



## **Working with religious institutions to provide Sexual and Reproductive Health Services for adolescents and youths**

**What barriers and what enabling factors can prevent or ease a fruitful collaboration**

Author: Valeria Sau

## Summary

CARE designed the Vijana Juu project (Swahili for “Up with Youth”) in collaboration with adolescents and youth<sup>1</sup> in the Democratic Republic of Congo (DRC). The project aimed to improve the youth-friendliness of reproductive health services for adolescents in Goma to improve their access to SRH services including family planning, while increasing their ability to create positive change in their lives and communities.

The Vijana Juu model is founded on a 3-pillar strategy based on proximity between health facilities, schools and churches. In a context like the DRC, where the State does not have the capacity to support health services, particularly in crisis-affected areas, many essential services are provided by religious institutions, primarily churches. Because of this the project adopted an approach where the church took a leading role facilitating access to health services in the facilities they run.

The project adopted a bottleneck approach focusing on both supply and demand side factors. On the supply side, the project promoted a youth-friendly approach, the provision of specific adolescent SRH supplies, ensured free availability of services and commodities to adolescents and youth, and improved accessibility of the health facilities. At the same time, it worked on the demand side by engaging youths, increasing knowledge on SRH, promoting engagement and community dialogue around SRH.

Using a qualitative approach based on in-depth interviews with key informants we took a deeper dive into the way that churches worked with the project to facilitate access to healthcare and found that churches offer a potentially powerful way to engage young people with issues of sexual and reproductive health.

The role of religious leaders and churches as partners was central to the success of the project. Churches were able to facilitate youths participation both because they are the ones running the schools and also because of their moral authority and influence within the community and their ability to endorse or to sanction the use of services.

Sexual and Reproductive Health among adolescents and youths can be a sensitive topic for a church whose doctrine preaches the sanctity of marriage and condemns the use of modern contraception, sexual intercourse outside marriage and abortion. Nonetheless, under this project CARE succeeded in partnering with four churches (one Adventist of the Seventh Day and three from the Central Africa Baptiste Community – CBCA) to provide free Sexual and Reproductive Health (SRH) services for adolescents and youths at the health centre of the church, on the church’s premises. The services were designed to meet the specific needs of young people. Compared to other Sexual and Reproductive Health programmes implemented in Goma that target the adult population and are more focused on family planning, this project included the provision of condoms, emergency contraception and treatment for STIs. Health and non-health staff in the structures were trained on youth-friendliness approaches, and youths and adolescents were consulted through a participatory approach to define what youth-friendly meant to them and to develop indicators to monitor the implementation of the project.

Given the peculiarity of this collaboration, interviews were conducted in order to better understand barriers and enabling factors, both internal and external that had a role in establishing this successful partnership. The main aim is to establish patterns that could guide CARE’s and other

---

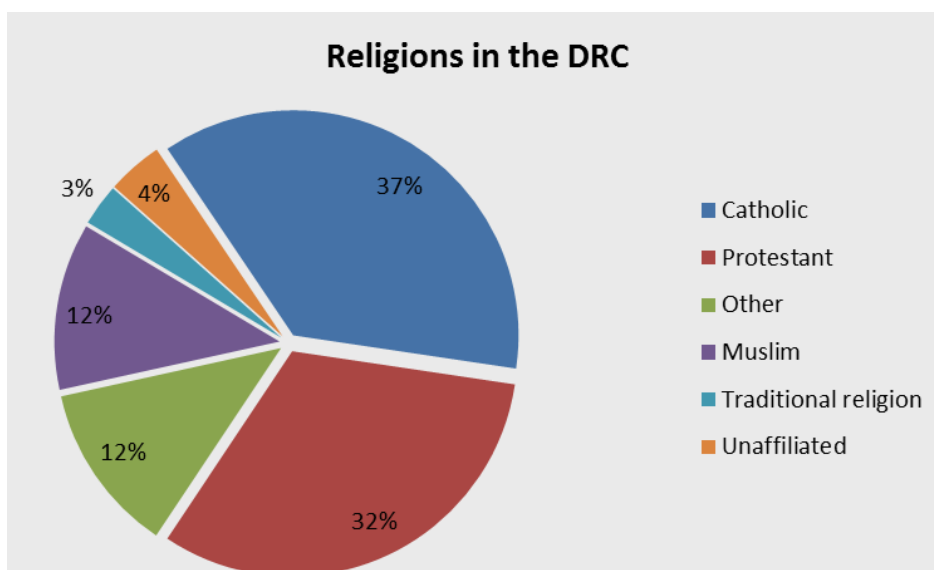
<sup>1</sup> The project targeted young people aged 15-24 years old but supported also young adolescents between 10-14 years old gaining access to care.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

NGOs' work in replicating the approach with other religious partners and, as much as possible, in adapting it for new, different contexts.

