

**SUITABILITY OF ADOPTION OF FAITH-BASED APPROACH TO
PROMOTE CHILD CARE PRACTICES THROUGH THE PASTORS'
WIVES IN IBADAN NORTH LOCAL GOVERNMENT AREA**

BY

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DEDICATION

This research study is dedicated to the Holy Trinity; God the Father, God the Son and God the Holy Spirit, my source of strength and joy.

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ABSTRACT

Despite the available simple and low-cost child care strategy, Nigeria continues to record unacceptable high child mortality rate with obvious un-accomplishment of the 4th millennium development goal by the year 2015. Interestingly, faith based setting as an approach to health promotion and education has proven positive in areas of health. However, its utilisation in developing countries including Nigeria has been minimal. This study therefore investigated the suitability of adoption of faith-based approach to promote child care practices through Pastors' wives in Ibadan North Local Government Area of Ibadan, Oyo State, Nigeria.

The study uses a descriptive cross-sectional design. It was targeted at all Pastors' wives of registered churches except the Roman Catholic Church which officially forbids marriage for her Pastors. Using the multi-stage sampling technique, selected pastors' wives completed a pre-tested interviewer-administered questionnaire that sought information on socio-demographic profiles, health related programmes involved in, knowledge of child survival strategy, communication methods, challenges and ways assistance can be given toward involvement in child care programmes. The study was conducted in compliance with standard ethical research procedures. The data were analysed using descriptive statistics, chi-square test, t-test and F test at $p \leq 0.05$.

A total of 128 pastors' wives and women leaders (mean age 46.1 ± 9.3 years) participated in the study. They were mainly Yorubas' (87.5%), had university degree (35.9%), into business and trading (29.7%), mothers with at least a child; except for 2.30% of the pastors' wives. The results showed that 49.2% had attended at least a health-related programme in the past. Interestingly, all were interested in attending and organizing health related programmes in the future with child care programme as of most importance ($n=85$ and $n=87$). Analysis showed that pastors' wives were unaware of child survival strategy as only 13.4% had some level of knowledge. However, the pastors' wives had different degrees of knowledge on the components in child survival strategy. Family planning (79.3%), breastfeeding (72.3%) and immunization (67.0%) were the most known while complementary feeding (40.2%) and growth monitoring (35.9%) were the least known. It was also observed that pastors' wives

(99.2%) and women (92.2%) communicate health issues among each other and that 58.6% reported to be faced with constraints. While all the pastors wives except 0.8%, were willing to conduct child care practice programmes in the church, 99.2% reported they required assistance to do so.

Many of the Pastors' wives were unaware of child survival strategy. However, the fact that they were interested in child care programmes, communicate health-related issues with mothers and women, coupled with their willingness to conduct child care programme indicate their suitability in the promotion of child care practice in faith-based settings. Nevertheless, the importance of training pastors' wives on child care programmes targeted at improving child health cannot be overemphasized.

Keywords: Child survival strategy, Child care practice, Pastor's wife, Faith-based setting, Health promotion

Word count: 456

CERTIFICATION

I certify that this research work titled; “Suitability of adoption of faith-based approach to promote child care practices through the Pastors’ wives in Ibadan North Local Government Area” was carried out by Mr Akpamu Uwaifoh (Matriculation number: 181700) in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria, under my supervision.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
BCG	Bacille, Calmette - Guerin
CDC	Centers for Disease Control
CSS	Child Survival Strategy
FBOs	Faith Based Organizations
FGN	Federal Government of Nigeria
HEBS	Health Education Board for Scotland
HIV	Human Immunodeficiency Virus
ITNs	insecticide treated nets
LGA	Local Government Areas
MDGs	Millennium Development Goals
NDHS	National Demographic Health Survey
NBS	National Bureau of Statistics
NGOs	Non Governmental Organizations
NIH	National Institutes of Health
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
SLT	Social Learning Theory
SPSS	Statistical package for social sciences
STIs	Sexually Transmitted Infections
UCH	University College Hospital
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Faith-based organisations	Faith Based Organisations are organisations that is influenced by stated religious or spiritual beliefs in its mission, history, and/or work
Setting	Setting is a place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing. For example, faith-based setting
Health promotion	Health promotion is the process of enabling people to increase control over, and to improve, their health
Child survival	Child survival is a field of public health concerned with reducing child mortality.
Child survival strategies	These are steps taken for children aged 0-5 years by individuals and communities to reduce risk, duration or severity of an adverse health condition that detrimentally affects the survival of infants and children.
Child survival interventions	These are designed to address the most common causes of child deaths that occur, which includes diarrhea, pneumonia, malaria, and neonatal conditions

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Faith Based Organisation (FBO) was defined by Santos (2014) as an organisation that is influenced by stated religious or spiritual beliefs in its mission, history, and/or work. However, Abdulmalik (2014) categorizes it as an organisation that holds religious or worship services, or is affiliated with a religious denomination or house of worship. The National Centre for Cultural Competence (2001) considered FBO as any group/organisation created by or for a religious or spiritual group including, but not limited to, individual places of worship, groups of community or tribal elders/spiritual leaders, intra- or interdenominational community coalitions, faith connected health and human service agencies, denominational hierarchies/governance bodies, religious orders and schools of divinity. Based on these definitions, the FBOs can therefore be said to include churches, mosques and other places of worship such as nonprofit organisations affiliated with religions and local nonprofit organisations affiliated with an umbrella or national faith-based network. Faith-based nonprofit organisations according to Fredrica (2013), generally maintain a faith-based mission but the services they deliver may or may not have a faith-based content and they do not necessarily restrict participants to those who adhere to that faith.

Interestingly, there are reports that FBOs can promote health and well-being both within congregations and throughout communities (DeHaven, Hunter, Wilder, Walton and Berry, 2004; Ellison and Levin, 1998; Maton and Wells, 1995). The interconnections between public health, health education and FBOs have been a topic of discussion (Chatters, Levin and Ellison, 1998), and the possible contributions of FBOs to improved community health outcomes have been described (Foege and O'Connel, 1990). In fact, many multidisciplinary studies have described features of successful health promotion programs and partnerships in churches (Sanders, 1997; Hatch and Derthick, 1992) and their importance as an ally in efforts to provide preventive health and social services to populations at risk have been documented (Sutherland, Hale and Harris, 1995). Despite their importance in service delivery, humanitarian aid, reconstruction and development, reports showed that the

nature, scale, activities and relationships of FBOs remain poorly understood and documented (Leurs, Tomalin and Kirani, 2006) and as such underutilized.

FBOs have played a key role in the global effort to promote health and well-being, especially among the most underprivileged and disadvantaged populations. There has been increasing interest; principally among underserved populations, in the role FBOs can play in promoting health and health care access (Asomugha, Derose, and Lurie, 2011). Fifteen years ago, the World Development Report (World Bank, 1993) called for the greater use of nongovernmental organisations (NGOs), particularly FBOs, to improve service quality and fill existing gaps in healthcare services (Gill and Carlough, 2008). This call was repeated in a 2006 assessment of the impact of religion and religious entities on achieving universal access to services in the context of the HIV epidemic (African Religious Health Assets Programme-WHO, 2006a). The Centers for Disease Control (CDC) and National Institutes of Health (NIH) therefore recommended a collaborative model of comprehensive educational programme, highlighting the importance of addressing cultural factors, such as religion, faith and spirituality, in the provision of care to improve health endpoints in ethnic/racial minority populations (CDC, 2007; CDC 2010). Also, the CDC and NIH recommended that community stakeholders such as universities, care providers, local leaders, and lay public, should partnership with FBOs to address public health challenges (CDC, 1999; NIH, 2010). Thus, FBOs are now considered important providers of health care, while Faith-Based Settings (FBSs) are important site for health promotion and education, as well as delivery of health services.

In this regards, several studies have recognized FBOs have as prominent cultural organisations within communities and provide trusted and culturally sensitive setting for the delivery of health promotion programs (Catanzaro, Meador, Koenig, Kuchibhatla and Clipp, 2007; Baskin, Reniscow and Campbell, 2001; Peterson, Atwood and Yates, 2002; Turner, Sutherland, Harris and Barber, 1995). In addition, due to insufficient local resources, FBOs have concentrated on building hospitals and clinics and training healthcare workers to improve access to affordable health and rehabilitation services (Widmer, Betran, Meriardi, Requejo and Karpf, 2011). Other studies showed that FBOs with tight religious networks have enhance the success of faith-based health programmes and related outcomes, particularly through fostering widespread and sustained participation in such programs

(Baskin, Resnicow and Campbell, 2001; Dyess, Chase and Newlin, 2010; Peterson, Atwood and Yates, 2002). For example, studies indicate that FBOs can be a promising avenue for delivering diabetes self-management education to Black Americans (Newlin, MacLeod Dyes, Allard, Chase and D'Eramo Melkus, 2012). The revival of interest in religious factors in health is especially indicated by several factors. These include findings linking religious involvement with a diverse array of physical and mental health outcomes, morbidity and mortality rates, quality of life indicators, discrete health behaviors and attitudes and use of health care resources (Chatters, Levin, and Ellison, 1998). Other studies reported that it was important to include pastors in the program development from their inception (Markens, For, Taub and Gilbert, 2002) versus expecting pastors to support and promote programme which were developed by programme planner, who may not have cultural sensitivity to the needs of the church members or the affected population (Butler-Ajibade, Booth and Burwell, 2012).

These several reports and studies showed that the scope of FBO-run activities has expanded over time. Of interest, a study suggested the development of strong partnerships between FBOs and the broader public health community including policy makers as potential strategies for reducing maternal and child mortality in high-burden countries (Gill and Carlough, 2008) particularly in Sub-Sahara Africa. This was based on the fact that 'the vast majority of people in sub-Saharan Africa identify themselves as adherents of Christianity or Islam, the world's 2 largest religions (Pew-Templeton Global Religious Futures Project, 2010) couple with evidence that indicates approximately 75% of Africans to trust their religious leaders (Ferrett, 2005). In a way of thought therefore, leveraging the influence of religious leaders and promoting faith-based or faith-inspired health services and programmes could be an effective means of addressing the maternal and child health challenges in Nigeria and Africa at large due to the poor maternal and child health indices in the region.

1.2 Statement of the Problem

In 1970, sub-Saharan Africa accounted for 11% of the world's births and 19% of global under-5 deaths but by 2006, her share of global births doubled to 22%, with global under-5 deaths soaring to almost 50% (UNICEF 2008). The WHO approximated that 10 million children less than five years old die annually and the majority of these deaths occur in developing countries (Valerie, 2001). The sub-Saharan contribution to global under-5

mortality is reported to increase from 19% in 1970 to 49% in 2008 (Kebede, Asamoah-Odei, Soumbey-Alley, Lusamba- Dikassa, and Sambo, 2010) and this figure is not on the decrease to date.

To curb the persistent child mortality, in 2000, at the Millennium Summit held in New York, World Leaders pledged to reduce child mortality and improve maternal health among other Millennium Development Goals (MDGs) to ensure human development by the year 2015. The Federal Government of Nigeria (FGN) responded by making one of the targets of the MDGs to be reduction of under-5 mortality to 64 deaths per 1,000 live births and infant mortality to 30 deaths per 1,000 live births by 2015 (FRN, 2010). In this regards, programmes were designed to increase the proportion of births attended by skilled health personnel, increase immunizations against vaccine-preventable diseases, provide early care and treatment to sick children, and to upgrade the status of women through education and enhanced participation in the labour force. These were strategies targeted toward improving the probability of survival of the Nigerian under- 5 children. Despite these programmes, the recent National Demographic Health Survey (NDHS) report showed that infant, child and under-5 mortality rates are 69 per 1,000 live births, 64 per 1,000 children surviving to age 12 months, and 128 per 1,000 live births respectively (NDHS 2013). These rates imply that 1 in 15 Nigerian children die before their 1st birthday and 1 in 8 die before their 5th birthday (NDHS 2013). The present figure with the time frame by the Millennium Summit held in New York coming to an end is not so what different and by implication, childhood mortality is still a major public health problem in Nigeria.

Worrisome, the World Health Organisation (WHO)-African Region report showed that sub-Saharan Africa has made the least progress in improving child survival as only five countries (Algeria, Cape Verde, Eritrea, Mauritius and Seychelles) in the region are on track concerning child mortality reduction (Habimana, Mwinga, Sagoe-Moses, and Ketsela, 2010). This indicates that the rate of decline in under-5 mortality is still grossly insufficient to reach the MDGs 4 and 5 by 2015. A baby born in Nigeria is 30 times more likely to die before age five than one born in an industrialised country (NPC/UNICEF, 2001). Infant and child mortality rates are exceedingly high, and Nigeria ranks 15th highest in the world among countries with high under-five mortality (UNICEF, 2001). These figures are in the light of the wealth of human and natural resources in the country.

