial of their right to freedom of religion? Will the law be rigorously enforced and, if it is, what will be the social cost of imposing legal sanctions on violators?

For the law to be used in this area, there has to be the political will first to apply the existing laws and to create any necessary new laws to try to stop harmful practices. The Apostolic community comprises a large constituency, and there may be reticence on the part of politicians to risk alienating or causing offence to such a large group of potential voters. However, since Independence, the Government of Zimbabwe has attempted to put a stop to various socio-cultural practices, which it considers contrary to modern values on the rights of women and children. For example, the Criminal Law (Codification and Reform) Act and the Domestic Violence Act have provisions criminalizing the following practices:

- Forced virginity testing
- Female genital mutilation (female circumcision)
- Pledging in marriage of a female under 18 by a lawful guardian or relative
- Pledging of a woman or a girl for the purposes of appeasing the spirits
- Forced marriage
- Child marriage
- Forced wife inheritance

This is in line with the provision in the current Constitution which emphatically provides that customs, traditions and cultural practices that violate the constitutional rights of women and children are void, and that a person cannot violate the fundamental rights of others when participating in own cultural life. The outlawing of these practices also affects some of the practices of the Apostolic community. These not only derive from religion but also from patterns of behavior expected in customary society.

However, there is reason to doubt that these laws have significantly reduced the performance of the banned cultural practices. After these practices were criminalized, the Government did not embark upon a nation-wide campaign to provide information about these new laws, and to try to bring about compliance with them. It did not carefully explain why the cultural practices in question were being criminalized, and therefore some people continue with these practices despite their criminalization. There have been relatively few prosecutions for these offences, especially cases emanating from rural areas. This shows that the law enforcement agencies are doing little to apply these laws. It is very likely that many of these practices continue unabated.

Many of the women and girls in traditional communities and rural areas are probably unaware of these laws; even if they were, the constraints upon them in traditional society make it unlikely that they would report contraventions of these laws to the police. For example, a rural woman in a traditional society is highly-unlikely to report to the police that
her husband continuously uses brutal force to have sexual relations with her against her will. A young girl in the ultra-conservative Apostolic sect is highly unlikely to report to the police that she had been forced to marry and have sexual relations with a much-older man.

Similar questions must be asked as to whether it is appropriate to use the criminal law to try to afford protection to those affected by Apostolic practices that detrimentally affect maternal and infant health, and whether its use is likely to be effective in changing Apostolic behavior in this regard. However, the question still remains as to what should be done if there was continued resistance to change from ultra-conservative sects, or the pace of change in Apostolic doctrine and practice was far too slow. What if the ultra-conservative sects refused to shift or modify their doctrinal stance on maternal and neonatal health care?

In the ultra-conservative Apostolic sects, women and children are locked in a patriarchal community in which they are indoctrinated and pressured to believe that all medical treatment is evil. They are often unable to challenge this belief and refuse to accept modern medical treatment because of threats of severe sanctions and strong religious convictions. Women are made to believe that they are to blame for any complications during pregnancy; and are accused of having committed adultery or of being a witch who wants to take the life of her child for ritual purposes (Maguranyanga 2011; Organization for Public Health Interventions and Development, 2014.)

Even with information and education on health and reproductive rights, it is questionable whether the women would be able to freely-exercise these rights given the pressures they would face from the religious leaders, elders and parents who continue to hold fast to these beliefs.

Therefore, the Government has an obligation under the Constitution and the international human rights Conventions that it ratified, to protect the lives of its entire people and their health and physical well-being. The lives and health interests of pregnant women and newborns are being severely jeopardized by Apostolic leaders’ adamant refusal to allow access to modern medical treatment on religious grounds. Can the Government allow the continued propagation of beliefs that can be highly-prejudicial to the health interests of women and children?

Already, it is a criminal offence for a person who has a protective duty towards another, such as a parent, to fail to obtain medical treatment for their child. If the child died from this failure, the parent could face a criminal charge of culpable homicide. It could be reasoned that the church elders in the Apostolic faith have a protective relationship with their congregants. Therefore when they refuse to allow pregnant women to seek medical treatment for pregnancy complications that threaten the life of the woman and her unborn child, they are responsible for the resultant death/s. They violate the right to life of their female congregants who are pregnant; their religious beliefs should provide no excuse for this violation. Similarly, it can be argued that the traditional birth attendants and spiritual healers who attend to pregnant women during the birthing process are responsible for the
consequences of their failure to obtain necessary medical treatment for seriously-ill pregnant women.

The law could simply prohibit Apostolic traditional birth camps or Zvitsidzo unless they complied with public health standards. In other words, the law could criminalize the holding of such camps unless the traditional birth attendants have some basic medical training; the conditions in the camps comply with basic hygienic requirements and the birth attendants commit to referring cases of birth complications for necessary medical treatment.

However, ultra-conservative Apostolic sects that totally prohibit medical treatment would probably refuse to comply with this law. If the law was enforced and the birth camp closed down, pregnant women would be faced with a dilemma: they would not be assisted by the traditional birth attendants assistants in a camp, but if they abided by the sect’s beliefs, they would not be able seek medical treatment. These women then would have been denied both sources of birthing assistance. If all Apostolic traditional birth attendants rendering home-based birth assistance were to be required to undergo basic medical training, ultra-conservative Apostolic sects may simply refuse to comply with this requirement. Therefore enforcement of this law may not only be difficult, but also counterproductive. Another issue that could arise from a law that obliges referral of birth complication cases to proper medical facilities for treatment would be whether such medical facilities are reasonably available and accessible.

It can be argued that Apostolic religious leaders and parents who prevent females from having their newly-born children immunized against dangerous infectious diseases are responsible for the deaths of the babies who die from these infectious diseases. An alternative to this would be for the law to make it a criminal offence to refuse to allow babies to be inoculated. The refusal by Apostolic leaders and parents to allow babies and children to be inoculated against dangerous infectious diseases has broader public health implications. If a sizeable number of people refused to allow their children to be immunized, the health policy of eliminating or drastically reducting of dangerous infectious diseases will be compromised with social and cost implications. The problem of religious objections to immunization has arisen in several countries. For example, in the U.S.A, all states except Mississippi and West Virginia allow parents to opt-out of their children's otherwise-mandatory vaccinations for religious reasons. The American Medical Association opposes such exemptions, on the grounds that they endanger health, not only for the unvaccinated individual, but also for neighbors and the community at large.

One of the areas where ultimately some compulsion may be appropriate is in respect of child marriages. If the Constitutional Court ruled that child marriages are unconstitutional, this would oblige the Government to amend the Customary Marriages Act to set the minimum age for marriage at 18. This would mean customary marriage to a girl under 18 will be able to be registered but it must be a criminal offence for a male to enter into an unregistered customary law union with an under-age girl. But amending the law will certainly not be enough. The Government will need to embark upon a concerted country-wide campaign, especially in rural areas and amongst the Apostolic community to inform people of the new law, why it has been passed and why there must be compliance with it. Following this campaign, the law enforcement agencies must properly enforce this law by arresting those who violated it so they could be prosecuted.
4

Operations Research Findings
PART 4: OPERATIONS RESEARCH FINDINGS

This section presents the findings of the primary operations research, which focused on Buhera District (specifically Ward 22) in Manicaland Province as a case study. The case study findings should not be generalized to the entire Apostolic community and merely illustrate the issues.

Case Study

Buhera District has a population of 245,878, with males accounting for 46.4% and females 53.6%. It has 58,527 households (ZIMSTAT 2013), with an average of 4.3 people per household (ZIMSTAT 2013, Census 2012). There are 29 primary care centers and two secondary centers covering the district’s population, with some communities not adequately covered since they are located very far from the health facilities. Ward 22, the purposively sampled ward in the district, has a non-functioning clinic and its community relies on neighboring wards’ clinics; Muzokomba (ward 24), Mudavose (ward 23), Munwira (ward 21) and Betera (ward 20). The clinics are within a 35 km radius around ward 22, the closest being 10 km away. Ward 22 is about 55 kilometers from Murambinda Hospital, which is the main referral hospital. Ward 22 has the largest proportion of the population in the Buhera Central constituency, under the chieftaincy of Chief Nyashanu.