### Context

The Democratic Republic of Congo is a predominantly Christian country. 80% of its population is affiliated to a protestant (40% of Christians) or a Catholic (46%) Church. The remaining 20% is Muslim (12%), affiliated to a Traditional religion (3%) or unaffiliated to any group (4%)<sup>2</sup>.



The DRC exhibits “very high” levels of gender discrimination, with the inequality between men and women embedded into the Family Code<sup>3</sup>. According to UNFPA<sup>4</sup>, 76% of women and girls aged 15-24 think that wife beating can be justified. With regards to access to SRH services, only 12.5% of married women 15-24 are using a method of contraception, and this percentage drops to 5.4% country-wide for modern methods of contraception. Abortion is illegal, except in cases when the mother’s mental or physical health is in danger. As a consequence young women and girls facing an unwanted pregnancy often resort to unsafe and illegal abortion.

The baseline study conducted by CARE in March 2016 in the areas of Goma where the project was implemented, indicate that 33.5% of youths aged 15-19 and 80.7% of youths 20-24 already had a sexual experience (n=709). Out of them, 20.5% of girls 15-24 gave birth and 11.2% were pregnant with their first baby at the moment of the survey. 47.5% of girls sexually active had an unwanted pregnancy.

Many essential services that the State is unable to supply, such as education and healthcare, are provided by different religious institutions as a means to address the needs of the population. This service provision further reinforces the link between communities and churches that do not simply provide spiritual guidance to their flock, but frequently also a lifeline.

<sup>2</sup> Pew Research Centre <http://www.pewforum.org/files/2010/04/sub-saharan-africa-chapter-1.pdf>

<sup>3</sup> With respect to parental authority, the Family Code stipulates that men are the head of the household and women must obey them. <https://www.genderindex.org/country/congo-democratic-republic/>

<sup>4</sup> <http://www.unfpa.org/data/adolescent-youth/CD>

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

It is against this backdrop that the project established the three pillars approach “church, health centre, school”, mindful of the pivotal role churches play in everyday life.

### Methodology

Our research is based on face to face Key Informants Interviews with religious leaders<sup>5</sup>. Each interview took around one hour to complete to allow enough time to explain the purpose of the exercise, build trust and cover four major topics:

- i) Governance structure and decision making process of the church;
- ii) Sexual Reproductive Health and Family Planning;
- iii) Personal engagement;
- iv) Working with CARE.

We interviewed 8 representatives from four church partners (including 7<sup>th</sup> Day Adventists and Central Africa Baptist Community, CBCA) and 6 representatives from three non-partners (Catholic Church, Community of Pentecostal Churches of Congo, CEPAC, and Awakening Church.

The findings of this work have a number of limitations:

- Gender representation: all the persons interviewed were male. Although some women do hold positions of responsibility within church management, their roles are usually administrative and they do not play a liturgical role. Because this study focused on the interplay between health science and church doctrine it was necessary that the study was limited to include only male informants, as the ones who act as pastoral leaders for the community and who have a greater decision-making power within their church.
- Limited sample: CARE worked with four Churches from two religious groups, which limited the size and the variety of the sample to interview. To broaden the perspective of this study, we collected views from non-partners from three other churches on the provision of SRH services to adolescents and youths.
- No baseline: this study focuses on the factors that helped or hindered the collaboration, rather than on the aspects that led to the collaboration itself.

Finally, we need to take into account the ethical and reputational risks faced by CARE and the respondents in conducting this survey. Sexual and reproductive health is a sensitive subject for all religions. Speaking openly on issues of sexual and reproductive health and family planning for young, unmarried couples, and promoting access to free family planning can be misinterpreted as an attempt to promote promiscuity and risky behaviours.

We accept that in some circumstances partners may feel uncomfortable responding to questions regarding specific activities conducted under this project and that drawing too much attention on these sensitive topics might led to the interruption of their collaboration with CARE. This concern occasionally informed our line of question in cases where it emerged the respondent has maintained a certain distance from the activities taking place in the health centres and was not

---

<sup>5</sup> This evaluation covers only CARE's collaboration with religious partners. Other aspects on the achievement of the project objectives have been analysed in an external endline evaluation which included both quantitative and qualitative data collection from beneficiaries and key stakeholders.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

entirely informed of the full extent to which emergency contraception, long term contraception and post-abortion care are provided.

Similarly, when interviewing non-participating church leaders to whom we explained the project's main activities, we had to ensure the reputation of those who did actively participate in the project. The experience confirmed the sensitivity of topics such as Emergency contraception, by some regarded as an incentive to interrupt unplanned pregnancies<sup>6</sup>.

## Findings

The analysis looked to identify similarities and differences among partners and between partners and non-partners. The key research questions were:

1. What pre-existing factors are necessary to work with churches on SRH services for adolescents and youths?
2. What role, if any, did CARE play in facilitating this collaboration?

To answer the first question, we looked into internal aspects of the church, from the governance and the structure, to the way they address health issues, the personal engagement of the Pastor, their commitment to reach vulnerable members of the community, etc.