Specifically, Nigeria, which constitutes just 1% of the world population, accounts for 10% of the world's maternal and under-five mortality rates (Ogunjimi, Ibe, and Ikorok, 2012). According to UNICEF Executive Director, Ann Veneman, "midway to 2015 deadline for MDGs, Nigeria continues to record unacceptably high maternal, newborn and child mortality" (Ogunjimi et al., 2012) and there has not been substantial changes just 2 years to 2015. Based on the recent NDHS report (NDHS 2013), under-5 mortality rate is still high at 12.8%; estimated as 1 in 8 children dying before the age of 5th birthday. It is tragic that 1 in 8 children of "the Giant of Africa" die before age 5 at the dawn of the twenty-first century. This is unacceptable in the 21st century. Although the Nigeria under-5 mortality rate has reduced from 185 deaths per 1,000 live births in 1999 to 162 deaths per 1,000 live births in 2008 and to 128 deaths per 1,000 live births in 2013 (NDHS 2013). This is 30.81% reduction in 13 years as against the proposed 65.41% reduction for 15 years. The difference of over 30% with the MDGs period coming to an end is still high considering the population of Nigeria- "the Giant of Africa". This places Nigeria high among the countries of the world in terms of the absolute number of under-5 deaths. In this regards, the realisation of the target for reducing child mortality by the year 2015 since the millennium declaration made in New York, seems to be an unattainable goal for Nigeria despite the availability of effective low cost interventions such as "the child survival strategies" to prevent two-thirds of these deaths.

Following the Alma Ata Declarations in 1978, series of large-scale programmes were launched in the 1980s and 1990s aimed at reducing child mortality. This included 'the child survival program' sponsored by United States Agency for International Development (USAID) and international organisations that was launched around 1985 and found to be very influential in numerous countries (Garenne, Darkaoui, Braikat, and Azelmat, 2007). The child survival strategy for the African Region was developed by WHO, UNICEF and the World Bank due to persisting poor child survival indices in the region and adopted by the 56th WHO Regional Committee in 2006 (WHO 2006). The strategy defines set of effective child care practices and interventions with the acronym "GOBIFFF"; Growth monitoring, Oral rehydration therapy, Breastfeeding, Immunisation, Feeding/nutrition, Female education and Family planning. The strategy aims to scale up a defined set of effective child care interventions, including antenatal care, newborn care, appropriate infant feeding, immunisation, management of common childhood illnesses and use of insecticide treated

nets (ITNs) (Habimana, Mwinga, Sagoe-Moses, and Ketsela, 2010). Member States were urged to develop policies for effective intervention scale-up; strengthen capacity for planning, implementation and monitoring child survival activities; develop communication strategies; develop effective partnerships; conduct operations research; document experiences and develop frameworks for monitoring and evaluation. Despite the child care practices and interventions in the child survival strategy and the policies by member states to scale-up effective interventions, Nigeria still continue to records unacceptable child survival indicators.

Considering the child care strategies in the child survival strategy, the hindrance to accelerated reduction of under-5 mortality rate in Nigeria is not the lack of know-how and resources, but structural and system wide weaknesses limiting access to information and services. Interestingly, studies have commended successful health promotion programmes and partnerships in churches (DeHaven, Hunter, Wilder, Walton and Berry, 2004; Sanders, 1997; Sutherland, Hale, Harris, 1995; Hatch and Derthick, 1992) and thus the importance of the church as an ally in efforts to provide preventive health care services. Worrysome however, despite the interesting findings on the utilisation of faith-based settings in the delivery of health programmes of various types, to date, data in Nigeria reflecting the delivering of child care practice programmes in faith-based setting is limited. By suggestion, for Nigeria to achieve the MDG-4 with the target period at hand, there is need to increasingly channel efforts to improve the health of children with special reference to under-5 and thus the determination of the suitability of FBOs in this regards.

1.3 Justification of Study

Interesting, studies have shown that FBOs can promote health and wellbeing both within congregations and throughout communities (DeHaven, Hunter, Wilder, Walton and Berry, 2004; Ellison and Levin, 1998; Maton and Wells, 1995). Specifically, investigations have shown that church-based interventions are particularly effective in increasing the number of African American women who screen regularly for breast cancer (Duan et al., 2000; Mann et al., 2000; Erwin, Spatz and Stotts, 1999). In this regards, utilisation of faith based settings may be an important approach in effectively promoting child health care through practices embedded in the child survival strategy. In line with this assertion, there is

evidence indicating faith-based settings to serve as a promising venue for providing quality health promotion programme that foster improved physiological outcomes among underserved populations (Newlin, MacLeod Dyes, Allard, Chase and D'Eramo Melkus, 2012).

FBO is a setting for health promotion and education and an important organ of social mobilisation that is increasingly being commended. Following their mission of healing and service, faith based settings can promote positive health values and endorse health promotion programmes to address the health needs of communities and their members. In fact, the interconnections between public health, health education, and FBOs have been examined (Chatters, Levin and Ellison, 1998) and the possible contributions of FBOs to improved community health outcomes have been described (Foege and O'Connell, 1990). However, studies have been on Pastors and positive and interesting results have been documented over time. On the other hand, recent findings suggest that Pastors face considerable demands that often impede programme success and sustainability (Markens, Fox, Taub, et al., 2002). It was then concluded that future church-based health promotion programmes should ideally reduce the burden of projects on pastors by working with pastoral delegates or lay church leaders such as pastors' wives (Ammerman, Corbie-Smith, George, et al., 2003). In the case of this study, due to the complexities of the health issues; maternal and child health, pastors may be constrained in their level of engagement and thus the need for the Pastor's wife. Engagement of pastors alone without recognizing the significant influence of pastors' wives may result in missed opportunities for intervention targeted toward women and children in the case of maternal and child health.

Considering the interventions in the child survival practice, the Pastors may not be the most suitable intervener as these are issues relating to women and children. Moreover, mothers and women in FBOs may be freer with the pastor's wife considering the culture of the country and other socio-cultural morals. In addition, women are known to care for children especially under five years than their husbands and thus the important of the pastor's wife in this regards.

Worthy of note, Pastors' wives are highly influential, esteemed, perceived to served as public modeling and are recognised figures as "first lady of the church" in churches. These powerful qualities of the "Pastors' wife" is no doubt expected to influence women in the

church and as such can help cultivate healthy relationships with mothers in the church. For these reasons, the suitability of faith based approach in the promotion of child health through the pastors' wives can have significant influence in averting the rate of child mortality. Therefore, given the high under-5 mortality rate in Nigerian coupled with the significant role Pastors' wives' play in the church, this study is justified.

In contrast, in the case of the Islamic religion, the Imams' wives in most cases are not the women leaders for women in the mosque. In fact, as reported by several Imams and practicing Muslims, the Imam sees his wife/wives special and she/they is/are required to remand at home and say her prayers. Moreover, it is uncommon and in other cases forbidden for a woman to lead or conduct some prayer sections for the mosque congregations (As reported by several Imams and practicing Muslims in Key Informant Interview). Although it was said to be a cultural thing that is common in the Northern Nigeria and a little difference from the south-West, young women (reproductive age women) are preferred to say their prayers at home and thus, it is uncommon to find young women in the mosque. For this reason, elderly women (menopausal women and the aged) are the most prevalence female found in the mosque. As reported by all in the Key Informant Interview conducted, a woman who says her prayers in the mosque is no different from that who says hers' at home. Thus most female, specifically the young and reproductive age female, prefer to say their prayers at home. For these reasons, this study was targeted only on Pastors wives.

1.4 Research Questions

To determine how suitable the Pastors' wives will be in the promotion of child care practices, the following questions were raised:

- i. What are the health related programmes that the Pastors' wives have been involved in?
- ii. What is the level of knowledge of Pastors' wives on child care practices?
- iii. What methods do Pastors' wives use to communicate health related information to nursing mothers?
- iv. What challenges do Pastors' wives encounter in providing health related information to nursing mothers?

- v. In what ways can the Pastors' wives be assisted to be more active in promoting maternal and child health?

1.5 Aim and Specific Objectives of the Study

The aim of this study is to investigate the suitability of the adoption of faith-based approach in the promotion of child care practices through the Pastors' wives in Ibadan North Local Government Area of Oyo State, Nigeria.

Specifically, the following objectives were investigated;

1. To identify the health related programmes that the Pastors' wives have been involved in.
2. To assess the level of knowledge of Pastors' wives on the child care practices in the child survival strategy.
3. To define the methods Pastors' wives use in the communication of health related information to mothers.
4. To identify the challenges encountered by Pastors' wives in delivering health related information to mothers.
5. To highlight the ways Pastors' wives can be assisted to be more active in promoting maternal and child health.

1.6 Research hypotheses

To guide the study, the following null hypotheses (Ho) were formulated;

1. There is no significant relationship between pastors' wives educational status and level of knowledge of child care practices.
2. There is no significant relationship between Pastors' wives previous attendance in any health related programmes and knowledge of child care practices
3. There is no significant difference in the level of knowledge of child survival strategy between Pastors' wives who had ever discussed child care issues with mothers and women of child bearing age and those who has not

1.7 Significance of the Study

Considering the fact that faith-based settings have a longstanding history of serving vulnerable populations, provide access to low socioeconomic and other medically underserved populations (Newlin et al., 2012) couple with their advantageous resources in volunteers and facilities, they can be utilized for health promotion activities. Hence, the findings from this study will be important in the planning of interventions toward the achievement of the MDGs 4 and 5 and thus bring the MDGs 4 to reality.

Moreover, considering that pastors' wives are involved, there is assertion that adoption of the child survival strategy by mothers will be accelerated, widely accepted and sustained because they serve as role model to the women in the church. Thus the findings of this study will add to the large-scale programmes launched to reducing child mortality.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 Health Promotion and Settings

As defined in the Ottawa Charter for Health Promotion, health promotion is the process of enabling people to increase control over, and to improve, their health (WHO 2009a). According to Mikkelsen, Poulsen and Jensen, (2014), health Promotion conceptualizes health promotion action like building healthy public policy; creating supportive environments; strengthening community actions; developing personal skills; reorienting health services (beyond its responsibility for providing clinical and curative services) and moving into the future (with caring, holism and ecology as central strategic elements). The notion of health promotion operating in a context beyond the individual is one that has found increasing popularity over the years and has been emphasized on context that has been reflected in the proliferation of related terms such as ‘settings for health’ (Baric, 1991), ‘organisational development for health’ (Grossman and Scala, 1993; Simnett, 1996), ‘health promoting environments’ (Nutbeam, 1997), community development for health’ (Labonte, 1998) and ‘health promoting arenas’ (Health Education Board for Scotland, 1994). One of the best developed and most popular expressions of this form of practice has been the emergence of ‘settings’ based activity during the 1990's (Baric, 1991, 1993).

WHO defines a setting as a place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing (WHO, 1998). To Poland, Green and Rootman (2000), settings are both the medium and the product of human social interaction and thus more than simply locations in space-time. By another author, settings can be seen as surroundings through which a particular and desired target group could be reached, but not as the target of actions per se (Torp, Kokko and Ringsberg, 2014). According to Mittelmark (2015), the term ‘setting’ refers to places where people congregate for work, play and fellowship, such as schools, workplaces, recreational spaces and places of worship. By implication, a setting is where people actively use and shape the environment and thus create or solve problems relating to health. The WHO give a list of all existing healthy settings to include cities, villages, Municipalities and Communities, schools, workplaces, markets, homes, islands, hospitals,

prisons and universities. The setting approach thus emphasizes the individual, social and structural dimensions of health promotion. Indeed, the actions specified in the Ottawa Charter were reported to be facilitated in schools, homes, work places and community settings because health is created and lived by people within the settings of their everyday life; where they learn, work, play and love (Mikkelsen et al., 2014). In addition, according to (Poland et al., 2000), these settings had been sustained and supported by international (WHO, 1986; WHO, 1991; WHO, 1997; WHO, 1998) and national sources (HEBS, 1994; Secretary of State for Scotland, 1999), and have resulted in a range of settings based movements (e.g. cities, schools, workplaces), and a volume of associated descriptive and evaluative academic literature (Chu et al., 2000).

2.2 Settings Approach to Health Promotion

The notion of health promotion operating in a context beyond the individual is one that has found increasing popularity over the years. Health promotion taking into account that contextual factors are important health determinants; that health should be dealt with preferably alongside the core business of the settings, not separately nor independently; and that the contextual factors of the settings interact with other settings (Dooris, 2013; Poland, Krupa and McCall, 2009).