Buhera district has a large population of members of the Apostolic religion, particularly of the ultra-conservative religious groups of Johane Marange and Johane Masowe ye Sabata, and other semi-conservative Apostolic groups including Paul Mwazha’s African Apostolic Church, Zion ya Mutendi (ZCC), Johane Masowe ye Chishanu and Jekenisheni.

Data Collection Methods

The evidence-gathering processing involved desk review (legal/policy and doctrinal review, peer-reviewed articles, gray literature and documents, newspaper articles, and internet publications) and primary research. The operations research generated primary data through key informant interviews with purposively sampled religious leaders, traditional leaders, local leadership, civil society organizations’ staff, government officials, security service officials, and health providers including nurses, village health workers and health promotion officers; and in-depth interviews with AtBAs and Apostolic members. Focus group discussions were conducted with pregnant and post-partum Apostolic women, male and female Apostolic adolescents, AtBAs, Apostolic religious leaders and men (see Table 3 below). The majority of the participants belonged to the Johane Marange Apostolic group due to the dominance of this religious group in Ward 22 and its close proximity to the Marange area.

Maternal and Neonatal Deaths in Buhera District

A rapid maternal audit was conducted using data from the District Medical Officer’s office in Buhera; particularly data submitted to the Health Information System and collected from Murambinda Mission Hospital. It was complemented with additional data from key-informant interviews with the relevant health officials and midwives.

Evidence from Murambinda Mission Hospital

The analysis of maternal deaths among members of Apostolic religious groups was conducted at Murambinda Mission Hospital for the period 2010, 2012 and 2013 (see Table 4 below). The data shows that most of the maternal deaths were among young women, aged 17 to 39. The majority of these women had primary education (Grade 7), thus reflecting low educational status. In 2010, there were eight maternal deaths, of which six women were not registered at ANC and only two were booked. The major cause of maternal mortality in 2010 was malaria (cerebral malaria), which affected four of those women who had not registered at ANC. The failure to register at ANC therefore exposed the women to risks of dying from preventable or treatable diseases. Malaria is
one of the conditions targeted at ANC visits; pregnant mothers were administered malaria prophylaxes. Cerebral malaria is an advanced complication of malaria; its related death reflects the human cost of delayed medical care seeking or failure to seek ANC. Women attending ANC had higher chances of having malaria diagnosed and treated than those not attending ANC.

The other four women died of different conditions such as Anemia, Hepatitis, CVA and TB relapse. One of the two women who died of Anemia had a home delivery, thus possibly indicating that the patient might have suffered hemorrhage after birth and the condition not well-managed. During ANC visits, women have regular checks of their iron and zinc levels, since pregnancy is a precursor of low levels of iron and zinc and they were administered iron supplement tablets. As stated earlier, failure to attend ANC and not-delivering with skilled birth attendants increases the risks of maternal death among Apostolic women as they experience poor management of pregnancy, childbirth or post-partum complications that could be fatal. The desk review findings indicate that Apostolic women were less likely to uptake ANC services and deliver at health facilities than women of other religions, and thus fail to enjoy the benefits of ANC, institutional delivery, PNC, and immunization of the newborn (Njovana 2014). They also miss out on HIV prevention and treatment services (PMTCT and Option B+) and essential knowledge on recommended feeding practices (e.g., exclusive breastfeeding).

Analysis of hospitalization period for the 2010 deaths shows that some women delayed seeking medical care and presented themselves at the hospital with severe/life threatening conditions. Such late

Table 3: Study Participant Characteristics by Age

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of respondents by age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women 1st Pregnancy/ &lt; 2 children</td>
<td></td>
</tr>
<tr>
<td>Women 2nd pregnancy/ &gt; 2 children</td>
<td></td>
</tr>
<tr>
<td>Pregnant women at waiting shelter</td>
<td></td>
</tr>
<tr>
<td>Women who have experienced loss</td>
<td>1</td>
</tr>
<tr>
<td>Men</td>
<td></td>
</tr>
<tr>
<td>Adolescent girls</td>
<td>2</td>
</tr>
<tr>
<td>Adolescent boys</td>
<td>18</td>
</tr>
<tr>
<td>ATBAs</td>
<td></td>
</tr>
<tr>
<td>Village health workers</td>
<td>2</td>
</tr>
<tr>
<td>Religious leaders</td>
<td></td>
</tr>
<tr>
<td>Traditional Leaders</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
</tr>
<tr>
<td>Grand total</td>
<td>166</td>
</tr>
</tbody>
</table>

** Some data on Apostolic leaders, Apostolic males, and traditional leaders is not available because they did not want to fill in the form except the consent form.
** KII and Resource Mapping information is not included in this table but appears on the Tally sheet.
presentation at a health facility can be associated potentially with religious beliefs and practices that require consultation with religious leaders. Two women died on the day of admission, with one dying after a birth complication (Post-partum Hemorrhaging/PPH) having not delivered at the health facility. Both women were relatively young (28 years old), had not completed secondary education, and were carrying their 5th pregnancy. In 2013, only two maternal deaths (booked and un-booked) were recorded. One of the deaths was due to congestive cardiac failure resulting from pregnancy-related complications, compounded by a history of miscarriage (one delivery out of four pregnancies). The other maternal death was due to advanced complications of Miliary Tuberculosis (TB); a condition that was not identified and treated as the woman did not attend ANC. The deceased also had a history of multiple births indicated by the fact that at 30 years of age, she was carrying her fifth pregnancy. Therefore, the findings indicate a number of factors contributing to maternal deaths among Apostolic sects, which include delays in making a decision to seek medical care, not registering and attending ANC, poor healthcare seeking behaviors, low-levels of education, and multiple deliveries at a young age.

Table 4: Apostolic Maternal Death Audit (2010, 2012 & 2013) Murambinda Mission Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Religion</th>
<th>Age</th>
<th>LOE</th>
<th>Booking Status</th>
<th>Gestation</th>
<th>Hospitalization Period</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Johane Masowe</td>
<td>20</td>
<td>Form 4</td>
<td>UNBOOKED</td>
<td>23/40</td>
<td>6 DAYS</td>
<td>Cerebral Malaria; Toxoplasmosis</td>
</tr>
<tr>
<td></td>
<td>Chishanu</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zviratidzo</td>
<td>17</td>
<td>Form 3</td>
<td>UNBOOKED</td>
<td>Aborted at 18/40 at Home</td>
<td>4 DAYS</td>
<td>Cerebral Malaria</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZION</td>
<td>30</td>
<td>ZJC</td>
<td>UNBOOKED</td>
<td>38/40</td>
<td>2 DAYS</td>
<td>Acute Renal Failure secondary to Malaria</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZION</td>
<td>29</td>
<td>Grade 7</td>
<td>UNBOOKED</td>
<td>Home Delivery Term</td>
<td>2 DAYS</td>
<td>Puerperal Psychosis; Anemia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Johane Masowe</td>
<td>34</td>
<td>Grade 7</td>
<td>UNBOOKED</td>
<td>Delivered Pre-term Baby at Mpilo Hospital</td>
<td>1 DAY</td>
<td>Severe Anemia; Drug Induced Hepatitis; Bulbar Palsy</td>
</tr>
<tr>
<td></td>
<td>Mugovera</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Johane Marange</td>
<td>23</td>
<td>Grade 7</td>
<td>UNBOOKED</td>
<td>Home Delivery Term</td>
<td>3 DAYS</td>
<td>Cerebral Malaria</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apostolic</td>
<td>39</td>
<td>Grade 7</td>
<td>BOOKED</td>
<td>38/40 + 2 days</td>
<td>&lt; 1 DAY</td>
<td>CVA; Pre-Eclampsia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mugodhi</td>
<td>30</td>
<td>Grade 6</td>
<td>BOOKED</td>
<td>Pre-term</td>
<td>4 DAYS</td>
<td>Cardiomyopathy TB Relapse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Zion</td>
<td>28</td>
<td>Form 3</td>
<td>Said to have booked at Rusape but no ANC card available</td>
<td>Full Term</td>
<td>&lt; 1 DAY</td>
<td>PPH/Postpartum Hemorrhaging</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mugodhi</td>
<td>28</td>
<td>Form 2</td>
<td>BOOKED</td>
<td>36/40 +6 days</td>
<td>&lt; 1 DAY</td>
<td>Cardiac Arrest</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Mugodhi</td>
<td>33</td>
<td>Secondary school</td>
<td>BOOKED</td>
<td>37/40</td>
<td>1 DAY</td>
<td>CCF/ Congestive Cardiac Failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sangano RavaPositori</td>
<td>30</td>
<td>Grade 6</td>
<td>UNBOOKED</td>
<td>Unknown</td>
<td>&lt; 1 DAY</td>
<td>Advanced Retroviral Disease and Miliary TB</td>
</tr>
</tbody>
</table>
Continuum of Care of Apostolic Women and Newborns