The second question focused on how CARE approached the church, if CARE was instrumental in directing the church's attention to SRH or if the church had previously engaged in it, what practical difference it made for the church to work with CARE, and if they encountered any internal (within the church) or external (from their congregation/community) resistance. For non-partners, we asked about their structure, if they were aware of the work CARE does with other churches, their opinion around it and if they would be scoping the possibility to work on SRH in a similar way (and if not, what are the barriers to that).

## Governance

Churches have a very clear structure with defined roles and responsibilities at all levels. Across different denominations<sup>7</sup> decision making processes vary considerably from one church to another where councils, assemblies and individuals can have more or less influence on the final outcome. CARE chose to partner with churches that enjoy a good level of autonomy from the global leadership.

For the purpose of this study we considered that there are two types of leadership decisions that church leaders/pastors take for their community:

1. They are responsible for the pastoral care of the believers, their spiritual guidance and for the propagation of the doctrine.

---

<sup>6</sup> Abortion is illegal in DRC. In respect of the law of the country, CARE did not provide abortion services nor train medical staff on how to perform an abortion. Post-abortion care is however a legal life-saving intervention included in our programme as part of the comprehensive SRH services, to ensure everyone has access to free and safe health care.

<sup>7</sup> Unless differently specified the general term *religions* refers to all the religious groups interviewed for this study: Adventist, Baptist, Pentecostal, Awakening and Catholic churches.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

2. They exercise their leadership over the church's social engagement and include the provision of recreational and social activities and services outside the core spiritual activities.

Our research focused primarily on the second domain and explored the extent to which an individual church enjoys the freedom to take decisions on the provision of services that otherwise would be delivered by the State. We looked at whether the provision of health and other services was viewed by church leaders as a channel to attract new converts and whether they limited access to the services they provide to members of other congregations or faiths.

The **Adventist church** is the Head of Central Kivu Adventist Churches, counting 512 churches in total. The regional structure sees an Association at Central Kivu which has 10 stations beneath it, each one counting 4 districts of 6-10 churches each. The representation in Kinshasa only has a diplomatic function, with the Union in Kenya and the General Conference in the USA having a stronger top-down guiding role. The President of the Association approves all decisions related to the congregation, including the inclusion of a new activity. However, this is guided by a collective discussion with representatives from the different departments (of Health, Youth, Women, Finance, etc.) within the Association making their suggestions on the focus of their work for the next year. This is largely a consensual discussion and if there is a division within the council, there will be a committee vote.

Similarly, the **Baptist community** of Central Africa has collective decision-making processes at all levels from the Elders council within the local church that meets weekly, to the church council every three months and up to the yearly General Assembly where all departments (of Evangelisation, Health, Family, Youth, etc.) attend and introduce the subject for the next year. At church level, the Pastor has to accept an idea first, before it can be discussed by the Elders but he cannot take a decision on his own. Local churches can introduce new activities and projects in autonomy and only if they work with other churches or posts they need to seek authorisation from the central leadership at Community level for Kivu.

Among the non-partners interviewed, the **Pentecostal church** also presents a collective decision-making process with the institution of the general assembly at church level to which the Elders, the pastors, secretary and accountants and representatives of different ministries attend. The Elders council is formed by one Clergy plus the Elders representing the different ministries and takes decisions collectively and autonomously for the church. At the **Awakening church**, decisions are taken by the council that meets once per month with the Elders, the Pastor, and president and secretary of each department. The National General Assembly is held once per year.

The main difference in the governance and decision-making structure comes from the **Catholic Church**. The Catholic Church has a more clearly delineated structure and channels due to the longer history and more centralised structure. It presents a strict vertical decision making process that goes from the precepts of the Pope, down to the Bishop, the Vicar and the Pastor. All new social activity at church level is approved by the Vicar and has to be in line with the Church doctrine and the precepts of the Vicar and the Pope. The existing commissions at church level can suggest activities to the vicar but he is the only one who can approve.

*This suggests that churches with a more horizontal structure could be keener in participating in similar projects as there are more opportunities and forum to introduce the idea for a new activity compared to churches with a strong, vertical leadership. Section 2.3 will examine the importance of individuals' personal engagement and how this has better chances to lead to the start of a new activity in a participatory structure.*

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

### *The role of women*

Women can have a role in providing spiritual guidance and pastoral care but they do not hold roles in ministry and they cannot be pastors. This relegates the position of women to secondary roles that exclude them from decision-making fora. For instance, to be part of the Elders council it is required that one be a Pastor. This limits the power of women to influence the agenda of the Church, including on topics related to Sexual and Reproductive Health.

Even when women take on leadership roles within the church these tend to be confined to areas of interest more stereotypically associated with women such as the head of the Family departments and the Women's groups. The activities of the Women Development Departments are limited to married women, leaving no space for adolescent girls to express their voices.