The settings approach to health promotion is the instrumental use of places where people gather and spend considerable time for purposes other than health promotion (e.g. where they eat, shop, work, learn, pray, play, get medical treatment) (Mittelmark, 2015). One of such settings and of interest in this study is the Faith-Based Setting (FBSs) as seen in Faith-Based Organisations (FBOs). The settings approach to health promotion has been widely advocated as offering opportunities to situate practice in its social context, optimize interventions for specific contextual contingencies, target crucial factors in the organisational context influencing behavior, and renders settings themselves more health enhancing (Frohlich and Poland, 2007; Poland et al., 2000; Whitelaw, Baxendale and Bryce, 2001; Leger, 1997; Baric, 1993).

Targeting the setting is what is regarded as settings-based work (Whitelaw et al., 2001), in which the contextual factors affecting health and health behaviors can be acknowledged. The settings-based approach to health promotion employs a social ecological

framework to integrate health promotion into the usual activities of the setting and to increase the setting's support for healthy choices (Mittelmark, 2015). This implies that peoples' health-related decisions could be supported through policies and changes in these contextual factors. One important, often overlooked, aspect of settings-based health promotion is the link between health promotion and the core business of the setting in question, like teaching and learning in schools, or productivity in companies (Torp et al., 2014). In addition to schools for children, WHO underlines that universities are important settings for promoting health among young adults (Tsouros, Dowding and Dooris, 1998). The workplace is an important health-promotion setting, since many adults spend much of their life at work and since their well-being is closely related to enterprise and national productivity; thereby being the basis for robust welfare states. In addition, almost all settings for health promotion include workers as one of several important stakeholders for health promoting activities. The settings approach is well known, widely utilized and top-rated, and has been developing for almost 30 years (Golden and Earp, 2012; Richard, Gauvin and Raine, 2011; WHO, 1986). That is, health promotion taking into account that contextual factors are important health determinants; that health should be dealt with preferably alongside the core business of the settings, not separately nor independently; and that the contextual factors of the settings interact with other settings (Dooris, 2013; Poland, Krupa and McCall, 2009). Of interest in this study is the utilization of faith-based setting which include places of worship.

2.3 The relationship between Health, Religion and Culture

The WHO defines health as the state of complete physical, social, mental and emotional wellbeing and not merely the absence of disease or infirmity (WHO, 1956). This state was said to be affected by factors termed "determinant of health" among which are broadly environmental factors and personal factors which include religion and culture. Although religion is a non-material aspect of culture, it is a social institution and cultural trait, characterized by its universality, its rituals, its sacredness and its persistence. It exists in all societies because it offers answers and some purported solutions to such ultimate questions as why we fail or succeed and why we die (Atere and Olagbemi 1997) as well as why we fall sick or are healthy. According to Oluwabamide and Umoh (2011), religion performs important functions that are vital for the survival and continuity of all societies and

these include, it function in making the world comprehensible to man, acts as a social control mechanism, as a major force both for personal and societal change and stability and its ceremonies that help reaffirm group togetherness and provide outlets for other emotional expressions.

Faith and spirituality play a vital role in the health and well-being of communities and individuals worldwide. A recent demographic study covering more than 230 countries and territories estimated there are 5.8 billion religiously affiliated adults and children around the globe, representing 84% of the 2010 world population of 6.9 billion (Pew Research Centre, 2010). While the vast majority of people in the world exercise faith in a supreme divine being, and have links with a religious community of some form (temple, mosque, church etc), every person has a 'world-view' and invests faith in something (Gray, 2011). During the eighteenth and nineteenth centuries, mission societies began providing medical aid under colonial governments in Asia, Africa, and Latin America. These historical roots remain evident in the continued presence and stature of FBOs in developing countries (Kagawa, Anglemeyer, Montagu, 2012). Over the past decade, a growing body of research has documented the relationship between religiosity and health outcomes among African with several studies reporting overall positive results for church-based programs.

Evidence from over 1,200 studies and 400 reviews has shown strong associations between faith and a number of positive health benefits, including protection from disease, coping with illness, and faster recovery from it (Bunn and Randall, 2011). One large study in the US found an average increase in life expectancy of seven years (14 for African Americans) for those who regularly attend church. The study investigators attributed the benefit to be due to more protective relationships, including marriage, and to healthier behaviours (Hummer et al., 1999). The Global Burden of Disease Study (2010), just published, is the largest ever systematic effort to describe the global distribution and causes of a wide array of major diseases, injuries, and health risk factors. Anxiety, depression, substance abuse (including alcohol and tobacco), dietary habits, exercise patterns, social and personal capital, are all affected by our beliefs, values and religious practices, as individuals and societies (The global burden of disease, 2012). Not only does faith bring positive health benefits to the individual but also to communities. Local faith communities such as churches, mosques and temples are often a focus for community action and bring the social capital that

builds civil society and forms the bedrock for development and community health (DFID, 2012)

On the other hand, culture is seen as “that complex whole which includes knowledge, belief, art, morals, law, customs or any other capabilities acquired by man as a member of society” (Cited in Oke 2004). Culture is a concept which distinguishes human beings from other animals (Kroeber 1968). That is, culture is solely associated with man (Alland 1980). In a simpler term, culture is the patterned way of life shared by a particular group of people. It includes a people’s law, economic organisation, political organisation, religion, language, education, kinship, arts, morals, technology, medicine etc (Oluwabamide and Umoh, 2011). From the definition of religion and culture, it can be seen that directly and indirectly, they affect health and are all determinants of health and it is obvious that religion is an aspect of culture and both determine health. Those who study religions are studying culture though with particular reference to belief systems (Awofeso and Ogunbodede 2000). Different cultures produce different systems of religious beliefs but they all share a common feature – they center around a fundamental belief in the supernatural (Awofeso and Ogunbodede 2000). It is obvious from the discussion so far that a religious approach to any human problem is more or less a cultural approach. In fact studies showed that secular intervention studies, tend to report relatively comparable maintenance and sustainability rates, particularly when culturally sensitive strategies are employed (Newlin, Melkus, Jefferson, Langerman, Womack and Chyun, 2006; Escobar, Tortolero, Masses, Watson and Fulton, 2002; Gilliss, Lee, Gutierrez, Taylor, Yewoubdar, Neuhaus and Murrell, 2001). Incorporating religious content into the health promotion programmes has reported overall positive health outcomes and this provided indication that religious social support contributed to programme success (Sbrocco, Carter, Lewis, Vaughn, Kalupa, King, Suchday, Osborn and Cintron, 2005; Barnhart, Mossavar-Rahmani, Nelson, Raiford and Wylie-Rosett, 1998; Kumanyika and Charleston, 1992). Thus, it may be challenging to disentangle the effect of contextual spiritual or religious factors on outcomes when faith-based programs are studied (Yanek, Becker, Moy, Gittelsohn and Koffman, 2001). With these factors considered, ongoing collaborative planning for program sustainability may foster community ownership of the health promotion program, and thereby maintenance of health benefits achieved by the research programme (Baskin, Resnicow, Campbell, 2001; Shediach-Rizkallah and Bone,

1998). Ontologically, offering a positivist perspective, a number of theoretical models have promising applicability in this area of research, proposing paths linking religious, spiritual, cultural, psychosocial, educational, behavioral, and other factors embedded in faith-based interventions to health outcomes (Koenig, McCullough, and Larson, 2001; Bolton and George, 1995).

2.4 The Role of FBOs in Health Systems Strengthening

The contribution of private for-profit providers has grown in the past decades and represents the majority of care in most developing countries (Forsberg, Montagu and Sundewall, 2011). Recent reports have stated that faith-based organisations play a substantial role in care (Schmid, Thomas, Olivier and Cochrane, 2008; WHO, 2007a; African Religious Health Assets Programme 2006), providing up to 70% of all services in developing countries (African Religious Health Assets Programme 2006a). For example, the Nigeria Health System Assessment published that faith-based organisations in Nigeria provide 60% of the country's healthcare (Kombe, Fleisher, Kariisa, Arur, Sanjana, et al. 2009). The National Congregations Study (2006–2007) found that 45% of congregations were involved in formal delivery of social services, while another 27% were involved informally (Chaves and Anderson, 2008).

In 1993, the World Development Report published that FBOs provide more than ten percent of clinical services in India, operate nearly half of hospitals in Haiti and own nearly 25 percent of health facilities in the three largest cities of Brazil (WHO, 1993). In Nepal, churches own 19% of the hospitals (Gilson, Sen, Mohammed and Mujinja, 1994) and in Jordan, 7% of the population receives care at mission hospitals and NGOs (Nandakumar, Wilwerding and Bhawalkar, 2002), and. A 2010 review of FBOs in Latin America notes their importance in health and social service provision in the region, but does not offer quantified measures (Derose, Kanouse, Kennedy, Patel, Taylor, et al., 2010).

The study by Kagawa, Anglemyer and Montagu (2012) describe the proportion of healthcare provided by FBOs as it pertains to the percentage of total number of hospitals, the percentage of total number of health facilities, the percentage of total healthcare provided, the percentage of total hospital beds, or the percentage of total staff of the national healthcare system (Figure 1). In order to provide a clearer picture of the role of FBOs in health systems

strengthening, a systematic review of existing literature and new meta-analysis of Demographic and Health Survey (DHS, 2011) data from 47 countries was undertaken (Kagawa, Anglemyer, Montagu, 2012). Although the study by Kagawa et al. (2012) was the first comprehensive assessment of the current importance of FBO-provided medical care in developing countries to attach only verifiable data to the estimates of FBO-provided care, 59 sources covering 48 countries were also contributory.

The data behind these numbers are sometimes difficult to pinpoint and seem at odds to national and regional survey data (Montagu, Yamey, Visconti, Harding and Yoong, 2011; Bustreo, Harding and Axelsson, 2003). Many studies have noted the lack of robust data on faith-based health care services and the need for more methodologically sound estimates to inform policy (Olivier and Wodon, 2011; Olivier and Wodon, 2010; Olivier, 2001). Although a “profiling exercise” rather than a “comprehensive, detailed survey”, at least a study has undertaken the exercise of describing the scale of FBO-provided care (Schmid et al., 2008).

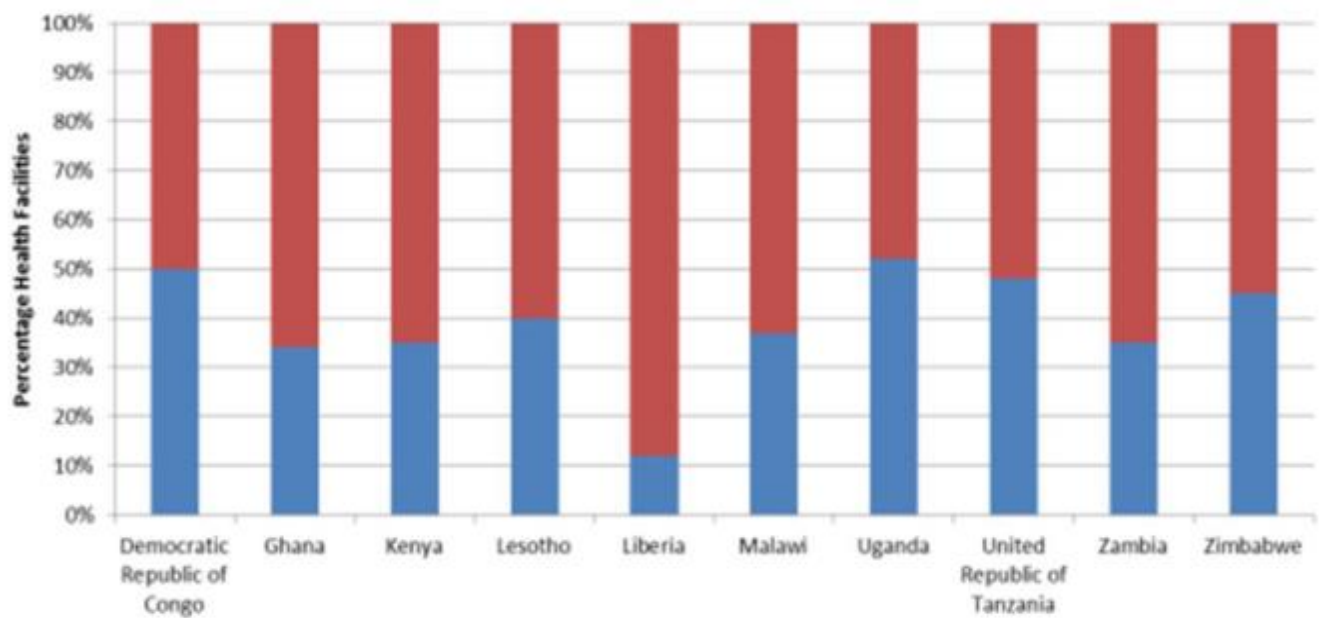


Figure 2.1. The Percentage of all Healthcare Services or Infrastructure in Low- and Middle-Income Countries that is Provided by Faith-Based Organisations (blue) and Ministry of Health (red) (Adapted from Santos, 2014).