In this section, we apply the “continuum of care” to examine Apostolic maternal and newborn health and explore key issues related to adolescence and pre-pregnancy, pregnancy, childbirth, and immediate post-natal care for the mother (up to six weeks) and newborn (up to 28 days after delivery). Understanding the continuum of care among Apostolic religious groups is critical for addressing the gaps in the care and designing interventions for promoting positive Apostolic maternal and newborn health outcomes. Earlier studies (Maguranyanga 2011; Ha, Salama et al 2012) showed sub-optimal health-seeking behaviors and poor utilization of modern MNCH services among Apostolic religious groups.

(a) Adolescence and Pre-Pregnancy: Adolescent Pregnancies in Buhera District

An assessment of records of institutional deliveries by pregnant adolescents at Murambinda Mission Hospital presents a gloomy picture of the prevalence of adolescent pregnancies in Buhera District (see Table 5 below). Buhera District has high-adolescent pregnancies, indicating challenges in adolescent sexual reproductive health (ASRH) and social challenges of early sexual debut, child/early marriage and limited educational opportunities.

Limited Educational Opportunities and Poverty

Adolescents from both ultra-conservative and semi-conservative Apostolic groups who participated in FGDs indicated limited educational opportunities among them, and stated that early/child marriages were also precipitated by poor educational opportunities and poverty within families:

“In Marange, they (families) actually support most girls to get married early; as-soon-as they finished Grade 7. They encourage their young girls to get married to older men…They preach that they should marry so that they ‘multiply like sand’.

“Some parents marry off their young girls so that they get food and material assistance. Poverty pushes young girls into marriage. Some girls are married off because of hunger or starvation at home. Girls were forced to marry an older man because parents would...”

Table 5: Adolescent Deliveries, Murambinda Mission Hospital, May-November 14, 2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov*</th>
<th>Sub-Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 - 15</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>10</td>
<td>3.7</td>
</tr>
<tr>
<td>16 - 17</td>
<td>13</td>
<td>14</td>
<td>8</td>
<td>13</td>
<td>10</td>
<td>18</td>
<td>9</td>
<td>85</td>
<td>31.4</td>
</tr>
<tr>
<td>18 - 19</td>
<td>32</td>
<td>31</td>
<td>22</td>
<td>26</td>
<td>27</td>
<td>29</td>
<td>9</td>
<td>176</td>
<td>64.9</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>48</td>
<td>32</td>
<td>39</td>
<td>40</td>
<td>48</td>
<td>18</td>
<td>271</td>
<td>100</td>
</tr>
</tbody>
</table>
have received lobola without the girl’s consent [Unotonzhi chero usingade itoenda kudhara riya nokutini mari takatodya]. Other girls marry old men because of the financial and material benefits”.

Religious Beliefs about Dreams and Virginity Testing

Religious ‘dreams’ play an important role in facilitating early/child marriages while virginity testing provides the pathway for choosing young girls to be married off to older men:

“They believe in ‘dreams’ [kuroteswa]. When a man has a dream marrying a young girl, then that girl should get married to the older men”

In addition, the religious practice of virginity testing also facilitates the process of marrying off young girls to older men in ultra-conservative Apostolic sects:

“Some are forced to marry old men if they fail the virginity test. If one is not a virgin, she will be given to an old man with no choice”.

“When one loses virginity, she will no longer get respect from others, and she loses her dignity publicly and is displayed as non-virgin” [FGD with adolescent girls from ultra-conservative Apostolic girls]

In addition, some adolescents noted the influence of strong religious convictions related to marrying men in their Apostolic church, non-use of modern family planning methods, and the value placed on big families encouraging young girls to marry early and ensure that “they multiply like sand” [Vanototii rooranai muwande sejecha regungwa].

When a girl falls pregnant before marriage, she is labeled “of loose morals” and forced into marriage.

Lack of ASRHR and Challenges of Unwanted Pregancies

The adolescent girls and boys who participated in the FGDs stated that adolescent pregnancies were also caused by lack of access to information on adolescent sexual and reproductive health (ASRH):

“Many Apostolic children do not know about adolescent sexual and reproductive health and rights. They are not allowed to go to the clinic since the churches do not encourage the use of clinics. Girls get pregnant so early because they lack the knowledge on condom use and not aware of health issues as well as how to prevent pregnancies” [FGD with adolescent boys from ultra-conservative Apostolic groups].

Given religious objection to the use of modern health services, some pregnant Apostolic adolescents used traditional birth attendants (TBAs) to abort unwanted pregnancies. When asked to explain the process of aborting unwanted pregnancies, the adolescents vividly described the TBAs’ approach:

“They insert into the vagina, crushed herbs (munhanzwa or kabatanai) mixed with water, to enlarge the birth canal, and then later use their hands to pull-out the baby, which may damage the girl’s vagina or womb”.

“Some use herbs and crush them; you drink them and by so doing, the pregnancy is terminated. Some boil Omo or Surf (commercial powdered washing detergent) or even a whole pack of boiled tea leaves for you to drink, and this terminates the pregnancy”.

The adolescent girls were aware of the toxicity of the herbal mixes and abortion agents used by the TBAs, but acknowledged that the pregnant Apostolic adolescents opted for abortion because of the stigma, negative social labeling and public humiliation associated with pregnancy outside marriage.

Adolescent pregnancies are generally associated with severe pregnancy complications and maternal deaths. Therefore, the dangers and social costs of adolescent pregnancies among Apostolic groups have to be understood in the context of multiple factors identified above, and multi-thronged approaches are required to address the drivers of and prevent adolescent pregnancies.

Religious Objection to Family Planning

In pre-pregnancy care, the key challenge facing the Apostolic women of child-bearing age (15-49 years) or adolescents in early marriages is Apostolic
religion’s reticence towards the use of modern family planning methods. The Apostolic doctrine, for all the Apostolic churches whose members participated in the study, totally discourage the use of modern family planning and prefers the withdrawal method:

“Our religion does not allow family planning [pills and modern methods] because it is murder. The Bible said, ‘do not kill’. The Ten Commandments say ‘do not kill’, so we have a way we teach at women’s meetings on how women can plan their families” [FGD with AtBAs]

“Men should have sex and when they get to the time when they feel like ejaculating; they should withdraw and spill on the ground. If you immediately want sex second-time-around, you should go and urinate while squeezing (uchikama), so that the sperms left by the penis’ mouth get out. If you repeat sex without urinating, the left-over sperms will cause pregnancy”.

[FGD with AtBAs]

“If women from Marange [ultra-conservative Apostolic groups] are caught using modern family planning methods, they are sometimes beaten by their husbands and temporarily banished from church until such time they are “fully-cleansed”. The women are also threatened with death as ‘God’s rage’ would fall upon them”.

Those women who take family planning pills should be aware of God’s rod that will come upon them. If you are not giving birth, death will come upon you. Then as a woman, I get scared and run to confess that I took pills and got injected with Depo-Provera [birth control injection] because I don’t want to die. Only then can I get released from the curse and have a child” [FGD with ultra-conservative Apostolic mothers with second pregnancy].

Therefore, modern family planning methods are viewed as antithesis to God’s purpose for big families and multiplication of Apostolic members as countless sand through female members getting pregnant as many times as divinely possible and avoiding contraceptives. Consequently, contraceptive prevalence tends to be extremely low among women of Apostolic religion.