The influence women have from their active roles in such departments or groups is subject to who holds the decision-making power. Contrary to the Pentecostal and the Catholic Churches, where this power is held by spiritual figures who are always male representing also the groups otherwise led by women, the Adventists and the Baptists involve laypeople in the collective decision-making. Heads of the departments (men and women) present their agenda for the next year and are included in the discussion towards the final agreement. This is true at least at higher communal level; while the dynamics at the local Church are in line with the ones of other religions with women's participation limited to some specific activities without final decision power<sup>8</sup>.

When working with religious partners, there is limited space to challenge gender roles and as NGO we might just be able to work within the existing framework. Every intervention should be aware of this and find ways to include the voices of women working in the church and of adolescent girls from the congregation. This should be respectful of the religious institution's structure and be sensitive of how challenging the gender roles within the church could compromise the collaboration. Participative approaches can facilitate engagement with women by letting them indicate the modalities to increase their involvement in Sexual and Reproductive Health aspects.

### *Youth engagement and participation*

Youth groups are present in all churches with a predominant objective of Bible study. There is great focus on youths and adolescents of different ages with specific services organised for them and a lot of engagement from the religious leadership in engaging youths and accompanying them in their path to faith. Youths are often organized in sub-groups engaged in both liturgy (including the church choir) and leisure activities (sport, art, etc.).

When we looked to understand what challenges the youths are facing in the communities, what their main concerns are, the answers varied from the lack of resources, immoral behaviours (outside the religious teaching) and poverty. Churches try to address these issues through two main channels: i) evangelisation campaign and ii) orientation activities and vocational training. Dialogue with youth about their problems is limited and defined by the two main options available to solve them.

The role of churches as a guide for youths and adolescents has the potential to effectively influence their lives. They are a place of encounter with other youths from the community, where they can share their experiences and express their worries. As illustrated above, the interaction between the Church and the youths and adolescents is centred on the doctrine and the spiritual lead of the Church, which is in line with the mandate of any religious. As an independent actor, external to the

---

<sup>8</sup> One representative of the CBCA in Katozi stated they would consider to accept a woman in the Elders' group if she is married and the husband agrees.

## **Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths**

congregation, CARE could facilitate this dialogue between generations, as it was done through this project for issues related to Sexual and Reproductive Health.

### ***Vulnerable groups***

In the context of the DRC, where there is lack of public services and the State is unable to ensure welfare for all, churches play an important role in filling the gaps and act to reinforce and repair the social fabric to reduce inequalities and help marginalized groups. Unemployment and poverty are seen as drivers of risky behaviours including transactional sex or drug taking. Evangelisation and vocational activities are the responses churches give to these problems.

Taboos represent a barrier for vulnerable individuals to access services. While the existence of marginalised groups is accepted by society, and churches organize outreach campaigns in an effort to include all in their services. However we also understand that some minorities may fear being labelled as sinner which could prevent some from accessing the services. The Youth Friendly Spaces and the introduction of an anonymous referral system to access the health centre is a way to bypass the inclusion challenges that might exist in the structures.

The extent to which a church is able to conduct outreach activities for vulnerable groups such as street children, sex workers, drugs users, etc. varies from church to church. Whilst all respondents clearly stated is that all groups and identities are welcome to participate in all activities (both Bible-focused and social activities). However not all churches have designated channels to reach out to marginalised groups in their own spaces. The CBCA actively reaches out to some vulnerable people and children of all backgrounds can enrol in their schools, health centres or Youth Friendly Spaces. The same spirit of inclusion extends to members of other congregations and faiths. The Adventists welcome all in their structures but they don't actively undertake outreach. Furthermore timing and locations of activities is publicly shared only with the congregation. Among non-partners, evangelisation is the main channel through which the church reaches out to non-members. The Catholic Church reaches out to marginalized groups by conducting evangelization campaigns. The Pentecostal church has a dynamic congregation where sinners are excommunicated (excluded from active role in ministry) but can be reintegrated after a period of reflection and new commitment to the faith.

Lesbian, Gay, Bisexual and Transgender communities (LGBT) were not recognised as vulnerable groups in need of support from the church. Instead, most interviewees either denied the presence of homosexuality in the community or doubted that someone would openly self-identify within the church community. Our findings from the research conducted on LGBT participants in the projects also reinforce this finding. Homosexuality is such a taboo in this context that self-identification is almost impossible and consequently outreach is also extremely challenging.

### ***Sexual and Reproductive Health and Family Planning***

All representatives agree that the Church, no matter which denomination, has a mandate to discuss SRH/FP with their congregation. All churches promote marriage and having a family. Family planning and healthy spacing of pregnancies are part of the lessons that couples receive ahead of their wedding. But what methods of contraception do different churches see as acceptable for both married and unmarried couples?

The way this is interpreted and implemented varies widely from one denomination to another.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

### *Separation between Health Services and Church*

Across all churches, the message provided by the pastor or by the spiritual guide is in line with the doctrine. Some churches, however, thread a subtle line by separating their leaders' responsibility in the two domains: faith and health. This enables them to take a more progressive stance with regards to SRH issues, also for adolescents and youths.