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2.5 Faith-Based Organisations in health

Caring for the sick and dying has been a hallmark of the Christian Church over the centuries. Mission societies, which initially sent only ordained men to save souls, began to realise that caring for the sick was an integral part of bringing Christ's presence into a needy world. In AD 259 the Christian community cared for plague victims in Alexandria, often losing their lives in caring for those infected (Lavy, 2013). Lavy (2013) added that in the middle ages, monasteries provided hospitals and leprosaria all over Europe with some early pioneers travelling across the world to bring care in Christ's name. In 1568 two Jesuit priests built the first Christian hospital in Japan and in 1699 Bernard Rhodes of Lyons, a monk trained in medicine and surgery, took his skills to China. There are records of other brave individuals but it was not until the middle of the nineteenth century that mission agencies started sending doctors in greater numbers. It is estimated that over 1,500 British doctors went to serve overseas between 1850 and 1950 (Browne, 1985). Over 200 of these were women, who pioneered obstetric care in Asia where women were shut off from the help of male doctors, starting with Fanny Butler who set off to India in 1880.

Today it is estimated that faith-based organisations (FBOs) provide 40% of the healthcare in Sub-Saharan Africa (WHO, 2007a), and it is reported that in India, 80% of Christians relate their conversion to a mission hospital experience at some point in their family history (PRISM Survey, 2011). Since 1950, hundreds more doctors have served overseas, many of them from Christian Medical Fellowship. A third of the membership responded to a survey in 2010 and of these, 230 (20%) had served overseas long-term in the past. Currently almost 200 members are working in resource-poor settings in 56 countries around the world. Hundreds more make short-term contributions, most commonly to train and teach (Lavy, 2013). In 2008 the Gates Foundation commissioned. The African Religious Health Assets Programme (ARHAP, 2012) to carry out a wide-ranging study looking at the contribution of religious entities to health in Sub Saharan Africa (ARHAP, 2008). They found that the proportion of services provided by faith groups of all kinds varied across the continent, ranging from 25% in some Francophone Muslim countries to as much as 70% in parts of East and Southern Africa (ARHAP, 2008). Mission hospitals and church-based clinics are the main providers of facility-based services. In addition to facility-based care, faith-based entities provided training centres for the health workforce (eg 60% of nursing

training in Uganda), community activities such as home-based care, advocacy, and a channel for funding. A study by PEPFAR of USAID (A Firm Foundation, 2012) highlighted the enormous contribution that FBOs have made in the fight against HIV, with a wide range of programmes, skills and knowledge, a clear commitment to serve local communities and the capacity to mobilise an army of volunteers in any corner of the globe. There are very few studies analysing the care given in faith-based hospitals and clinics and more research is needed. One study published in the *International Journal of Obstetrics and Gynaecology* (Widmer et al., 2011) looked at the role of FBOs in the area of maternal/newborn health care in six African countries. It was found that the services provided by FBOs were similar to those offered by governments, but the quality of care received and the patients' satisfaction were reported to be better, due to better service quality, staffing levels, supplies and cleanliness. The ARHAP study contains much anecdotal evidence that people prefer to be treated in mission hospitals, where they feel staff are motivated by their faith to treat patients with dignity and respect, give spiritual care and have a commitment to serve the poor (ARHAP, 2008)

2.6 Faith-Based Organisations and health: How effective?

There is a sizable multidisciplinary literature describing the health-related activities of FBOs. Studies have described the features of successful health promotion programs and partnerships in FBO; especially with churches (Sanders, 1997; Hatch and Derthick, 1992) and the importance of the church as an ally in efforts to provide preventive health and social services to at-risk populations (Sutherland, Hale and Harris, 1995). In addition, the interconnections between public health, health education, and FBOs have been examined (Chatters, Levin and Ellison, 1998), and the possible contributions of FBOs to improved community health outcomes have been described (Foege and O'Connell, 1990). Moreover, community-based participatory has been reported to appear to be an especially promising approach for African Americans, many of whom distrust healthcare professionals due to the infamous Tuskegee Syphilis Study and enduring years of racial discrimination (Hamilton et al., 2006; McCallum, Arekere, Green, Katz and Rivers, 2006; Wallerstein and Duran, 2006; Williams and Mohammed, 2009).

A number of literatures have indicated the effectiveness of FBO in health. Since FBOs and churches are familiar community-based institutions, they frequently succeed when outside health professionals cannot (Public Health Service, 1989). This is expected considering the fact that as many as 57% to 78% of congregations are involved in health activities (Chaves and Tsitsos, 2001; Hilton, 2000). More thorough collaboration between researchers and FBOs will facilitate better understanding of the community on the part of these health professionals, contribute to building the credibility of their projects (Sutherland, Hale and Harris, 1995; Randall-David, 1989). In addition, 7 intervention studies have reported significant findings involving either a quasi-experimental (Erwin, Spatz, Stotts and Hollenberg, 1999; Wiist and Flack, 1990) or an experimental (Duan, Fox, Derosé and Carson, 2000; McNabb, Quinn, Kerver, Cook and Karrison, 1997; Toh and Tan, 1997; Voorhees, Stillman, Swank, Heagerty, Levine and Becker, 1996; Campbell, Demark-Wahnefried, Symons M, et al., 1990) design with faith based settings.

The interesting findings in studies where FBOs were used as setting are not surprising. This is based on the fact, the church or more broadly FBOs are considered the most important social institution (Bronner, 1995) and is the key community agent linking the African American community to the wider society beyond the congregation (Eng, Hatch and Callan, 1985). Moreover, they can reach large numbers of individuals in the communities outside of their particular congregations (Winett, Anderson, Whiteley, et al., 1999) and can sponsor community activities for all of those in need (Taylor, Ellison, Chatters, Levin and Lincoln, 2000; Lasater, Becker, Hill and Gans, 1997).

2.7 Adoption of Faith Based Organisation in Health Promotion

As government entities, not-for-profits, and for-profit organisations have taken a more dominant role in funding and delivering health and human services, faith communities have continued to play an active, though less obvious, role in providing community services. At least one in five congregations report supporting or providing cash assistance, food assistance, hospital/nursing facilities, counseling/hot lines, elderly housing and other senior services, services in prison, child care, substance abuse services, tutoring, health education, or employment services (Dudley and Rozen, 2001); hence, faith communities continue to play a vital role in community services that create a “national, personal network of human

services extending to virtually every community” (Dudley and Rozen, 2001; Canning, 2005). Existing literatures showed that FBOs have been a setting for social activities, a vehicle for disseminating information, a tool for organising the community, and a conduit for providing social services and they continue to fulfill these roles today (Krause, 2003; Zuckerman, 2000; Billingsley, 1999). By implication, FBOs can be said to serve as an important gateway to services and care for people and communities in need or in conflict. FBOs as a settings for health promotion have a long history of independently and collaboratively (Thomas, Quinn, Billingsley and Caldwell, 1994) hosting health promotion programs in areas such as health education (Wilson, 2000), screening for and management of high blood pressure (Smith, Merritt and Patel, 1997), and diabetes (McNabb, Quinn, Kerver, Cook and Karrison, 1997), weight loss (Kumanyika and Charleston, 1992), promoting heart health in stroke (Butler-Ajibade, Booth and Burwell, 2012) and smoking cessation (Schorling, Roach and Siegel, 1997), cancer prevention and awareness (Duan, Fox, Derose and Carson, 2000; Earp and Flax, 1999; Davis, Bustamante and Brown, 1994), geriatric care (Cowart, Sutherland and Harris, 1995), nutritional guidance (Barnhart, Mossavar-Rahmani, Nelson, Raiford and Wylie-Rosett, 1998), and mental health care (Jensen, Flynn, Cozza and Karabin, 1998) as well as the provision of education, water, sanitation, health, food, spiritual and other services (Moyo and Keir, 2014).

Over the past decade, a growing body of research has documented the relationship between religiosity and health outcomes especially among African Americans, with several studies indicating overall positive results for church-based programs aimed at improving self-care health practices and treatment of diseases (Peterson, Yates and Atwood, 2005; Oexmann, Ascanio and Egan, 2001; Yanek, Becker and Moy, 2001; Duan, Fox and Derose, 2000; Mann, Sherman and Clayton, 2000; McNabb, Quinn and Kerver, 1999; Weinrich, Holdford and Boyd, 1998; Schorling, Roach and Siegel, 1997; Smith, Merritt and Patel, 1997; Voorhees, Stillman and Swank, 1996 Turner, Sutherland and Harris, 1995). Faith-based organisations often assume service needs that have been abdicated or inadequately met by other service institutions (Mattis and Jagers, 2001; Billingsley and Caldwell, 1991).

Although the practice has not become widespread (Francis and Liverpool, 2009), churches traditionally have been involved in a variety of health interventions (Peterson, Atwood and Yates, 1999), and they can be an important vehicle for disseminating accurate

and sensitive information regarding behaviours that parents are often uncomfortable discussing with young people (Coyne-Beasley and Schoenbach, 2000). For example, providing health education about HIV/AIDS and sexually transmitted infections (STIs) through faith-based institutions (Campbell, Hudson, Resnicow, Blakeney, Paxton and Baskin, 2007; Hartwell, Gaddis and Fletcher, 1990) and the outcomes have been significant and encouraging.

In the area of HIV/AIDS, the potential of religious organisations to mitigate the societal impact of HIV/AIDS is often invoked in both policy and general public discourse (POLICY Project, 2004; Green, 2003). Faith-based responses to the pandemic have found enthusiastic support at the highest political level (The President's Emergency Plan for AIDS Relief-PEPFAR, 2006), and funding agencies have been looking to channel their AIDS assistance through churches and other religious organisations (CDC, 2004; POLICY Project, 2004, Green, 2003). However, relatively little systematic and unbiased evidence exists to show how this potential has been realized in practice (Tiendrebeogo and Bukyx, 2004; Takyi, 2001). On the other hand, much of the information on the involvement of religious organisations in HIV/AIDS-related care and support comes from leaders and advocates of such organisations (Catholic News, 2003; Bate, 2003; Byamugisha, Steinitz, Williams and Zondi, 2002; Paterson, 2001). This information is often selective and self-congratulatory and does not allow for an impartial assessment of the achievements and problems in the provision of HIV/AIDS-related assistance by religious organisations. The volume and frequency of HIV/AIDS-related assistance provided by religious organisations, as well as the relative distribution of that assistance between members and nonmembers of religious organisations, generally remain unknown.

In the area on improving self-care health practices as in cancer screening many studies have documented positive results for church-based programs in this regards. Although this topic has not been studied extensively, several investigations have shown that church-based interventions are particularly effective in increasing the number of African American women who screen regularly for breast cancer (Duan, Fox, Derosé, et al., 2000; Mann, Sherman, Clayton, et al., 2000; Erwin, Spatz, Stotts, et al., 1999). In studies in which churchgoers were non-adherent with cancer screening before intervention, results from the study by Mann and colleagues (Mann, Sherman, Clayton, et al., 2000) promoted cancer

screening in church congregations through literature, health fairs, testimonials by cancer survivors, and visits by medical practitioners and nearly 50% of participants who were non-adherent for at least one cancer screening at baseline reported up-to-date screening at 7-month follow-up.

For diabetes, specifically in diabetes self-management education (DSME), findings suggest faith-based setting may provide a positive psychosocial environment for the delivery of DSME (Newlin et al., 2012). Indeed, CDC and NIH have previously recommended partner with faith-based organisations (FBOs) to address the public health challenge posed by diabetes among Blacks (CDC, 1999; NIH, 2010). In developing a culturally sensitive church-based weight loss program for Black women at-risk for diabetes, McNabb, Quinn, Kerver, Cokk and Karrison (1997) conducted focus groups with urban community women to identify salient behavioral and sociocultural issues related to weight loss. In another study, community volunteers received informal training to assist with delivery of interactive nutritional sessions aimed at improving glycemic control (Hahn and Gordon, 1998).

In cardiovascular health, weight management and hypertension, Yanek, Becker, Moy, Gittelsohn and Koffman (2001) have held focus groups and in-depth interviews with churchgoing African-American women to inform the development of a faith-based cardiovascular program. On the other hand, the study by McNabb, Quinn, Kerver, Cook and Karrison (1997) to test the effectiveness of PATHWAYS, a weight loss program designed specifically for urban African-American women, when administered in urban churches by trained lay facilitators, reported effectiveness and positive results. Another study by Kumanyika and Charleston, (1992) at the Baltimore Church High Blood Pressure Program (CHBPP) offers a behaviorally oriented weight control program consisting of eight weekly 2-h diet counseling/exercise sessions. The weight loss and related dietary or behavioral changes programmes resulted in weight control and enhance blood pressure control. In the case of healthy dieting, strong pastor supports have motivational effect fruit and vegetable consumption through Black churches (Resnicow, Jackson, Wang, De, McCarty, Dudley and Baranowski, 2001). Many other studies by FBOs have reported programs to bring about significant improvement in overall health status, increased fruit and vegetable consumption, and decreases in weight and blood pressure (Moore-Harrison, Johnson, Quinn and Cress, 2009; Anderson, 2004; DeHaven, Hunter, Wilder, Walton and Berry, 2004).