(b) Pregnancy
The Apostolic women depend largely on AtBAs and faith-healers (Prophets, church leaders, elderly women in the church with “special anointing”) to deal with pregnancy-related issues. The Apostolic faith healing systems and Zvitsidzo enable pregnant Apostolic women to get ‘ANC’ assistance within their religious community without necessarily depending on modern health services. Apostolic ‘antenatal care’ is primarily guided by church doctrine, regulations and beliefs related to spiritualization of illness. It includes pregnancy-related care and support from the church; and the care involves prayer, spiritual diagnosis and healing, and prophesies on the pregnancy:

“I am now pregnant. I have counted my pregnancy’s months and right now maybe four or five. I go to the traditional birth attendant, and she will be constantly checking on me if the pregnancy is progressing well until I am due. I will be going for check-ups at the traditional birth attendant. If the baby is breached, she will just fix it until the day of delivery [FGD with ultra-conservative Apostolic mothers with second pregnancy or more].

Often AtBAs attend to pregnant women usually from three months onwards until delivery. During this period, the AtBAs encourage a mother to “be prayerful and focus on the spiritual realm” as well as maintain good health. They stated that any pregnancy-related complication can be spiritually diagnosed “exactly what the doctors do” [Interview with AtBA]. The AtBAs linked pregnancy complications and miscarriages to sin and evil spirits, and hence confession of sin is a prerequisite for spiritual healing from pregnancy complications. It is therefore not surprising that such spiritualization of pregnancy complications and miscarriages reinforce the importance of faith/divine healing (prayer, the laying of hands, use of ‘holy water’ and stones) and non-use of modern health services.

According the AtBAs, the Holy Spirit diagnoses pregnancy complications, diabetes and hypertension:

“Some of the things we do as people that pray are: the ‘holy spirit’ tells us; we are taught by the holy spirit
on what help to give based on the problem the person has" [AtBA from Paul Mwazha’s African Apostolic Church]

Consequently, Apostolic women who depend largely on AtBAs and Apostolic ‘healing camps’ (Zvitsidzo) miss out on the benefits of modern ANC services including identification and management of pregnancy complication, HIV prevention and treatment (including HIV testing, STI screening, and PMTCT), vaccination, and proper management of pregnancy-induced hypertension etc.

In the Apostolic community, the pregnancy rate is high. The more pregnancies a woman carries during the course of her life, the more she is socially valued. If she has a miscarriage, she is expected to immediately get pregnant again.

(c) Childbirth

The majority of Apostolic women deliver mainly at home or at Apostolic birth-camps (Zvitsidzo) assisted by AtBAs because of Apostolic doctrine and practices. The Apostolic birth facilities and AtBAs lack the requisite skills and equipment to deal with extreme childbirth complications including hemorrhaging, cord prolapse, prolonged labor and breach presentation etc. Childbirth complications are linked to sin and evil spirits; hence spiritualized. In the case where a young girl or woman struggled to deliver, she was emotionally abused and subjected to pain/torture through beating or burning with hot roundnuts to facilitate “confession” and enable her to push:

“Those traditional birth attendants will be saying to the mother, ‘you have something to confess. So confess.’ Time will be ticking, sometimes from morning till evening; you are just lying down and maybe into the following day. While you are lying there, you are being told to confess” [In-depth interview with Village Health Worker].

The AtBAs deal with childbirth complications and ensure smooth childbirth mainly through prayer, use of divine healing concoctions, physically administering the concoctions, and manually extracting the baby.

In general, the Apostolic ‘health systems’ – AtBAs and Zvitsidzo – lack the critical capacity to handle childbirth complications, and increase risks of maternal and newborn deaths as well as severely constrain safe motherhood. Most AtBAs expressed limited knowledge of prevention of mother-to-child transmission (PMTCT) of HIV. In addition, the AtBAs and church leaders hardly referred women presenting pregnancy and childbirth complications to modern health facility. Thus, they failed to identify pregnancy and childbirth complications in their early stages. They also lacked knowledge of danger signs or essential care for the mother during childbirth and for neonates; this compounds poor diagnosis which is often influenced by emphasis on ‘spiritual diagnosis’ and religious convictions on faith healing and spiritual counseling:

“It is their belief not to seek medical help but spiritual healing. These don’t send the women to the hospital. The women are at the traditional birth attendant for six to seven days in labor, and only when the traditional birth attendant states that it is beyond her
powers, only then can they decide to send the patient to hospital. In some cases, women come with raptured uterus; the mother might have had an obstructed labor. In others, the baby will be too big for the birth canal, so it does not come out despite good uterine contractions. The baby will finally die in the uterus” [Interview with a nurse at Murambinda Mission Hospital].

(d) Post-Partum / Post-natal Care (PNC) for Mother and Newborn

After childbirth, most women from ultra-conservative Apostolic groups continue to seek care from the AtBAs, Spiritual Healers and Zvitsidzo. They hardly openly use modern post-natal care services unless one chose to violate church doctrine on use of modern health services. In contrast, semi-conservative Apostolic women without childbirth complications seek post-natal care from the health facility within 24 hours after childbirth, mainly to get a birth record for the child as well as facilitate first immunization. However, there were instances where Apostolic women experienced childbirth complications at home or Zvitsidzo, suffered from “raptured uterus and post-partum hemorrhage”, which are some of the key causes of maternal deaths among Apostolic women in Buhera [Interview with a nurse at Murambinda Mission Hospital]. The failure of AtBAs to refer delivery complications creates challenges for a number of Apostolic women during post-partum period. In addition the AtBAs adopt traditional/non-conventional methods that potentially threaten the health of the mother and the newborn.

Therefore, AtBAs and Apostolic women’s newborn-care has glaring weaknesses due to their limited knowledge of optimal management of post-partum complications and neo-natal illness, prevention and management of HIV, care for pre-term babies including kangaroo mother care, and immediate emergency care for newborn babies. In addition, most AtBAs rarely promoted exclusive breastfeeding, and encouraged women to give their babies holy water, anointed cooking oil, thin porridge, cold tea and fizzy drinks.

Discussion of the Evidence

In applying the Social Ecological Model and Continuum of Care to MNCH challenges among Apostolic religious groups, one realizes that key MNCH and social issues were located at multiple social ecological levels. The behavior of the individual Apostolic woman has to be understood in the context of her family/peers, community, and society and policy/level (institutional) levels since she is nested within larger social systems/environments.

The poor health outcomes of Apostolic women and newborns can be tackled by addressing the challenges and barriers at the various social levels. In a community that emphasizes faith healing, use of Apostolic makeshift ‘clinics’ or Zvitsidzo, home deliveries, spiritual counseling, and care from AtBAs, there is need for targeted interventions at various levels to ensure that Apostolic women overcome steeply-entrenched Apostolic religion and developed skills for self-efficacy and empowered decision-making related to using modern MNCH services.

The findings clearly indicated the challenges within the Apostolic ‘health systems’ and lack of knowledge among AtBAs and faith healers on the contents and benefits of ANC. These limitations cause Apostolic women to completely miss out on ANC and fail to get malaria prevention, intermittent preventive treatment in pregnancy, tetanus immunization and PMTCT services. In addition, ‘spiritual diagnosis’ of pregnancy and childbirth complications potentially results in maternal deaths worsening severe complications. This undermines proper identification and treatment of medical conditions, and often result in late presentation at health facilities.

When pregnancy and childbirth complications are treated largely as “spiritual” and requiring ‘confession of sin’ and faith healing - use of holy water and anointed oil – to protect from evil spirits, medical care is marginalized. Therefore, there is need to improve the knowledge of AtBAs and strengthen referrals and linkages between AtBAs and health providers, to ensure timely update of modern health services by Apostolic women and children.
The legal/policy review on the intersection of Apostolic religion and fundamental human / constitutional rights (right to healthcare, right to education, right to dignity, freedom of conscience etc.) provided interesting insights on shifting the debate and thinking on maternal and newborn health issues. The legal/policy and advocacy interventions focus on promoting positive maternal and newborn health outcomes based on nurturing compliance with legal/policy and constitutional provisions; promoting the rights and welfare of adolescents, women and newborn babies; addressing child/forced marriages, gender-based violence (GBV), limited educational opportunities; and sub-standard and makeshift Apostolic ‘health’ centers or Zvitsidzo within the Apostolic community. In addition, legal reforms and institutional framework strengthening requires advocacy and engagement with policymakers, religious and traditional leaders on key legal/policy and social issues.