The two Churches who partnered with CARE in this project – the Adventist and the Baptist – have very strong Health Departments with driven people at their head who started to introduce the issues of SRH for youths and adolescents in the Church agenda before the collaboration with CARE started. While the spiritual lead of the church is able to continue promoting abstinence until marriage and use of modern methods of contraception only to space births for married couples, they are also aware that not everyone is willing to commit to this. Unintended pregnancies among adolescents are common in the community, and so are unsafe practices of illegal abortion and the spreading of STIs. In their words, the Church cannot turn its back on these youths but needs to support them. Having strong health departments facilitates the mandate for the church as it creates a separation that allows the parallel coexistence of two messages for adolescents and youth: promoting abstinence on one hand and gaining knowledge as a mean of protection.

Health departments of non-partner churches<sup>9</sup> have show less autonomy from the religious leadership and do not touch topics against the doctrine. The Catholic Church has a Health group under the Caritas branch working mostly with people living with HIV and accompanying them through the illness. Family Planning is under the responsibility of the Family commission and is structured around five pillars (dialogue, guidance for engaged couples, education of children, family planning and single parents). All modern methods of contraception, including condoms, are not aligned with the doctrine of the Catholic Church.

The CEPAC, has a community health department also covering education. All couples are screened for STI/HIV before the marriage and if either partner has an infection or if the woman is pregnant, the couple is excommunicated from the church<sup>10</sup>. SRH/FP is taught at the Church and during Sunday school also to adolescents and youth but this is limited to the teaching of the doctrine. Abstinence is the first and recommended method. All churches believe that openly endorsing the use of modern methods of contraception, including condoms, equates to condoning sexual activity not aimed at procreation. Compared to the Catholic Church, CEPAC is more open to exceptions on ad hoc basis. Examples provided included the case of rape, where it is accepted to take the emergency contraception and in any case the person should seek assistance within 72 hours, or in case of adultery, where subsequently the married couple can use a condom to avoid transmission of STIs. These are however exceptions and cannot be considered as the general advice from the church.

---

<sup>9</sup> A key limitation in our conclusions is due to the fact that none of the non-partner churches we interviewed declared themselves against partnering with CARE on such topics with the Catholic Church as the only exception to this. It is therefore impossible to discern between those religious groups who would in principle be willing to engage on such topics with some accompaniment and resources. Our study suggests that CARE selected willing partners who were already favourably predisposed and strengthened their commitment through the collaboration. It is however hard to say that the same results might not have been achieved by partnering with other churches.

<sup>10</sup> Excommunication means that the members found to have lapsed in their judgement will be excluded from taking leadership roles in the church until they have proven to be genuinely contrite and have reformed their character, at which point they will be fully reintegrated. Members of a church who are excommunicated are still able to take part in worship and all other church activities but they are not able to take any leadership or prominent role neither in worship nor in social activities.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

The Church of the Awakening was the only non-partner church openly promoting the use of modern methods of contraception to delay births and of condom to prevent STI/HIV. Reportedly they direct members of their congregation to the health centre of the CBCA for medical support.

**Table 1 – Acceptance of different modern methods of contraception by denomination**

Church	Condoms	Modern Methods of Contraception (incl. pill, implant, IUD, etc.)	Emergency contraception
<i>Adventist</i>	Yes	Yes	Yes
<i>CBCA</i>	Yes	Yes	Yes
<i>CEPAC</i>	<i>No, with ad hoc exceptions</i>	<i>No, exception possible</i>	<i>Yes, in case of rape</i>
<i>Catholic</i>	<i>No, no exception</i>	<i>No</i>	<i>No*</i>
<i>Awakening</i>	Yes	<i>Yes, for married couples</i>	<i>Yes, in case of rape</i>

\*One of the interviewed accepted EC in case of rape only within 24h. The same was not confirmed by the other interviewed.

*“Not every contraceptive method will be right for every person; women and adolescents can realize this right only if they have access to a full range of contraceptive methods in a setting that allows them to make an informed choice as to the appropriate method for them. A full range of methods includes male and female condoms, vaginal barrier methods, oral contraceptives, implants, injectables, intrauterine devices, male and female voluntary sterilization, and EC.”<sup>11</sup>*

It is important to note that the messages of the non-partner churches on SRH are restricted to family planning to delay or space births through abstinence and natural birth control. The risk of STI/HIV is well-known and all couples are screened before their wedding. If a person is found to test positive for HIV, he/she is referred to medical services for treatment whilst provided with psychological support and spiritual guidance. There is however a gap in the support for adolescents living with HIV as there is no response adapted to their specific vulnerabilities. In addition, the Catholic Church provides long-term accompaniment of AIDS patients through its GRAM/Caritas centre. The Catholic Church is the most engaged in assisting people living with HIV/AIDS but is also the strongest objector on the use of condoms.