In the case of smoking cessation, Schorling, Roach, Siegel, Baturka, Hunt, Guterbock and Stewart (1992) involved church coalitions as the principal organisations through which to implement the interventions in an effort to address smoking cessation as principal target behavior. The results showed successfully implemented through a church coalition and associated significant progress along the stages of cessation. On major depressive disorder, known as is one of the leading causes of disability for adults worldwide (Greden, Riba and McInnis, 2011; Murray and Lopez, 1997), the church has been reported to be uniquely suited to facilitate mental health promotion (Bopp and Webb, 2012).

In the area of peace-building, the activities of faith and community-based organisations have been suggested to promote peace-building in spite of the complex nature of the conflicts that are associated with economic deprivation, political marginalization and inequality among the diverse groups in the state (Abdulmalik, 2014). Reconciliation and peaceful co-existence through faith and community-based organisations dialogue, aim at promoting better understanding of one another for lasting peace, harmony and peaceful inter-group relations has also been reported.

In the area of rural development; known to an absolute tool for fighting poverty and achieving economic prosperity at the grassroots level (Nwachukwu and Ezeh, 2007), the participation of FBOs is not left out. For example, in the case of Nigeria, a study finds that NGOs through FBOs have executed programmes/projects ranging from loan disbursement, support for HIV/AIDS infected/affected persons, provision of water and market information, adult literacy class and computer training, supply and processing of farm produce, and construction/ rehabilitation of schools, road rehabilitation and cooperative formation (Dimelu, Salua and Igbokwe, 2013). Based on the foregoing, FBOs have taken strong leadership roles in providing training, economic development, educational support, food and spiritual support.

2.8 Adoption of Faith-Based Organisations for Improving Child Health

Recall that the Millennium Development Goals 4 and 5 focus on reducing child mortality and improving maternal health, respectively (UN, 2000) and that achieving this is based on innovative approaches to service delivery and the establishment of inclusive partnerships (Yadamsuren, Merialdi, Davaadorj, Requejo, Betrán and Ahmad, 2010). In this

regards, the World Development Report in 1993 called for the greater use of NGOs, particularly FBOs, to improve service quality and fill existing gaps in healthcare services (Gill and Carlough, 2008). Interestingly, a study has reported that one potential strategy for reaching the MDGs 4 and 5 in high-burden countries could be the development of strong partnerships between FBOs and the broader public health community including policy makers (Gill and Carlough, 2008). This is predictable considering the fact that “the vast majority of people in sub-Saharan Africa identify themselves as adherents of Christianity or Islam (Pew-Templeton Global Religious Futures Project, 2010)” couple with the fact that “approximately 75% of Africans trust their religious leaders (Ferrett, 2005)”. In addition, findings indicate that leveraging the influence of religious leaders and promoting faith-based or faith-inspired health services and programmes could effectively address the challenges in maternal and child health in Africa, where a growing proportion of maternal and child deaths occur (Widmer, Betran, Merialdi, Requejo and Karpf, 2011).

After over three decades ago when the World Development Report called for partnership with FBOs, a study reported it was repeated in 2006 with the assessment of the impact of religion and religious entities on achieving universal access to services in the context of the HIV epidemic in Zambia and Lesotho (African Religious Health Assets Programme, 2006b). This assessment was said to be carried out by the African Religious Health Assets Programme at the Universities of Cape Town, Witwatersrand, and KwaZulu Natal and stressed the need for greater appreciation of the contribution FBOs can make in the fight against HIV/AIDS in high-prevalence countries. Thus, considering the inter-relationship between HIV/AIDS and MDGs 4 and 5, there is no doubt that such programme can be extended to maternal and child health care services. Moreover, the WHO has estimates that 30–70% of the sprawling healthcare infrastructure across the African continent are owned or run by FBOs, with percentages varying within this range in different countries (WHO, 2009b). This is also observed in Nigeria as portrait by several television programs where churches demonstrate pregnant women seeking services from them.

2.9 Gaps in the Literature

Majority of the available literature on the involvements of FBOs in health promotion and education have been on other issues of health without looking at their suitability and

feasibility in the promotion of child care which is also a public health problem. In the area of FBOs involvement in maternal and child health, paucity of literature is available. In this regards, strategies to overcome such unmet maternal health needs was reported to be increasingly embracing collaborative approaches between public and private (for-profit and not-for-profit) entities in health (Yadamsuren, Merialdi, Davaadorj, Requejo, Betran, Ahmad et al., 2010; Nishtar, 2004). However, the establishment of stronger partnerships continues to be hampered by lacking recognition of FBOs' contribution to health service delivery (Vogel, Betran, Widmer, Souza, Gulmezoglu, Seuc, et al., 2012; Widmer et al., 2011; WHO, 2007b). In fact, a systematic review on the contribution of FBOs to maternal and newborn health in Africa over the past 20 years, found that only six articles had been published on the subject (Widmer et al., 2011). This notable gap in the academic literature was also acknowledged by Vogel et al. (2012), who stressed the need for greater research efforts in this field.

Based on literature search on the World Wide Web, only a study published in the International Journal of Obstetrics and Gynaecology (Widmer et al., 2011) has documented the role of FBOs in the area of maternal/newborn health care in six African countries. In the case of Nigeria, no study was found in the literature that has documented on the contribution of FBOs to maternal and newborn health; this is in the presence of poor maternal and child health indices in the country. The available literatures on the contributions of FBOs in Nigeria are on HIV/AIDs, blood pressure and cardiovascular health, healthy nutrition, cancers education etc. No literature has documented on child care practices even when the MDG 4 is target towards improving child health in the country. Thus, this study is the first in Nigeria to observe the feasibility of FBOs in health promotion and education targeted towards child health. By implication, the findings in this study will provide information and fill the gaps in the areas of;

1. The suitability of promoting child care practices in the community through the Pastors' wives in FBOs and settings.
2. Health related programmes that the Pastors' wives have been involved.
3. Level of knowledge of Pastors' wives on the child care practices in the child survival strategy.
4. Methods Pastors' wives use in the communication of health related information to mothers.

5. Possible challenges encountered by Pastors' wives in delivering health related information and
6. Ways the Pastors' wives can be assisted to be more active in promoting maternal and child health.

2.10 Theoretical frame work

The conceptual framework used for this study is the social learning theory (SLT) propounded by Bandura in 1977 (Bandura, 1977). The initial phase of Bandura's research analyzed the foundations of human learning and the willingness of children and adults to imitate behavior observed in others, with special reference to aggression. He found that according to SLT, models are an important source for learning new behaviors and for achieving behavioral change in institutionalized settings (Henry and Charles, 1982). According to Bandura (1973) SLT posits that there are three regulatory systems that control behavior. First, the antecedent inducements greatly influence the time and response of behavior. The stimulus that occurs before the behavioral response must be appropriate in relationship to social context and performers. Second, response feedback influences also serve an important function. Following a response, the reinforcements, by experience or observation, will greatly impact the occurrence of the behavior in the future. Third, the importance of cognitive functions in social learning. For example, for aggressive behavior to occur some people become easily angered by the sight or thought of individuals with whom they have had hostile encounters, and this memory is acquired through the learning process.

By the mid-1980s, Bandura's research had taken a more holistic bent, and his analyses tended towards giving a more comprehensive overview of human cognition in the context of social learning. The theory he expanded from social learning theory soon became known as social cognitive theory (a comprehensive framework for understanding human behaviour) in which he re-conceptualized individuals as self-organizing, proactive, self-reflecting, and self-regulating, in opposition to the orthodox conception of humans as governed by external forces (Bandura, 1986). Bandura (1986) advanced concepts of triadic reciprocity, which determined the connections between human behavior, environmental factors, and personal factors such as cognitive, affective, and biological events, and of reciprocal determinism, governing the causal relations between such factors. Bandura's emphasis on the capacity of

agents to self-organize and self-regulate would eventually give rise to his later work on self-efficacy.

The SLT is complex and includes many concepts that are useful in health promotion. SLT assumes that people and their environments interact continuously (National Institutes of Health, 2005). It is important to recognize that SLT clearly addresses both the psychosocial factors that determine health behaviour and strategies to promote behaviour change. Considering the assumption in SLT that people and their environments interact continuously, it is expected that the Pastor's wife can have influence on women and mothers in the church, which in this case is the environment.

In SLT, human behaviour is explained in terms of a three-way, dynamic, reciprocal theory in which personal factors, environmental influences, and behaviour continually interact. A basic premise of SLT is that people, for example mothers, learn not only through their own experiences, but also by observing the actions of others, in this case the Pastor's wife, and the results of those actions. SLT synthesizes concepts and processes from cognitive, behaviouristic, and emotional models of behaviour change. As a result, it is very complex and includes many key constructs. Selected key concepts are defined and their applications presented in Table 2.1.

According to Bandura, much complex behaviour could never be learned unless people are exposed to some other humans who modeled them, in this case the pastor's wife who are seem as "First lady" and often referred to as "Mummy". Thus, observational learning permits human to acquire many new responses in settings where their "models" are simply pursuing their own interests and are not trying to teach any one anything. Now, the question that arises is: how does Bandura's observational theory bring about improvement of child care? The answer to the question is very simple and not far. Women and nursing mothers belong to one or the other organisation in the faith they belong; as it is often heard "Christian Women Organisation", "Christian Mothers", "Good Woman" and "Good Mother", which in most cases are headed by the pastor's wife or by the woman leader; whom most time is the wife of the pastor. This create an intertwine relationship between mothers, children and the pastor's wife in a setting. Imagine therefore that the pastor's wife is equipped with, preaches and practices child survival strategies and share experiences among the women in such organisational setting. Considering that the pastor's wife is revered and

'worshipped' as high and mighty. As such and most importantly because humans are essentially hedonistic, women and nursing mother tend to learn and internalize such health behaviours of who they, invariably, serve as a models or mentor. This can be thought of as shown in figure 2.2 a conceptual framework of the pastor's wife and improve child health through child survival strategy; a model for the present study through adaptation of social learning theory.

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Table 2.1: Social Learning Theory (adapted from National Institutes of Health, 2005 with modification from the present study)

Concept	Definition	Application	In the case of the present study
Reciprocal Determinism	Behaviour changes result from interaction between person and environment; change is bidirectional	Involve the individual and relevant others; work to change the environment, if warranted.	Person interaction: mothers and the pastor's wife Environment: FBO-the church
Behavioural Capability	Knowledge and skills to influence behaviour	Provide information and training about action.	Child care practices
Expectations	Beliefs about likely results of action	Incorporate information about likely results of action in advice.	Reduction in child mortality
Self-Efficacy	Confidence in ability to take action and persist in action	Point out strengths; use persuasion and encouragement; approach behaviour change in small steps.	The belief in religious leader and the mentoring qualities of the pastor's wife
Observational Learning	Beliefs based on observing others like self and/or visible physical results	Point out others' experience, physical changes; identify role models to emulate.	Pastor's wife and other workers in the FBO setting
Reinforcement	Responses to a person's behaviour that increase or decrease the chances of recurrence	Provide incentives, rewards, praise; encourage self-reward; decrease possibility	The FBO and Pastor's wife and philanthropies in the church