The legal/policy analysis the tension between legal/constitutional rights and Apostolic religion, and pointed to the limitations of freedom to conscience (i.e., Apostolic religious doctrine and practices) in relation to the right to healthcare, dignity and education. It raised fundamental questions on religious limitations. It debunked religious objection in light of the best interest of the child or in the interest of public health.

The argument for regulating traditional birth attendants and unregistered ‘health centers’ speaks to the threats posed by non-registered Apostolic ‘clinics’ or Zvitsidzo and operations of AtBAs to the health of mothers and newborn babies. There are fundamental gaps within the institutional framework, which therefore calls for a regulatory framework for traditional birth attendants, religious organizations and service provision. Without a regulatory framework on the operations of traditional birth attendants (TBAs) and clearly-defined acceptable minimum standards for ‘religious health services’, informal, makeshift ‘clinics or Zvitsidzo’ will increase and continue to pose risks to women and children. Therefore, the Ministry of Health and Child Care has to regulate traditional birth attendants through a clear institutional framework – policy and legislation – in order to promote safe motherhood.

In the legal review, we re-examined the legal/policy (institutional) framework in Zimbabwe, and explored gaps and opportunities in addressing religious objections to uptake of healthcare services among Apostolic women and children, child/early marriages, gender inequality, and limited educational opportunities among Apostolic children etc.
5
Apostolic Maternal and Newborn Interventions
PART 5: APOSTOLIC MATERNAL AND NEWBORN INTERVENTIONS

The Apostolic Maternal Empowerment and Newborn Interventions (AMENI) emerged from the evidence generated through desk review and operations research conducted in Buhera District, Manicaland Province in Zimbabwe. The AMENI package of interventions focuses on: (i) improving maternal and newborn child health (MNCH) outcomes through increased uptake of MNCH interventions services, and social and behavioral changes that facilitate adoption of optimal health-seeking behavior among Apostolic religious groups; (ii) reducing maternal and neonatal morbidity and mortality among Apostolic religious groups; (iii) empowering Apostolic women and adolescents for self-efficacy and decision making related to the use of modern health services; (iv) building relationship with key Apostolic stakeholders to ensure support for MNCH interventions and advancement of gender equality, social equity and rights of women and children in the Apostolic community.

AMENI applies the social ecological model (SEM) to address challenges and enable changes at individual behavior, interpersonal level (family and peers), community context, socio-cultural environment (religion, social and gender norms, and practices) and institutional level including laws, policies, health systems and practices. It examines the gaps and challenges within the Apostolic community in relation to Continuum of Care of Apostolic women and children. It targets the continuity of care of Apostolic women through the lifecycle – adolescence, pregnancy, childbirth/delivery and post-natal period for mother and newborn, and childhood. In tackling the challenges and gaps in Apostolic maternal and newborn health care, AMENI offers a multi-faceted and multi-sectorial approach to MNCH and key social issues in the Apostolic community in order to facilitate positive maternal and newborn health outcomes.

Objectives (O)

- To increase dialogue with Apostolic religious leaders and traditional birth attendants in order to nurture positive engagement and changes that support positive outcomes among Apostolic religious groups (O.1. Apostolic Engagement and Relationship Building)
- To increase awareness among Apostolic adolescents of ASRHR and opportunities to stay longer in school (primary, secondary to tertiary), and equip them with knowledge and skills to prevent early/child marriages and adolescent pregnancies (O.2. Adolescent Empowerment)
- To increase acceptability and uptake of modern MNCH services among Apostolic women (O.3. Maternal Empowerment)
- To increase religious acceptability of, and reduce barriers to, modern MNCH interventions and educational opportunities, and gender equality among the Apostolic community (O.4. Behavioral and Social Change)
- To increase skilled attendance at delivery among Apostolic women; timely referrals of pregnant women to health facilities by Apostolic traditional birth attendants (AtBAs); and effective / improved links between Apostolic healthy systems and modern health facilities (O.5. Health Systems Strengthening)
- To facilitate enabling policy/legal environment for positive MNCH outcomes and rights of women and children (O.6. Policy and Advocacy)

Anticipated outcomes (AO)

- Reduced Apostolic maternal and neonatal morbidity and mortality due to preventable conditions and religious objection
- Increased knowledge, awareness and acceptability of ASRHR and modern MNCH among Apostolic religious leaders and AtBAs (AO.1. Apostolic Engagement and Relationship Building)
- Empowered Apostolic adolescents with knowledge of ASRHR and other rights; and advancing educational opportunities;
and delayed sexual debut and increased age of marriage and first childbirth (AO.2. Adolescent Empowerment)

- Increased uptake of ANC services due to improved self-efficacy: this enables improved SRH and use of MNCH services (including increased/early ANC uptake with 4+ ANC visits; skilled birth attendance; improved PNC for maternal and newborn care) among Apostolic women (AO.3. Maternal Empowerment)

- Increased acceptability of modern MNCH interventions, educational opportunities, and gender equality among members of the Apostolic community, particularly religious objectors (AO.4. Behavioral and Social Change)

- Increased referrals by AtBAs and Apostolic faith healers to, and improved links with, modern health facilities (AO.5. Health Systems Strengthening)

- Improved enabling environment for positive MNCH and rights of Apostolic women and children (AO.6. Policy and Advocacy)

**Brief Description of AMENI**

The AMENI intervention model targets behavioral and social changes of key Apostolic community stakeholders (religious leaders, women of reproductive aged 15-49, adolescents, Apostolic traditional birth attendants, and Apostolic men) in order to improve MNCH outcomes among Apostolic religious groups. It facilitates processes that strengthen dialogue and engagement with these key Apostolic stakeholders as part of penetration and relationship building as well as generate demand for MNCH services.

The AMENI intervention operate in ways that support on-going multi-sectorial interventions and reinforce synergies and complement efforts of other development partners and government in achieving intended health and developmental outcomes among Apostolic religious groups. This package of interventions incorporates short-term, medium and long-term strategies aimed at reducing maternal and neonatal morbidities and mortality among Apostolic religious groups by tackling barriers and drivers of health and social inequities within the Apostolic community.

The AMENI intervention has six major components:

(a) Apostolic Penetration and Relationship Building
(b) Adolescent Empowerment and ASRHR
(c) Maternal Empowerment
(d) Behavioral and Social Change
(e) Health Systems Strengthening
(f) Policy and Advocacy

All these seek to address legal/policy gaps and strengthening rights. It rests on a “theory of change” that seeks to empower Apostolic women and female adolescents to exercise their rights, achieve self-efficacy in the face of restrictive religious doctrine and the uptake of modern services, and promote transformative dialogue and engagement that nurture positive MNCH outcomes.

Specifically, the intervention addresses key Apostolic religious doctrine, beliefs, attitudes and social norms relating to the use of maternal and new born services/interventions and the rights of women and children. Drawing on evidence-based information, this intervention takes a holistic, multi-sectorial, participatory and multi-faceted approach to address socio-cultural and religious drivers of Apostolic objection to modern health services (ASRH, family planning, ANC, skilled attendance at delivery, PNC etc.), poor Apostolic maternal and child health outcomes, child/early marriages, teen pregnancies, and limited educational opportunities for Apostolic children. It also deals with the lack of awareness of adolescents sexual and reproductive health and rights, challenges of gender inequality, health and social inequities, weak child protection, and continued reliance on Apostolic makeshift facilities for the care of women and children.
As a package of interventions, the AMENI intervention model applies communication for development (C4D) strategies to facilitate behavioral and social changes, dialogue, and advocacy among targeted audiences at the various social ecological levels – individual, interpersonal (family & peers), community, social-cultural environment and institutional levels including policies/laws, health systems (health service delivery), social welfare and child protection.