### **SRH for adolescents and youth**

The Vijana Juu project is centred on improving free access to SRH services including family planning for adolescents and youths. While some family planning services already exist for married couples, for a young unmarried girl or boy it can be very difficult to get the information they need

<sup>11</sup> <http://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf>

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

and access the services at the health centre. This is for a number of reasons that range from stigma and the fear of being labelled as promiscuous, to the lack of money to purchase treatments.

For the Catholic Church, the Pentecostal and the Awakening, family planning is a matter for married couples only (though CEPAC and Awakening Church are open to some exceptions). The engagement towards adolescents and youths in this regard is in line with the doctrine and promotes abstinence.

CARE's partners, on the other side, believe in the importance of informing youths about SRH and modern contraception methods, whilst they would still prefer they did not engage in sexual activity until marriage. Their representatives who participated in this survey showed greater openness to compromise in acknowledgement of the pressures faced by youths as well as awareness of the fact that nowadays youths have access to much more information through the internet. Like non-partners they keep their spiritual messages in line with the doctrine but the existence of an independent Health department, engaged in SRH as mentioned above, allows youths to seek advice, treatment or contraceptives free of charge for as long as the project will supply them. Whilst this might be in open contrast with the church's teaching, the presence of a strong health department within the structure of the church allows for these two, often conflicting, positions to coexist in the same space.

When discussing the importance of sharing information, two priests quoted a verse from the Bible "My people are destroyed from lack of knowledge"<sup>12</sup>. This verse is used as a bridge between the faith and the more scientific position embraced by the health departments of the churches, giving validation to this approach. Evidence from the endline evaluation of the project also shows that greater knowledge on puberty and fertility awareness and contraception does not lead to greater sexual activity.

*"As children enter adolescence, as their bodies change and as many of them begin exploring their sexuality, access to sexual and reproductive health information and services becomes critical to their enjoyment of human rights, their health and their wellbeing."<sup>13</sup>*

The dissemination of information occurs both during private consultation with a medical professional at the health centre, as well as within the Youth Friendly Spaces that have been created under this project. These spaces are adjacent to the health centre and managed by Youth Peer Leaders who organize sessions to inform on sexual and reproductive health, family planning, but also encourage a dialogue on confidence, self-esteem, etc. Peer leaders (including one health worker in each site) are available 24/7 and their contact information can be found in all the centres. Youths can access this space without restriction or discrimination. Some partnering Pastors proudly stated that their children (boys and girls) go to the spaces and that there should be no shame in that because the misconception that suggest a correlation between getting information on SRH with having sexual relations is overcome.

### Personal engagement

We analysed in section 2.1 the governance of the different Churches and confirmed that despite some churches having a more collective and collaborative decision processes, every new activity or agenda has to be validated by the Lead Pastor or equivalent. As such, it is a prerequisite to any collaboration to have their endorsement. In some cases the Pastor was already engaging with SRH, passing messages to his congregation and looking at ways to improve access to information and

---

<sup>12</sup> Hosea 4:6

<sup>13</sup> [http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO\\_Adolescents\\_WEB.pdf](http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Adolescents_WEB.pdf)

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

health services. In others the Pastor was more reluctant but the presence of a charismatic and well-respected member of the church facilitated his engagement and led to the consent to start activities.

In two cases, with the Adventists and one CBCA, this role was covered by the head of the churches' Health Departments. As "men of science" they understand the importance of SRH information and services for adolescents and youths before they start their sexual lives which may or may not coincide with married life. They both presented a pragmatic approach acknowledging that men and women behave in ways condemned by the Bible (stealing, adultery, murder, etc.) and that the Church needs to be more rooted into the everyday realities of its congregation including their weakness. Working in health centres and assisting young boys and girls who contracted an STI or had an unplanned pregnancy further pushed them to act to prevent this in the future. They initiated discussions within their ministries and presented their ideas for action during the general assemblies, where they got approval from the respective Pastoralist Presidents who identified passages of the bible to validate their actions.

The difference in the personal engagement was clearly noted during the interviews but brings into question the long-term sustainability of the initiative. In fact, two Pastors from two CBCA churches that were leading the programme, having fruitful discussions with CARE and boosting the participation of youths at the friendly spaces and at the health centre, have since been transferred to other churches in 2017 and have been replaced by colleagues who may not share the same personal commitment for the topic. Among them was an Adult Champion from the project, a person of high regard within the community who passes messages on SRH/FP to the youths and the wider community. Before starting the collaboration, he also supported CARE in the baseline study and invited CARE to present the findings to the congregation in order to demonstrate the need for the intervention to start. The two new pastors that were interviewed didn't know much about the project and were doubtful about the alignment between the project's activities and the Church's doctrine. In our interviews, it emerged that their main concern centred on future funding for their health centres<sup>14</sup> rather than a true commitment to continuing supporting these particular health services. Having new leaders in post will require that CARE reignites their engagement and rebuilds trust and acceptance in order for these activities to continue. With regards to the CBCA churches, these risks should be mitigated by the fact that the work on SRH/FP with adolescents and youths was endorsed by the North Kivu General Assembly, meaning that all CBCA churches have to align to that guidance. Similarly, this is the same with the Adventist church as CARE signed an agreement with the Association for Central Kivu.