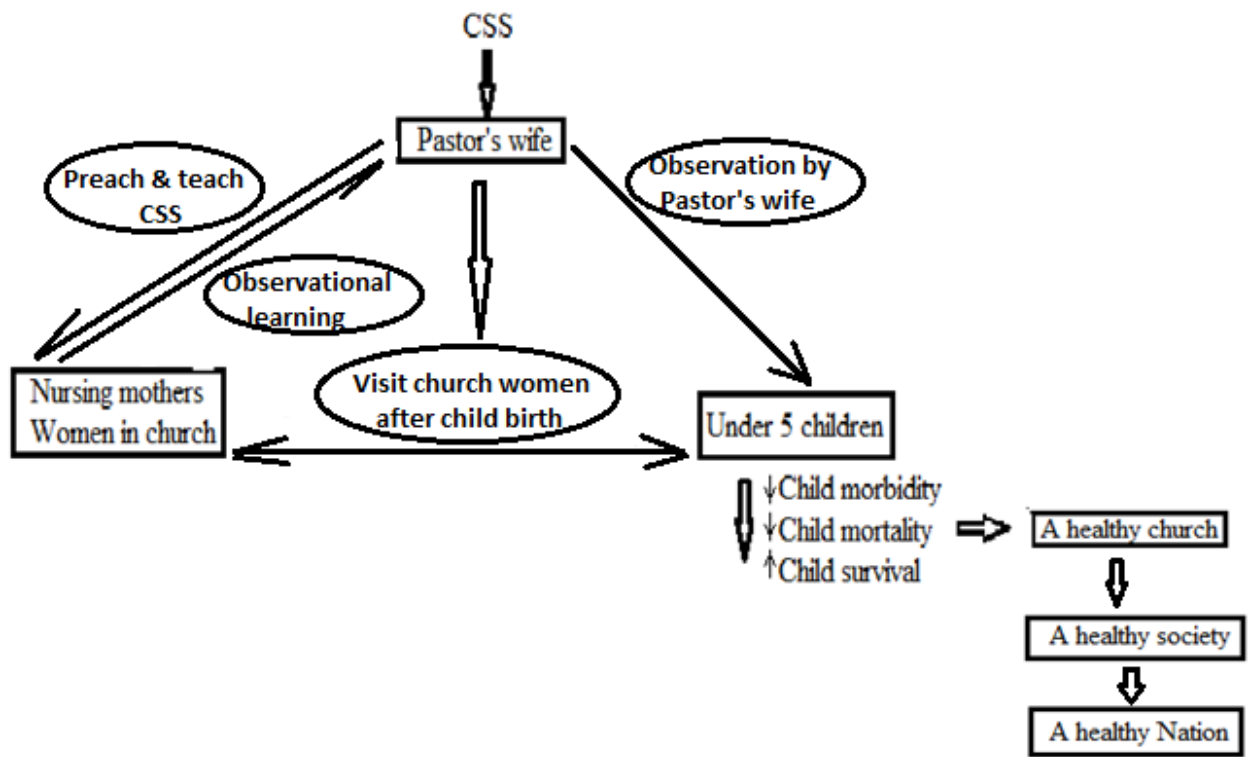


Figure 2.2. Conceptual framework of the pastor's wife and improve child health through child survival strategy. A model for the present study through adaptation of social learning theory

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CHAPTER THREE

METHODOLOGY

3.1 Study Design

The study is a descriptive cross-sectional study designed to investigate the suitability of faith-based settings in the promotion of child care practices through the pastors' wives in the study area. This study design was adopted in order to have base-line information on how suitable the Pastors' wives will be in the promotion of child care practices in the study community via identifying the health related programmes they have been involved in, assessing their level of knowledge on child care practices as well as identifying their methods of communication, challenges in delivering health related information and assistance they will require to active in promoting maternal and child health.

3.2 Study Area

The study was conducted in Ibadan North Local Government Area of Ibadan, the State capital of Oyo State located in the South West Geo-political zone of Nigeria. Ibadan North Local Government Area is located approximately on longitude 8°5' East of the Greenwich meridian and latitude 7°23' North of equators. Ibadan North Local Government Area comprises of 12 wards (table 3.1) and the 2006 population census placed the population of the study area at 306,763 (153,039 male and 153,756 female) (National Bureau of Statistics, 2006) with a landmass of 132,500 Km² with a population density of 2,626 persons per Km². Ibadan North LGA is bounded by Akinyele LGA in the North, Ido and Ibadan North West LGA in the West, Ibadan South West LGA and Ibadan North West LGA in the South, and Ibadan North East LGA and Lagela LGA in the East. Figure 3.1 is a diagrammatic representation of Ibadan North LGA and environs and table 3.1 shows the wards and areas in each wards.

The Local Government Area houses several educational institutions including the Nigeria Premier University- the University of Ibadan, The Polytechnic Ibadan and many private and public secondary and primary schools, health care centres (University College

Hospital, and several Maternity Centres and dispensaries, General Hospital, Traditional Healing Centre, and other primary health care and specialist hospital). These put Ibadan North LGA advantageous and ahead of other LGAs. In addition, the area is favoured and consists of multi-ethnic nationalities predominantly dominated by the Yoruba, Igbo, Edos, Urhobos, Itsekiris, Ijaws, Hausas, Fulani and foreigners who are from Europe, Asia and other parts of the world. The inhabitants are mostly traders, university and polytechnic lecturers, civil servants, students etc. As such the area is favoured with many churches.

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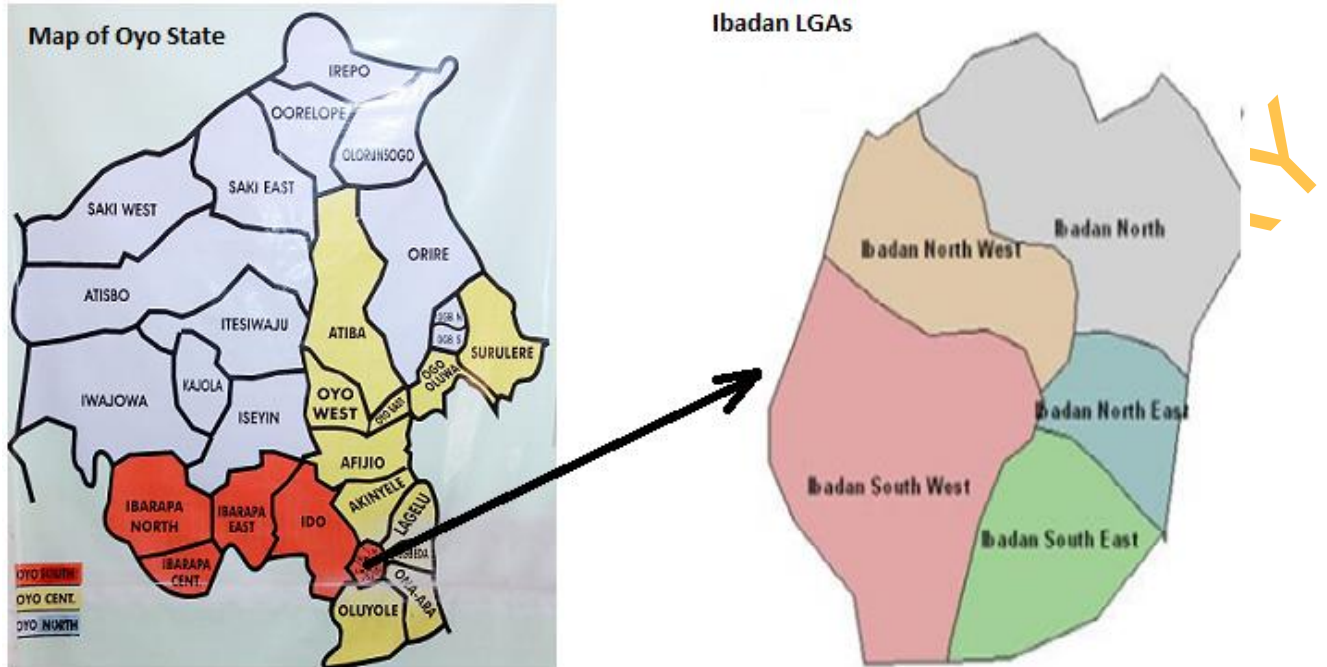


Figure 3.1: Map showing the Location of the study area (Adapted from Oloyede-Kosoko and Akingbogun, 2013).

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Table 3.1: Wards and areas in Ibadan North Local Government Area (Obtained from the LGA secretarial)

Ward	Name of ward	Areas
1	Oke Aare ward	Agala, Agbadagbudu, Are Latosa, Arogoja, Galaxy, Idi Agbon, Idi Eko, Ile Balogun, Ile Bodija, Ile Agbo, Ile Jonbola, Kannike, Obanibasirl, Ode Funke, Odo Iye, Oke Are, Olubodun, Sapati, Temidire, Tonibelo and Yerokun
2	Inalende Ward	Adeta, Agala, Akowo compound, Alomesin, Alubarika, Alagba, Afiku, Arowojobe, Dandary, Elizabeth area, Elelede, Ebu oko, Inalende, Ireakarl, Laniyonu, Liadi Area, Layanju, Lakanpo compound, Ode-Oolo, Ode Sina compound, Odunade area, Ojo Oniro, Olumola, Oke Oloro and Oniyarin, Oniyeye, Samibary area, Shafayo area, Yakubu area, U.N.A
3	Yemetu ward	Adeoyo, Aladorin, Adabale, Akablako, Barrack, Delesol, Isale, Adeoyo, Korukoru, Motherless baby home area, Oke Alfa, Oke Aremo, Oje Igosun, Ojo Badan, Omo lewa, Obadara, Oritamefa, St. Paul area and Yemetu Oja.
4	Agodi ward	Agodi, Agodi G.R.A., Alagbafo, Abenla, Ali-Iwo, Asanwale, ile Otun, Ifaola, Iyana Irefin, Igo sun, Gbenla, Idi Omo, Itutaba, Methodist, NTA area, Ogala, Oke Apon, Owo tutu, Oyakaka, Onike area, Odonigi, New star, Oje Igosun and Oke Apon.
5	Bashorun ward	Akingbola, Ashi, Abake st, Are Avenile, Bashorun, Deeper life, Favours area, Gate, Ikolaba, Idi Ape, Iyana Express, Inu koko, Kongi, Laamo, Oluwo kekere, Oluwo nla, Olona mosque area, Osunkaye, Oyebami and Winner way..

- 6 Sabo ward Alafia Hospital area, Christus Hospital area, Con oil area, Ganger 1, Ghana, Ile Ajo, Magae Ika, Oke esu, Oke Hausa, Sabo central, Sabo garage, Turumu sawa,
- 7 Oke Itunu ward Ajegunle, Adeola, Ade royaol, Amusu, Ayetoro, Baba Sala, Coca Cola, Fayemi, Jayeoba, Oke Itunu, Oke koto, Oladimeji area, Olusogo area, Popoola, Sotomi and Veterinary.
- 8 Sango ward Agbaje, Akorede, Aladire, Alaro, Alemuloke, Bembo, Bisimarafa, Gbaremu, Idi-Ito, Ijokodo, Loco, Odo Baale, Ori Apata, Patako, Poly road and Surulere.
- 9 Ago Tapa ward Alli St, Adeloja, Alafia area, Ago Tapa, Balogun, Bolarinwa, Culturalcenter, Cralg Avenue, Darlington, Gbade bo, Kabiawu, Mokola, Obembe, Okumade, and Premier Hotel area.
- 10 Old Bodija ward Alabiamo, Ajibade, Adeyi, Aperin, Arigidi, Awosika, Awolowo, Davies, Ede. Ekiti, Elewure, Housing, Ibikunle, Lebalam, SS Perter and Paul, New Bodija, Ogborie fon, Obasa, Oyesina, Ondo, Osanaye, Subuola, Sanusi, Secretarial, Trinitu and UCH.
- 11 Samonda ward Abadina, Afadebo, Expoyo, Hasfat area, Ile Pupa, Jaja, Mechanic, Orita UI., Old airport, Polytechnic area, Sango garage, Sango Barrack, Samonda and University of Ibadan area.
- 12 Agbowo ward Aduloju, Ade Tumobi, Akinfala, Alamuyo, Agbegba, Ansarudeen, Agbowo, Barika, Bodija market, Farayola, Ilupeju, Ile Eja, Iso Pako, Kara, Lagos/Ibadan Express way area, Major Salawu, Oju Irin, Oke Imule, Olive, Ojo kondo, and Orogun .
-

3.3 Study Population

The study was targeted at all Pastors' wives of registered churches in Ibadan North Local Government Area of Ibadan, Ibadan-Nigeria.

3.4 Inclusion Criteria

All Pastors' wives of churches registered with Christian Association of Nigeria (CAN) in the study area. Table 3.2 shows the list of registered churches in the study area. This was obtained from the CAN office in Ibadan North Local Government Secretariat at NTA area.

3.5 Exclusion Criteria

The Roman Catholic Church officially forbids marriage for her pastors. Hence, the Roman Catholic Church was excluded from the study and other churches not registered with CAN in the LGA were also excluded.

3.6 Sample Size Determination

Sample size was determined as described by Araoye (2008) using the formula below

$$N = \frac{Z^2 p (1-p)}{d^2}$$

Where N = minimum sample size required; Z = confidence limit of survey at 95% (1.96); p = prevalence of under-5 mortality in Ibadan, which is 9.0% according to NDHS (2013); d = absolute deviation from true value (degree of accuracy) =5% =0.05

$$N = \frac{1.96^2 \times 0.09 \times (1- 0.09)}{0.05^2} = 125.85 = 126$$

A non-response rate of 10% of 126 was added to the sample size to address possible cases of loss and rejection of questionnaires due to filling

$$\frac{126 \times 10}{100} = 12.6 = \text{this was approximated to } 13$$

Therefore, the minimum sample size estimate for the study was 126 + 13 = 139. This was approximated to one hundred and forty (140).