It focuses largely on the demand-side – it is mainly about facilitating the shift in the behaviors, attitudes and practices of key Apostolic stakeholders’ (religious leaders, Apostolic faith healers, Apostolic traditional birth attendants, women of reproductive age, female adolescents, Apostolic men and male adolescents), in relation to the uptake of modern health services. This entails the promotion of key messages and communication materials to increase awareness of rights, available resources and nurture self-efficacy particularly of women and female adolescents so that they optimally-uptake modern health services.

**Core Elements of AMENI**

The AMENI package of interventions rests on the Apostolic Community Transformation (ACT) theory of change, which recognizes the need for Apostolic members to confront radical religious beliefs and contextual barriers undermining health, education, gender equality, and other development goals. It recognizes the fundamental importance of relationship building (dialogue, engagement, and penetration) with key Apostolic stakeholders in facilitating processes that nurture empowerment, self-efficacy, uptake of modern MNCH and sexual and reproductive health services, and promoting health and social equity. The transformation manifests in the transition from religious objection to acceptability and use of modern MNCH services and advancing social equity and the rights of women and children.

Therefore, AMENI is a sub-component of the broader theory of change, the Apostolic Community Transformation, which will ensure demand generation for MNCH services (including ANC, skilled birth attendance, immunization, PNC, sexual and reproductive health services, HIV prevention and treatment, etc.) and tackle religious barriers to uptake of health services. In overcoming religious objection and enabling acceptability and the use of modern MNCH services, AMENI requires religious engagement and sensitivity to the needs of the Apostolic community.

**Hence, the effectiveness of AMENI depends on the following key elements:**

- Demand generation strategies that are built on active participation of key Apostolic stakeholders, mainly religious leaders, faith healers (prophets, influential church members with the ‘anointing’ of the Holy Spirit/Mweya), Apostolic traditional birth attendants/AtBAs, and women of reproductive age, men and adolescents
- Sensitization and dialogue with Apostolic leaders and local community/traditional leaders
- Apostolic community mobilization and action around key health and social issues is critical for change, and requires strengthening understanding of the scale of the challenges within the community
- Health providers, civil society organizations and various government agencies positively engage Apostolic and Zionist ecumenical bodies (e.g., UDACIZA & Apostolic Christian Council of Zimbabwe/ACCZ) in identifying and overcoming critical health and social challenges within the Apostolic and Zionist community in Zimbabwe. In addition, the service providers should be willing to explore new innovation in the provision of services to the Apostolic community, particularly religious objectors or ultra-conservative Apostolic sects. The interventions of the various development partners and service providers have to be religious and culturally sensitive to the Apostolic community, and address both pragmatic (practical) needs and strategic needs
- Targeted adolescent and maternal empowerment strategies that strengthen self-efficacy (empowered decisions and choices) and behavioral change for optimal healthcare seeking behaviors
Community dialogue and consultations to facilitate engagement with community and religious structures, and improve understanding of local MNCH and social challenges, and needs of the local Apostolic community. In fostering trust, respectful and meaningful engagement between Apostolic religious groups, other community stakeholders and service providers is essential.

Enabling environment that facilitates the realization of rights of Apostolic women and children to healthcare (accessing quality MNCH services), education, dignity, and life while exercising their freedom to conscience (right to practice religion). Therefore, policy and advocacy form key aspects in the facilitation of an enabling framework, and must be supported by the political will to address the key health and social challenges within the Apostolic community (see Figure 5 below).

**Figure 5: AMENI Framework**

**APOSTOLIC MATERNAL EMPOWERMENT & NEWBORN INTERVENTIONS (AMENI)**

- Reduced Apostolic maternal and neonatal morbidities and mortality due to preventable conditions and religious objection
- Increased engagement with Apostolic religious leaders and groups
- Decreased religious objections to MNCH and SRH interventions, educational opportunities & gender equality
- Increased religious acceptability of modern MNCH services supported by behavioral and social changes among key Apostolic stakeholders
- Increased access to MNCH services for Apostolic religious groups through improved links and referrals, and enabling environment

**Supply-Side Strengthening**

- AIBAs referral and links with health facility
- Service innovation and sensitivity to the needs and religion of Apostolic members; training & workshops for AIBAs to improve care
- Policy & advocacy; regulatory framework for traditional birth attendants & 'informal clinics'
- C4D strategy and Social Behavioral Change
- Communication targeting Apostolic groups

**Demand-Side: Apostolic Engagement, Empowerment & Mobilization for MNCH Services Uptake**

- Apostolic community mobilization around child marriage norms, and social norms that inhibit positive MNCH outcomes & social equity. Apostolic community dialogue
- Relationship building initiatives; adolescent & maternal empowerment activities – life skills education, livelihood programs

**Key Apostolic MNCH & Social Issues (Qualitative)**

- Early/child marriages; high adolescent pregnancies; limited educational opportunities; unsafe abortions; negative attitudes on SRH
- Low ANC/PNC services uptake, objection to MNCH services, spiritualization of pregnancy/delivery complications; spiritual diagnosis & monitoring of pregnancy; emphasis on faith healing; unsafe delivery practices by AIBAs; limited HIV testing; low rate of institutional delivery; use makeshift birth camps/Zvitsidzo; abuse of women during delivery; delays in referrals; unreported maternal and newborn deaths – “the invisible, faceless, nameless”;
- Limited knowledge of danger signs for mother and newborn; poor neonatal care & feeding practices; modern family planning objected
- Religious objections based on radical beliefs and entrenched doctrine of founding fathers of Apostolic sects
**Contextual Factors:**
- Enabling legal/policy environment & regulatory framework
- Political and economic conditions that allow for appropriate Apostolic engagement and AMENI funding
- Development partners with appropriate programmatic responses for MNCH among Apostolic groups
- Multi-faceted development & poverty alleviation interventions

**Medium Term Change:**
- Changes in gender/social norms: Apostolic adolescent with increased age of marriage, school enrolment & more years in school; use ASRH services
- Apostolic women: engaged in multi-component empowerment initiatives including income generation & livelihoods, education and health/WASH forums, & family planning
- Apostolic community engaged in policy & advocacy, and influence MNCH & social interventions
- Multi-sectoral approach to the development challenges & needs of Apostolic religious groups

**AMENI Vision:**
"No Apostolic woman & newborn dying from preventable conditions due to religious objections and sociocultural barriers"

**Long Term, Lasting Changes:**
Apostolic community with improved MNCH outcomes and reduced maternal & neonatal mortality

**Key Assumptions:**
- Apostolic community stakeholders (& religious objectors; Apostolic ecumenical bodies) sufficiently reached & engaged, and accept AMENI.
- Appropriate C4D strategy
- AMENI interventions implemented as planned & achieving intended outcomes
- AMENI with sufficient funding & resources, and appropriate implementation framework
- Enabling political and economic environment to facilitate AMENI

**AMENI Implementation**
A multi-faceted, multi-sectorial approach is needed in implementing the AMENI package of interventions given the diverse drivers and challenges of MNCH and social inequities among Apostolic religious groups in Zimbabwe. In addition, the sheer size of the Apostolic community population within Zimbabwe presents huge demand on efforts and resources to tackle the challenges. However, implementing AMENI at the local (village or ward), district, provincial and/or national levels requires consideration of the diversity
of the Apostolic community based on the extent of religious objection to the use of modern health services, the type of services, and available channels of engagement with the specific leadership of that Apostolic religious group. A "one-size-fits-all approach" to implementation of AMENI will undermine its success.

**Keys to Success:**

- Be cognizant of the key elements of AMENI, and focus on relationship-building through persuasion, community consultation and mobilization, and meaningful engagement with progressive religious leaders and sects. Apostolic community engagement provides the avenue for sustained participation and ownership of the interventions.

- Work with Apostolic leadership and religious structures at various levels to facilitate buy-in of the interventions. It is essential to leverage the influence of the founding fathers and influential leaders of the Apostolic churches as well as engage their immediate network/circle of leadership including family members with influential positions in the church.

- Improve knowledge and awareness of MNCH and social issues within the Apostolic community, particularly among religious leaders, AtBAs and women to motivate behavioral and social changes.