Having the support and endorsement of key figures in positions of authority will, to a large extent, guarantee this continued engagement by CBCA.

Among the non-partners, personal engagement is also a key element. Even if they are not providing SRH messages and services within their structures, in two cases (CEPAC and Awakening, which keep a certain degree of autonomy from the central church) the Pastors confirmed that they reached out to the Youth Pastors from CARE's partners to go and talk in their churches and that they would also refer youths to the centres and advise them to reach out to a Peer Leader for more information on SRH.

In the case of the Catholic Church, it is less likely that the strong commitment from a pastor could lead to a collaboration on SRH/FP that includes information on modern methods of contraception, as the church's doctrine does not oppose knowledge-sharing. However it is unlikely that this would

---

<sup>14</sup> The health services provided range beyond SRH to include other medical services including antenatal and postnatal care as well as a range of other medical services to the entire community. These services are typically funded through benevolent contributions from international donors including CARE and USAID and through user fees.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

ever result in acceptance to the creation of health services within a parish's premises that include the free distribution of modern contraceptives. This is due to the more centralised power structure within the Catholic Church that would not allow for personal leadership to be exercised in this manner.

## Working with CARE

### *Partners*

CARE signed individual partnership agreements with each of the Churches after negotiations that lasted up to three months. This time was used to create a common ground around the core activities of the project, ensure understanding of all its components and that all of them would have been implemented without any restriction. The project asked religious representatives to authorize the distribution of contraceptives and inform adolescents and youths on SRH issues within their spaces. Despite approving in principle, the Churches had to think broadly about how this could be justified within the doctrine and consider possible backlashes it could create. The lead Pastors and presidents of the Adventist Association and the CBCA community had discussions with their colleagues from the health departments, consulted with the elders and the councils and identified some biblical passages that would serve as a basis for the activities. Initially, the agreement was signed with the Adventists at Association level and the CBCA at Community level to then identify the churches where it was possible to implement in line with the three-pillar approach: religion, education and health. According to one representative of the CBCA, this approach reflects the integrated mission of the church to work on spirit, body and education within the community. The agreement also establishes clear roles and responsibilities of both parties and includes a strategy for continuation after the end of the project. CARE conducted joint sessions with representatives from the Adventists and the CBCA to share the findings of the baseline evaluation and trained all Church health staff on SRH/FP and non-health personnel on confidentiality and how to approach adolescents and youths also with regards to GBV issues.

Particularly, partners identified two aspects of the work with CARE that enabled the start and the success of the activities: the provision of medical supplies and the facilitation of a dialogue within the families. The first one is straightforward in the sense that, especially for the churches that had SRH/FP as part of their agenda, it allowed them to go from theory to practice, giving them the means for a comprehensive response to the needs of adolescents and youths. The second one is more subtle and refers to the support provided by CARE in creating community acceptance for these services. One of the major challenges faced by the churches wanting to introduce specific activities on SRH/FP was the resistance from the parents of adolescent children. Sexual health is not a topic that is generally discussed within families. Consequently, adolescents access information passed through word of mouth that is often laden with myths and misconception at a great risk to their health and wellbeing. It is therefore easy to see the Churches' fear that parents might see their engagement on the issue, and particularly the endorsement of free access to contraceptives as an encouragement to promiscuity. Specific information sessions were organized jointly by CARE and the churches to have open discussions with the parents, listen to their worries and address them with explanation based on the findings of the baseline, informing them on the activities at the Youth Friendly Spaces, the peer leaders' approach, etc. During the sessions parents were made aware that at present youth access many sources of information beyond parents' control and these often propagate myths and misconceptions that could have a detrimental effect on the youths' wellbeing. The awareness session therefore proposed taking a more proactive role in sharing scientific information to counter the prevalence of false and risky information hoping it would empower the youth to make the right choices.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

CARE was also invited to attend the Bible Camps of the CBCA and set up a desk to provide information on SRH/FP to the boys and girls attending those camps. After some of the youths who attended the Bible Camps and received the information on SRH still took the abstinence pledge, parents were reassured that SRH information does not promote promiscuity

Religious leaders report that, as a consequence of the activities done with CARE, they saw an increase in youths taking part in religious services. They also reported that families are more open to discuss SRH and parents recommend their children to go to the youth spaces to learn what they are uncomfortable or unable (for lack of knowledge) to teach them.

### *Non-partners*

In some instances partnering churches received criticism from other churches on their work on SRH issues. Our research suggests that the process by which a church can engage on SRH is influenced by a number of internal and external factors, from the church's governance and decisional power to the personal drive from the church's own leadership.