Table 3.2: List of registered churches by block in Ibadan North Local Government Area (Obtained from CAN Ibadan North LGA; see appendix ii)

S/N	BLOC	Group
1	CCN BLOC	Anglican church, Methodist church, African Church
2	PFN/CPFN BLOC	Winner Chapel, Christ Apostolic Church, Redeem Church, The Apostolic Church, Christ Life Church, Overcomer Church of Christ, Voice of Christ Church, Soul Harvester's Church, Vineyard of Grace Church, Rehoboth Living Church.
3	CSC BLOC	Catholic Church
4	ECWA/TEKAN BLOC	ECWA Church
5	OAIC BLOCK	Celestial Church of Christ, New Eden Light of Jesus, Cherubim and Seraphim Church, Christ Worker Gospel Mission, Inspiration of God Church Int'

Table 3.3: List of selected wards and registered churches in the wards

Serial number	Selected Ward	Registered churches in the selected wards
1	1	Baptist Church, Anglican Church, Cherubim and Seraphim Church, Celestial Church of Christ, Christ Apostolic Church, Redeem Christian Church of God, Assemblies of God Church, No way but Christ Evangelical Ministry, Glory of God Church, Voice of Christ Universal Church, The Apostolic Church.
2	3	ECWA, Anglican Church, Celestial Church of Christ, Cherubim and Seraphim Church, Baptist Church, Anglican Church, Christ Life Church, Christ Apostolic Church, Assemblies of God Church, Redeem Christian Church of God, Christ Progressive Ministry, Soul Harvester Church, Grace and Power Bible Church, The Apostolic Church.
3	5	Methodist Church, Baptist Church, Anglican Church, Cherubim and Seraphim Church, Celestial Church of Christ, Living Faith Church, Christ Life Church, Christ Apostolic Church, Redeem Christian Church of God, The Apostolic Church.
4	7	Baptist Church, Anglican Church, Celestial Church of Christ, Cherubim and Seraphim Church, Christ Apostolic Church, Redeem Christian Church of God, The Apostolic Church,
5	10	Methodist Church, Baptist Church, Anglican Church, Cherubim and Seraphim Church, Celestial Church of Christ, Living Faith Church, Christ Life Church, Christ Apostolic Church, The Apostolic Church, Assemblies of God Church, Redeem Christian Church of God, Believer's Heritage Church.

6 12 ECWA, Anglican Church, Cherubim and Seraphim Church,
Baptist Church, Celestial Church of Christ, Living Faith Church,
The Apostolic Church, Christ Life Church, Christ Apostolic
Church, Assemblies of God Church, Redeem Christian Church of
God, Soul Harvester Church, Christ Dominion International
Church, Elects of God Evangelical Ministry.

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3.7 Sampling Procedures

The study employed the multi-stage sampling technique involving four stages.

1. In the first stage, the Local Government Area (LGA) was stratified into wards and since the LGA consist of 12 wards, 12 strata were obtained.
2. In the second state, 6 wards were randomly selected from the 12 wards by balloting (see table 3.3 for selected wards); this was important so that data derived can be a representation of the LGA.
3. In the third stage, chairmen and representatives of each of the block of registered churches in the selected wards were visited and meetings were held.
4. In the fourth stage, pastors' wives of the 4 selected blocks of churches in the 6 selected wards were invited and all present who gave informed consent were sampled (see table 3.3 for churches in the selected wards).

This sampling procedure was adopted because of the problem of having the entire population of pastors' wives at the same time in the same place.

3.8 Instrument of Data Collection

A structured questionnaire was developed after reviewing existing literature and was used for data collection (see appendix iv). The questionnaire consisted of 6 sections aimed at providing answers to the stated objectives;

Section A contained the Pastors' wives socio-demographic characteristics/ profile.

Section B consisted of open and close ended questions that assess the health related programmes the Pastors' wives have been involved in.

Section C consisted of open and close ended questions that assess Pastors' wives level of knowledge on the child care practices in the survival strategy. The level of knowledge was examined using a 50 points knowledge scale. Scores from 24 points and below were classified as poor level of knowledge while scores between 25 - 34 points were classified as fair level of knowledge and scores above 34 points were classified as good level of knowledge.

Section D contained open and close ended questions that document the methods Pastors' wives use in the communication of health related information to nursing mothers.

Section E contained open and close ended questions that identify the challenges that the Pastors' wives encounter in providing health related information to nursing mothers.

Section F consisted of open and close ended questions that identify the ways that the Pastors' wives can be assisted to be more active in promoting health of mothers and babies.

3.9 Validity of Data Collection Instrument

Validity of the instrument for data collection was ensured through the development of a draft instrument by consulting relevant literatures and subjecting the draft to independent, peer and expert reviews, particularly expert in public health and comments from supervisor were used to validate the instruments.

3.10 Reliability of Data Collection Instrument

Reliability was determined by first subjecting 15 questionnaires (10% of the calculated sample size) to pre-test among pastors' wives in churches located at Oluyole Local Government Area. The data from the pre-test was coded, entered into the computer and analyzed. Reliability testing was then determined using the Cronbach's Alpha coefficient and a coefficient of 0.803 (see appendix v) was obtained and considered reliable since it was greater than 0.5.

3.11 Data collection procedure

The questionnaire used for the study was interviewer-administered. The data were collected by the researcher with assistance from 4 public health students who had received training and had previous experience on data collection. The data collection procedure follows the following stages

In the first stage, contacts of the chairmen and representations of each block of registered churches were obtained from the CAN chairman. They were contacted and visited separately and were provided with correct and understandable information about the study. The benefit and possible harm (in this case it only required the time involved in the interview) that can result from participation in the study was also explained to them. This was done in order to obtain assent from the pastors in charge (who served as the gate keeper) of the churches.

In the second stage, the leaders of the pastors' wives in each of the block were contacted and visited. The study was explained to them and also provided with same correct and understandable information about the study as well as the benefit and possible harm that may result from participating in the study.

In the third stage, meetings were fixed on dates when all the pastors' wives in each block will be invited. Again at the meeting with all pastors' wives a particular block, the study was explained to all. This was done in order to obtain informed consent from the pastors' wives who agreed to participate in the study (see appendix iii for inform consent form; the English and Yoruba version).

After obtaining informed consent from the pastor's wife, the validated structured questionnaire was administered (interviewer administered), completed and obtained from other research assistance.

3.12 Data Management

All copies of administered questionnaire after interview exercise were checked for completeness and accuracy and thereafter the questionnaires were assigned serial numbers for easy identification and for correct data entry and analysis. All ethics concerning data management were followed and adhered to. Coding guide was developed and all copies were coded and enter into the computer for statistical analysis.

3.13 Indicators of "suitability of Pastors' wives"

The following variables were used to determine how suitable the pastors' wives will be in the promotion of child care practices in faith-based settings.

1. High educational status: Education is known to influence how suitable an individual will be in carrying out an action and doing it well. Thus, high educational status will determine how suitable the Pastors' wives will be in the promotion of child care practice.
2. Involvement of Pastors' wives in health-related programmes: High level of attendance in health-related programmes in the past by Pastors' wives will mean that they have previous experience on health-related programmes and thus, their suitability. Similarly, high future interest of Pastors' wives to attend a health-related programme; specifically on child care programmes, will indicate their interest in child care issues and thus determine their suitability.

3. Level of knowledge on child care practices: High level of knowledge on child care practices in child survival strategy by the Pastors' wives will signal suitability of Pastors wives to promote child care practice in faith-based settings.

4. Communication of health-related issues between Pastors' wives and nursing mothers: High level of communication of health-related issues between the Pastors' wives and women and nursing mothers in the church will indicate the suitability of Pastors' wives in the promotion of child care practice in faith-based settings.

3.14 Data Analysis

Data analysis was carried out using the Statistical package for social sciences (SPSS) version 20. The data was entered into the computer and subjected to descriptive statistic (frequency, percentage and mean) and inferential statistics (odd ratio, Chi-Square test, t-test and F-test). Where applicable, statistical difference was determined at a confidence interval of 95% and $p < 0.05$ was considered significant. Results were presented in suitable tables and charts.

3.15 Ethical Consideration

Permission and approval to carry out the study was obtained from the Oyo State Ministry of Health Ethics Review Committee (see appendix i). The research participants (Pastors' wives) were provided information about the study and consent was obtained after provision of adequate, clear and complete information. They were informed they could withdraw from the study without any sanction and that the study was voluntary. Informed consent form was signed by all participants. The study was conducted in compliance with the Declaration on the Right of the subject/participant (WMA, 2000).

Confidentiality of data was guaranteed by not including name of the participants or any information in connection with them. The questionnaire was translated to local language for easy communication for participants who may require local language communication or not fluency in English. The Pastors' wives were also informed that participating in the study may not have immediate benefit for them but will help in the development of intervention toward improving child care and maternal health. However, the study can serve as a way of informing them on the existence of simple and low-cost effective child care practices. They

were also told that participating in the study has no harm or injury and is not malfeasance in any way except for the time it will take them to provide answers to the questions.

3.16 Study Limitations

That pastors' wives do not have one umbrella under where they meet is a limitation for this study considering the unequal chances of being selected. Another study limitation was the time given to conduct this study. The lack of logistic means to have the whole state in this study is also considered to be a limitation, thus, generalization of the findings may be limited. The small sample size, inclusion of only registered religious denomination, and geographic location in this study can serve as a study limitation because the findings may not reflect perspectives of other pastors' wives from other religious backgrounds, not registered churches and those living in diverse regions of the States.

CHAPTER FOUR

RESULTS

4.1 Socio-demographic characteristic of the pastors' wives that participated in the study

One hundred and twenty-eight (N=128) pastors' wives and women leaders took part in this study. Overall, the mean age of the pastors' wives was 46.1 ± 9.3 years (ranges from 27.0 years to 72.0 years). Except for 4.7% (n=6) who reported to be widows, they were all married and 95.30% (n=122) are currently living with husbands. They were majorly Yoruba (87.5%; n= 112) in ethnicity and had one form of education or the other with those with university education forming the majority (35.9%; n=46) and those with primary education forms the minority (11.7%; n=15). Except for 6.3% (n=8) and 7.0% (n=9) of the pastors' wives who reported to be full house wives and prophetess respectively, they all had one form of occupation with those on business and trading forming the majority (29.7%; n=38) and followed by those in education (teachers and lecturers) (21.9%; n= 28), civil servants (17.2%; n=22), health workers and nurses (7.8%; n= 10), and retiree (5.5%; n= 7). The mean number of biological children by the pastors' wives was 3.6 ± 1.5 . With the exception of 2.3% (n=3) who reported not having a biological child, they have at least a child with 8 children been the maximum recorded number of biological children by the pastors' wives (see Table one for detail of socio-demographic characteristics).

Table 4.1. Socio-demographic characteristics of pastors' wives that participated in the study

		N=128			
Demographic characteristics	Variables	Frequency (%)	Mean±Std. deviation	Minimum	Maximum
Age (years)	*	*	46.1±9.3	27.0	72.0
Marital status	Married	122 (95.3%)			
	Widow	6 (4.7%)	*	*	*
Ethnicity	Hausa	1 (0.8%)			
	Igbo	8 (6.3%)			
	Yoruba	112 (87.5%)			
	Edo	4 (3.1%)	*	*	*
	Calabar	2 (1.6%)			
	Delta	1 (0.8%)			
Highest educational status	Primary	15 (11.7%)			
	Secondary	21 (16.4%)			
	OND/NCE	31 (24.2%)			
	HND	15 (11.7%)	*	*	*
	University degree	46 (35.9%)			
Occupation	Business/Trading	38 (29.7%)			
	Teacher/Lecturers	28 (21.9%)			
	Civil servants	22 (17.2%)			
	Retired	7 (5.5%)			
	fashion designer	2 (1.6%)			
	Manager	4 (3.1%)	*	*	*
	Full house wife	8 (6.3%)			
	Health workers	10 (7.8%)			
	Prophetess	9 (7.0%)			
Number of biological children		*	3.6±1.5	0	8

* Not applicable

Table 4.2 shows the denomination, churches that participated in the study and the duration of service as a pastor's wife or women leaders by the pastors' wives who took part in the study. Except for the Catholic Church that fell within the exclusion criteria, all denominational block was represented. PFN/CPFN block forms the majority (51.6%; n= 66), and followed by the CCN block (27.3%; n=35), OAIC block (18.0%; n=23) and lastly the ECWA/TEKAN block (3.1%; n=4). See table 4.2 for the churches of the pastors' wives.