- Invest in processes that nurture trust and confidence in the AMENI interventions, and overcome suspicion among Apostolic religious groups while improving understanding of key MNCH and social issues as well as the benefits of the interventions.

- Identify influential role models (positive agents of change) within the Apostolic community and broader local community in order to facilitate relationship building and dialogue on critical MNCH and social issues.

- Emphasize practical, pragmatic benefits of modifying Apostolic doctrine and practices, and recognize that changes to core religious and socio-cultural aspects Apostolic religious identity may take time.

- Explore confluence of interests between the Apostolic community (leaders) and development partners and health providers, and find collective, shared solutions to the MNCH and social challenges among Apostolic religious groups.

- Avoid labeling and stereotyping the Apostolic community members, and appreciatively build on positive attributes of Apostolic religion and practices while exploring aspects that could be re-examined for improved MNCH and social outcomes.

- Incentive framework (i.e., conditional cash transfers or vouchers) for facilitating uptake of modern MNCH services among targeted pregnant and post-partum women belonging to ultra-conservative Apostolic groups (religious objectors).

**Barriers to Implementation:**

- The primary barriers or challenges to effective implementation of AMENI include religious objection to the interventions by Apostolic religious leaders and key influencers within the ultra-conservative sects.

- Resistance to recommended behavioral and social changes.

- Resistance by ultra-conservative Apostolic sects with radical religious beliefs towards health and education, and demanding members’ strict commitment to doctrine of the founding fathers of the Apostolic sects or church.

- Religious and socio-cultural beliefs and practices that militate against AMENI interventions. The “double-burden” of religion and tradition adds to the complex challenges faced by women and children in the Apostolic community.

- Failure to engage Apostolic sect founders, leadership structures, and wives of Apostolic leaders.

- Lack of Apostolic male involvement in the interventions.

- Apostolic leaders and members’ attitudes towards modern health services, and continue to emphasize faith healing rather than refer members to health facilities for medical treatment and care.
AMENI primary beneficiaries (female adolescents and women of reproductive age particularly from ultra-conservative Apostolic groups/religious objectors) may be difficult to openly recruit and retain longer in the interventions because of fear and/or religious sanctions imposed for participating in health-related initiatives.

Production and re-production of stereotypes of Apostolic religion, which may entrench prejudice, discrimination, and intolerance towards Apostolic religious groups/members. This undermines understanding of the diversity within the Apostolic community, and contributes to banding together of all Apostolic members as “polygamists; averse to western medicine, shave their heads, wear white robes and that they all do not send their children to school” (Chari 2014:123).

Lack of understanding of diverse religious practices and differences within Apostolic religious groups potentially weakens situational, appropriate application of AMENI interventions to different Apostolic groups with varying levels of objection or tolerance of modern MNCH services.

Failure to recognize positive shifts within specific Apostolic sects as well as transitions in leadership values, beliefs, teachings, and practices.

Inability to re-engage the Apostolic leaders and community in re-interpreting the original Apostolic doctrine, beliefs and practices in the context of modern values and emergent public health threats in modern society.

Political expediency or lack of political will in addressing MNCH and social issues within the Apostolic community (Manyonganise 2014).

Lack of resources committed to AMENI.

Possible Benefits of the AMENI Model

The AMENI model has the following potential benefits:

Direct Benefits:

- Improved engagement – dialogue and understanding – with Apostolic religious leaders and key stakeholders
- Improved awareness and knowledge of MNCH issues, rights of women and children and key social challenges among Apostolic leaders, AtBAs and female Apostolic adolescents, and women
  - Sensitization, training and improved understanding among religious leaders and AtBAs to address negative attitudes towards modern MNCH services and encourage them to support Apostolic women’s uptake of these services
  - Dialogue on doctrine on religious objections to MNCH services and modern family planning
- Improved uptake of MNCH and SRH services among empowered Apostolic women and adolescents
  - Improved self-efficacy among Apostolic women and female adolescents
- Improved referrals by AtBAs due to strengthened links between AtBAs and health providers
- Multi-faceted, multi-sectorial approach and engagement with the Apostolic community in order to address the drivers of health and social inequities
  - Overall benefit: reduced maternal and neonatal morbidity and mortality among Apostolic religious groups who objected the use of modern MNCH services
  - Improve access to SRH, ANC and PNC
services as well as the adoption of modern FP methods

- Improved health service delivery to the Apostolic community through service innovations such as outreach service and flexible opening/closing times to meet the needs of the Apostolic religious groups
  - Improved attitudes and religious-cultural sensitivity of health providers
  - Transformed relationship between the Apostolic community and health providers and development partners
- Creating Apostolic-friendly spaces for improved uptake of MNCH and other health services
- Exploring task-delegation to AtBAs on simple, less-risky pregnancy and childbirth cases but allowing for effective referral mechanisms and links to a health facility for Apostolic members / patients showing danger signs
- Improved neonatal health and child protection
- Improved maternal and neonatal death monitoring and strengthened maternal and newborn surveillance and follow-up systems. This is critical in monitoring and improving assessments of, and responsiveness to, drivers of maternal and neonatal deaths in the community. Strengthened surveillance and follow-up systems will enable health providers to actively seek pregnant and post-partum women, and newborns at-risk rather than waiting for Apostolic members to seek the MNCH services.

Indirect Benefits of AMENI Model:
- Policy and advocacy initiatives that facilitate an enabling environment for the realization of positive MNCH outcomes and development goals
- Regulatory framework on traditional birth attendants and religious-based health service delivery for non-registered religious groups
- More health providers / development partners with Apostolic-friendly approaches to programming and service provision
- Strengthening linkages between MNCH and other human rights and child protection
- Promoting a multi-faceted, multi-sectorial approach to MNCH issues and social equity in the Apostolic community in Zimbabwe

Limitations of AMENI Study Design:
- Insufficient data on Apostolic religious community in Buhera District, and nationally
  - Limited quantitative evidence and disaggregated data on the Apostolic community in Zimbabwe. The evidence was largely qualitative based on case studies and limited samples that lack representation or generalizability
  - Lack of a clear, universally acceptable typologies on the Apostolic community / religious groups, hence posed challenges in objectively determining whether the group can be termed ‘religious objector’ or not
  - Time and resource constraints for the primary research, which required ethnographic methodology to build trust and rapport with ultra-conservative Apostolic groups / religious objectors

However, the consultants had had prior experience researching Apostolic religious groups, which provided insights on possible processes and practices that could facilitate the success of the AMENI package of interventions. Such insights were also useful in identifying challenges or barriers to AMENI implementation success. The past research experience and relationship established with UDACIZA increased opportunities for local buy-in and support of Apostolic stakeholders, and ensured that UDACIZA played a critical role in mobilizing study participants.
Conclusion and Recommendations
CONCLUSION & RECOMMENDATIONS

This report has attempted to answer a fundamental question; how can members of Apostolic religious groups, particularly religious objectors be supported to increase their uptake of modern MNCH services (ANC, institutional delivery, PNC, family planning services, and immunization) and tackle drivers of social inequities in the community? In answering this question, various sources of evidence were utilized, and legal/policy review conducted to examine the tension between Apostolic religion and the law in Zimbabwe.

Evidence points to high maternal and neonatal deaths among Apostolic religious groups (Ha et al. 2011); it is indisputable that women and children are denied access to modern healthcare due to religious objections. The literature review and primary research findings clearly indicated that Apostolic religion (particularly ultra-conservatives / religious objectors) undermine fundamental rights of women and children resulting in needless or preventable deaths of women and children to health conditions that could easily be managed by medical care. Consequently, the lives of women and children are sacrificed at the alter of religion, religious doctrine, beliefs and practices. (Maguranyanga, 2012).

Given the evidence pointing to the increased maternal and neonatal deaths among Apostolic religion, should the right to conscience [i.e., Apostolic religious beliefs] set in the clause in the new Constitution be indisputable? Sociologically, it should be disputable recognizing that women and children are denied access to modern healthcare due to religious objections, and hence fundamentally affecting their right to healthcare. Some Apostolic religious groups practice child marriage, virginity testing, and public shaming of girls/adolescents who are not virgins, and often have radical views on family planning (sexual and reproductive health). All these highlight harsh realities of religion in modern society.