Among the non-partners interviewed, three people (two from CEPAC and one from Catholic Church) are aware of the work done by CARE, two (Awakening) don't know about the work of CARE but are familiar with the activities a CBCA church does under the project with CARE and only one (a Catholic priest) didn't know what CARE or the partners do.

Out of those that are familiar with the work of CARE, the representatives from CEPAC said they would be interested in working with CARE in the future and already contacted peer educators and youth pastors from CBCA to talk at their churches as well as refer those in need to the health centres. One Catholic representative approached CARE in the past about Caritas' work with people living with HIV. However, he didn't see a possible collaboration on SRH/FP. The other Catholic priest interviewed, after being informed on the work done by CARE with other churches, condemned it.

The Catholic Church has the biggest congregation in Goma. Many representatives from other churches pointed out that it would be key to collaborate with them in order to see a major change in the community. They also said that many Catholic youths access the friendly spaces and health centres in their churches.

Finally, representatives of the Awakening church looked also interested in a similar collaboration with CARE and were to receive more information on SRH themselves.

## Conclusion and Recommendations

Following the research, there are no clear answers to define what can lead to a collaboration with churches to address SRH issues among youths and adolescents.

Nonetheless, we can affirm with a certain degree of confidence that the structure of the church can be an indicator of openness. Where decisions are taken in a collective way, with voices from different departments and grades being heard (including women's, though to a lower extent) there are greater chances to introduce activities outside the normal umbrella of the church. The leading role of specific people in a position of influence within the church, however, brings a very subjective interpretation to this. Also, the views expressed in this report reflect the information received from KII and should not be considered as the official position of the Churches in SRH matters.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

The research highlights that churches who partnered with CARE in this project were already engaging on SRH as a community issue, even if to a very limited extent. This engagement was the basis for the collaboration with CARE. Rather than drastically challenging and changing churches' towards SRH, CARE gave them the means, both practical and in terms of knowledge, to increase their efforts and reach adolescents and youths from the community. This should not minimize the role of CARE in this project. CARE has extensive experience implementing SRH programmes in Goma and has strong expertise on gender which is integrated into the SRH programme by looking at the specific needs of boys and girls. The Vinjasa Juu was the first attempt to work with religious institutions as partners in this area. As a first and unique experience with a number of risks for both the partners and CARE as highlighted in the first section of this report, a cautious approach was the most appropriate. It is worth mentioning that at first the project only worked with three partners and that CARE was approached by a fourth church to set up the same SRH services within their health centre.

The interest that is shown by non-partners was also reported during the interviews for this study with representatives of CEPAC and the Awakening Church linking with CARE's partners at the CBCA to refer to them youths from their congregation in need of SRH services.

For future partnership with religious institutions to deliver SRH services to youths and adolescents, the following recommendations should be considered:

1. Understand the structure of the church and how decisions are taken. This is necessary to identify the key person that can endorse the decision to engage in SRH and who is a key influencer within the church. Churches with a more horizontal and participatory structure could be easier to access because of their decision-making process and the stronger influence an individual could have on the agenda.
2. Work together to identify the specific and gendered needs of the communities and justify the introduction of SRH services. A participatory approach should acknowledge the expertise of the partner and its specific role in the community.
3. Assess the real interest of the partner in working in SRH and explain what such collaboration entails. The minimum standard package of comprehensive SRH services has to be provided.
4. Do not force partners to agree to something they are not comfortable with. SRH is a very sensitive topic and in order to be effectively implemented there is the need for a real and full endorsement by the partner. If a partner expresses resistance to certain aspects of SRH services, additional engagement and explanation (e.g. by emphasising the health aspects and the importance of the provision of a comprehensive SRH services) might be needed.
5. Offer support to engage discussion with the community, especially with parents who might object to the introduction of these services within the Church.
6. Be aware of which vulnerable groups are marginalized and what specific challenges they face in accessing services. When working with vulnerable groups that could not be accepted in the society, CARE should be conscious of the potential risks related to the exposure of these individuals. To mitigate those risks, the intervention should be informed by a "Do no harm" analysis.
7. Consider the controversial aspects of working in sexual and reproductive health due to its linkages to some practices that can be illegal (eg the provision of post-abortion care where abortion is illegal) or taboos (working with LGBT, sex workers, etc.) and ensure the safety of staff at all times.

## Working with religious institutions to provide Sexual and Reproductive Health services for adolescents and youths

8. Provide continuous support and capacity building at the health centres and within the church. Be particularly conscious of the turnover of staff and how this could jeopardise sustainability of the programme if the relationship is not fostered.

Front cover photo: Marceline Kanku holds her baby at a health centre  
in Kasai-Oriental province, Democratic Republic of Congo  
© Carey Wagner / CARE 2017

CARE International UK  
89 Albert Embankment  
London SE1 7TP

[www.careinternational.org.uk](http://www.careinternational.org.uk)

Registered charity number 292506

May 2018