In view of the needs of modern Zimbabwe, re-examination of Apostolic religion in the context of applicable laws and regulations is critical. Collective responsibility of society to ensure rights of women and children is required. This report therefore makes a clear plea for addressing the intersection of Apostolic religion and the law in Zimbabwe, and provides a framework for addressing the conflict between religion and the fundamental human rights of women and children, and creates opportunities for improving maternal and child health outcomes among Apostolic religious groups.

This report tackles the key legal and sociological question about the use and consequences of legal instruments (sanctions) to drive changes in Apostolic doctrine and practices related to maternal and child health and negatively affecting the rights of women and children. It advises against a heavy handed response in the use of legal sanctions but rather calls for variable responses – “carrot or stick” – depending on the extent to which persuasion, dialogue and engagement with Apostolic religious leaders and community fare. It argues that persuasion and education present viable change approaches to behavioural and social change and to induce modification in Apostolic practices and behaviors. It notes that the law could also harden attitudes of Apostolic leaders and sects, particularly ultra-conservative sects whose doctrine, beliefs and practices have been long-standing.

Therefore, the law can have a countervailing influence when applied indiscriminately for social change without paying attention to persuasive techniques (soft approaches – persuasion, dialogue, engagement) first. A delicate balance has to be struck; the use of legal interventions when soft approaches have failed and sending a clear warning that the wrath of the law will be applied in the absence of desirable changes in behaviors and practices.

In contrast, there has been realization that criminalization of certain long-standing cultural practices may not necessarily free women and children totally from patriarchal structures and practices, which continue to limit women and children’s ability to demand their rights. There is need to recognize that the Apostolic religious community
commands strong political influence in Zimbabwe, which makes them a key political constituency in the voting and political landscape. Given the Apostolic community’s political muscle, there are limitations to the extent to which applicable laws and regulations can be enforced, consequently resulting in political expediency. Maguranyanga (2012) argues that the lives, rights and health of women and children are being sacrificed at the altar of Apostolic religion and political expediency. Essentially, lives are lost to preventable deaths due to religious objections to modern medical care medicines.

However, the Government of Zimbabwe has demonstrated its capacity and political will to address cultural and traditional practices that violate the rights of women and children, and were antithetical to modern values and human rights. In such cases, legal instruments / interventions have been deployed to change the social fabric and practices, and send clear signals and messages to communities that certain traditional / cultural practices are unacceptable in modern society. Consequently, legal interventions prove that certain things are not acceptable, and that society has collectively sanctioned certain behaviors and practices with penalties for non-compliance or violation of the values stipulated in the law. Legal instruments (laws and regulations) make it possible for women and children to break free from the shackles of ultra-conservative, traditional practices and entrench the legal rights and interests of women and children.

In meeting the needs of modern Zimbabwe, religion should not be a forgotten variable as it has a bearing on the health and rights of women and children. No Zimbabwean woman or child should be left to die because of religious doctrine or objection. The AMENI package of interventions calls for concerted, targeted efforts to address the drivers of poor MNCH outcomes and social inequities among Apostolic religious groups in Zimbabwe.

Based on the legal review and operational research, we recommend the following:

- Multi-sectorial approach to AMENI implementation, guided by a clear implementation framework with programmatic priorities and responses and resourcing approach.
- Operationalization of AMENI for implementation.
- Effective engagement of Apostolic ecumenical bodies (UDACIZA and ACCZ) for mobilization of Apostolic religious groups (Matikiti 2014).
- Apostolic leadership and AtBAs forums at district, provincial and national levels to address key social issues within the Apostolic community, and facilitate dialogue and social mobilization.
- Interpersonal communication (IPC) with key Apostolic religious leaders, including the remaining founding fathers and families of the Apostolic churches in Zimbabwe.
- Emphasis on engagement, persuasion and information dissemination to try to induce members of the Apostolic faith to make greater use of maternal and neo-natal health care services so as to reduce maternal and neonatal morbidity and mortality.
- Respectful engagement and dialogue with key Apostolic groups such as Apostolic ecumenical bodies, religious leaders, Apostolic traditional birth attendants, and members of ultra-conservative groups, including women and female adolescents.
- Education and awareness raising on values and rights contained in the new Constitution and the various laws and Government amongst Apostolic adherents, particularly those relating to maternal and neo-natal health care.
- Campaigns to increase knowledge and awareness among Apostolic adolescents of Adolescent Sexual and Reproductive Health and Rights, and empower them to assert their right to health care.
- Apostolic adults-focused campaigns to overcome the Apostolic objection to modern, secular education and ensure that girls are given opportunities to attend and stay longer in school. This enables them to acquire with knowledge and skills.
to avert child marriages and adolescent pregnancies. However it should be noted that the present Education Act [Chapter 25:04] does not obligé parents and guardians to take their children to school, and does not make it a criminal offence for parents and guardians not to take their children to school.

- Enforce the law and legal interventions if persuasive soft techniques (dialogue, persuasion and engagement) fail but recognize the social and political challenges and limitations associated with legal interventions.
- Apostolic community-focused social and behavioral change communication (SBCC) strategy with key messages for addressing barriers to desired changes and utilization of modern health services.
- Collaborative health and social interventions, particularly with Apostolic sects already displaying signs that they were amenable to persuasion and change. Dedicate resources to support and encourage changes in patterns of behavior.
- Recognize the limitations of directly targeting ultra-conservative Apostolic sects with health and social interventions. Rather, take a community-wide approach that equally addresses the issues/challenges and thereby allowing untra-conservative Apostolic sects to benefit as part of the community.

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ZIMSTAT (2012) Zimbabwe Demographic and Health Survey 2010/11, Harare: ZIMSTAT


Zimbabwe Legislation:

Children’s Act [Chapter 5:06]
Criminal Law (Codification and Reform) Act [Chapter 9:23]
Customary Marriages Act [Chapter 5:07]
Education Act [Chapter 25:04]
Medical Services Act [Chapter 15:13]
Public Health Act [Chapter 15:09]
Termination of Pregnancy Act [Chapter 15:10]

International Human Rights Conventions:

The Convention on Economic, Social and Cultural Rights
The Convention on the Rights of the Child
The African Charter on the Rights and Welfare of the Child
The Convention on the Elimination of All Forms of Discrimination against Women
The African Charter on Human and Peoples’ Rights on the Rights of Women in Africa
Annex:

Resource Mapping: An Overview

A rapid resource mapping of civil society organizations, community-based organizations and development partners in Buhera District was conducted to determine the services provided, by whom, where, and how. The resource mapping exercise provided insights into available services and development interventions, and their relevance to targeted the Apostolic community. The gathered evidence fed into the AMENI design, and offered lessons on ways of working that could be beneficial to the Apostolic community.

Government is the main key partner and leads most of the development interventions while working with civil society and community-based organizations to reach the community. The following line ministries are critical in the implementation of AMENI:

(i) Ministry of Health and Child Care
(ii) Ministry of Primary and Secondary Education
(iii) Ministry of Women’s Affairs, Gender and Community Development
(iv) Ministry of Justice and Legal Affairs
(v) Ministry of Home Affairs
(vi) Ministry of Local Government, Public Works and National Housing

The civil society organizations have various capacities and levels of experience that could benefit work with Apostolic religious groups. The list below shows some of the organizations that could play a part in the specific components of AMENI:

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<th>AMENI Intervention</th>
<th>Organization</th>
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<td>Penetration and Relationship Building</td>
<td>• Union for the Development of Apostolic Churches in Zimbabwe (UDACIZA)</td>
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<td>• Apostolic Churches in Zimbabwe (ACZ)</td>
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<tr>
<td>Maternal Empowerment</td>
<td>• World Vision Zimbabwe</td>
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<td>• Goal</td>
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<td>• Musasa Project</td>
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<td>Social and Behavior Change</td>
<td>• New Life</td>
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<td>Health Systems Strengthening</td>
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<td>• Goal</td>
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<td>Addressing Legal and Policy Gaps</td>
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<td>• Musasa</td>
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<td>• Legal Resources Foundation (LRF)</td>
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