Table 4.3 shows the duration of service as a pastor's wife or women leaders and frequency of preaching or teaching to women in the church. The mean duration of serving as a pastor's wife or women leader by the participants was 13.0 ± 9.3 years with minimum and maximum periods of 1 year and 46 years respectively. Except for 9.4% (n=12) of the pastors' wives who reported not to have taught or preached to women in the church before, others reported teaching and or preaching in different degrees (see Table 2). Interestingly, 50.0% of the pastors' wives that participated in the study claimed to have discussed on child care issues with women of child bearing age in the church before.

Table 4.2. Denomination and churches that participated in the study
N=128

Variables		Frequency (%)
Denominations/	CCN	35 (27.3%)
Blocks	PFN/CPFN	66 (51.6%)
	OAIC	23 (18.0%)
	ECWA/TEKAN	4 (3.1%)
CCN block churches	Methodist	2 (1.6%)
(number of pastors' wives)	Baptist	18 (14.1%)
	Anglican	10 (7.8%)
PFN/CPFN churches	Living faith church	6 (4.7%)
(number of pastors' wives)	Christ Life Church	6 (4.7%)
	Christ Apostolic Church	13 (10.2%)
	Assemblies of God Church	2 (1.6%)
	Redeem Christian Church of God	21 (16.4%)
	The Apostolic Church	5 (3.9%)
	Christ Progressive Ministry	3 (2.3%)
	No way but Christ Evangelical Ministry	2 (1.6%)
	Soul Harvester Church	2 (1.6%)
	Christ Dominion International Church	2 (1.6%)
	Grace and Power Bible Church	2 (1.6%)
	Elects of God Evangelical Ministry	1 (0.8%)
	Glory of God Church	2 (1.6%)
	Believer's Heritage Church	2 (1.6%)
	Voice of Christ Universal Church	2 (1.6%)
OAIC block churches	Cherubim and Seraphim Church	13 (10.2%)
(number of pastors' wives)	Celestial Church of Christ	10 (7.8%)
ECWA/TEKAN churches	ECWA	4 (3.1%)
(number of pastors' wives)		

Table 4.3. Duration of service as a pastor's wife or women leaders, frequency of preaching or teaching as a pastor's wife
N=128

Variables	Frequency (%)	Mean±Std deviation	Minimum	Maximum
Duration of service as pastor's wife/women leader (years)	*	13.0±9.2	1.0	46.0
Frequency of teaching or preaching to women in the church	Not at all 12 (9.4%) Once a month 4 (3.1%) Occasional 28 (21.9%) Once a week 30 (23.4%) Twice a week 5 (3.9%) 3 times a week 1 (0.8%) Many times possible 48 (37.5%)	*	*	*
Ever discussed child care issues	Yes 64 (50.0%) No 64 (50.0%)	*	*	*

* Not applicable

4.2 The health related programmes that the Pastors' wives have been involved in

On the health related programmes the pastors' wives had been involve in, 49.2% (n=63) reported they have attended at least a health related programme before while 50.8% (n=65) reported not to have attended any health related programme. There was no significant difference in the number of women who had attended a programme before and the number who had not attended a programme in the past (see Figure 4.1). Among the pastors' wives who had attended health related programme(s) in the past, 46.0 (n=29) reported it was 1 to 6 months ago while 53.9 (n=34) reported over 6 months ago. However, the mean was 57.9 ± 44.0 months with minimum of 1 month ago and maximum of 108 months ago.

Table 4.4 shows the health related programmes the pastors' wives had attended in the past, organised/conducted, interested in attending and willing to organise in the future. The most attend health related programmes by the pastors' wives were Nutritional (n=29), family planning (n=27), maternal health (n=26), and HIV/AIDs (n=25). Some of the pastors wives that had attend a health programme reported to have organised a health program in the church in the past and reported to be majorly targeted at the general population of the church (n=26) while other reported theirs were targeted at women (n=12), youths (n=2) and adults (n=3) (see Figure 4.2). The most organised health related programmes by the pastors' wives were family planning (n=17), HIV/AIDs (n=15), maternal health (n=14) and nutritional health (n=11) (see Table 4.4).

Interestingly, all the pastors wives (100.0%; n=128) were interested in attend at least a health related programme in the future and child care program was the most reported programme of interest (n=85). This was followed by nutritional health (n=78), maternal health (n=77), family planning (n=74), cancers (n=66), adolescent health (n=64) and many more with programmes on pain/ stress management (n=23) and Ebola (n=10) been the least. Also, all the pastors' wives were willing to organise in the future at least a program they attend. Similarly, the most health related program of interest to organise in the future was child health program (n=87) and when prompted on the interest to organised child care programmes 124 (96.9%) of the pastors' wives showed interest while only 4 (3.1%) reported not interested (see Table 4.5 and Figure 4.3).

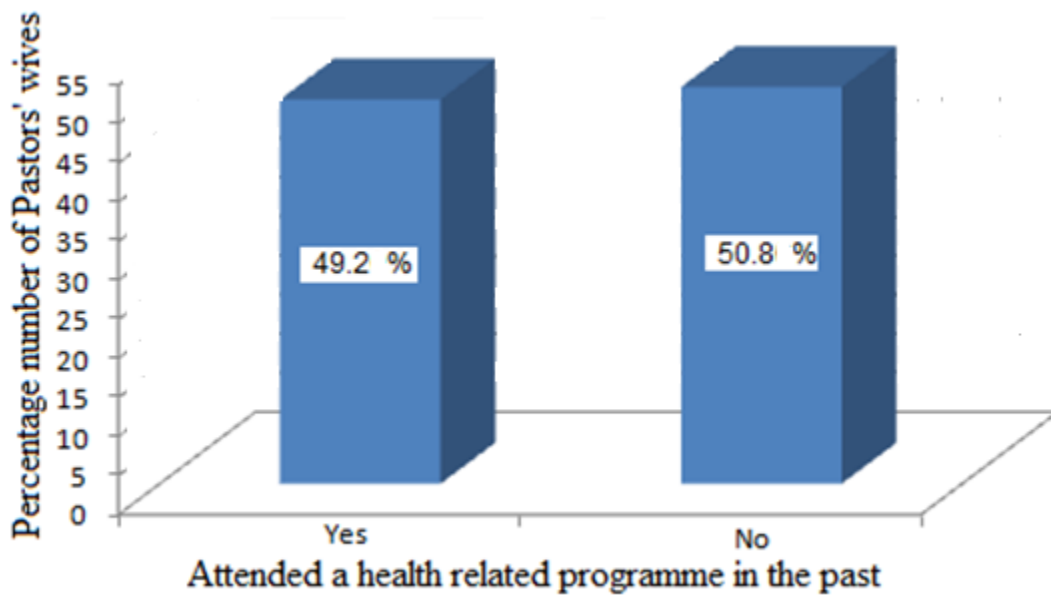


Figure 4.1. Percentage of pastors' wives who had attended a health related programme(s) in the past

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Table 4.4. Health related programmes the Pastors' wives had attended in the past, organised/conducted, interested in attending and willing to organized
N=128

Health related programmes	In the past (N=63)		Interest in the future (N=128)	
	Attended	Conducted	Attending	Organizing
Cardiovascular health	14	8	54	26
Family planning	27	17	74	47
Cancers	20	8	66	34
Nutritional health	29	11	78	50
Mental health care	10	2	48	27
Maternal health	26	14	77	69
Child health	22	8	85	87
Health/care for the elderly	10	2	55	37
Health behaviour	16	9	57	39
Adolescent health	12	5	64	44
HIV/AIDs	25	15	58	34
Diabetes	18	6	51	26
Obesity/weight loss	13	6	47	24
Dental care	13	1	41	23
Eye care	11	3	48	19
Sickle cell disease	11	2	49	22
Ebola	10	5	10	10
Pain/stress management	10	0	23	10
*Total	297	122	972	628

*Multiple responses applicable

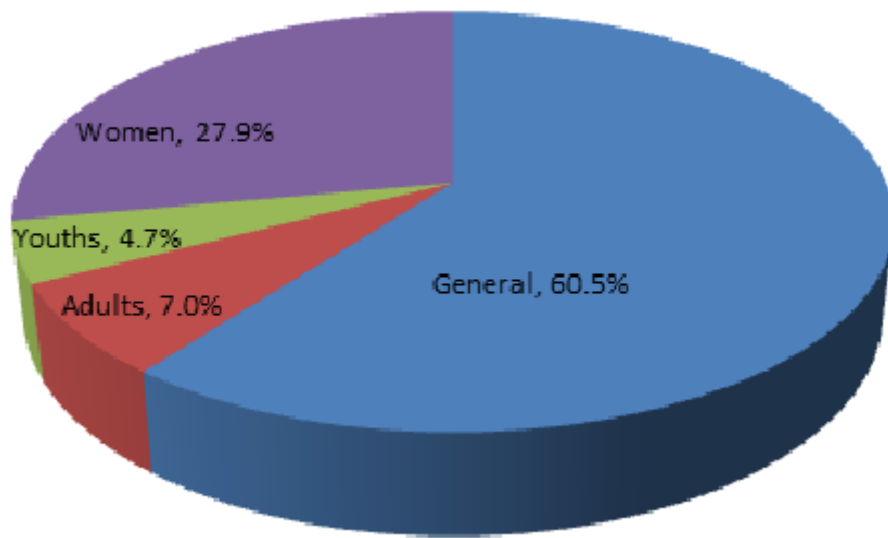


Figure 4.2. Targets of programmes organised by Pastors' wives in the church

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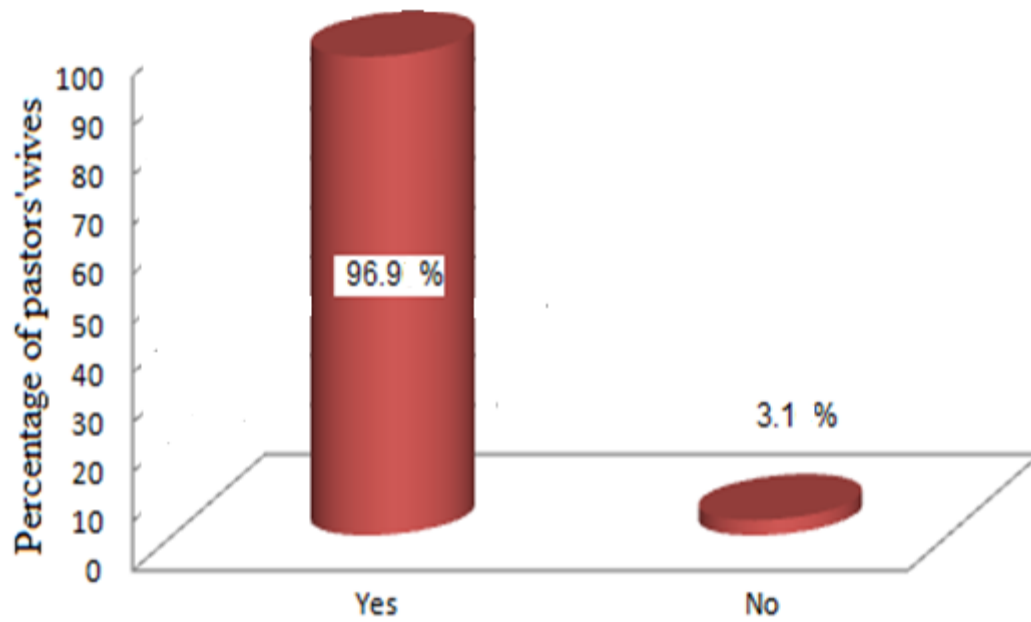


Figure 4.3. Percentage of Pastors' wives willing to organise child care programmes in the church in the future

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4.3 Level of knowledge of Pastors' wives on the child care practices in the child survival strategy

Figure 4.4 shows the level of knowledge of the pastors' wives on child survival strategy. Only 13.4% of the pastors' wives were aware of child survival strategy. However, the overall level of knowledge was 53.3% (mean score 26.6 of the total 50 points knowledge scale). However, only 15.6% (n=20) of the pastors' wives had good knowledge of the child survival strategy while 40.6 (n=52) had fair knowledge, 43.8% (n=56) had poor knowledge. The knowledge level of the strategies in child survival strategy were 35.9% for growth monitoring, 51.6% for oral rehydration therapy, 72.3% for breastfeeding, 67.0% for immunization, 57.4% for complementary feeding, 40.2% for female education and 79.3% for family planning (see Figure 4.5).

On categorisation, 25.0% (n=32), 66.4% (n= 85), 92.2% (n=118), 70.3% (n= 90), 31.3% (n= 40), 62.5% (n= 80) and 96.1% (n=123) of the pastors' wives had good knowledge of growth monitoring, oral rehydration therapy, breastfeeding, immunization, female education, complementary feeding and family planning, respectively (see Figure 4.7).

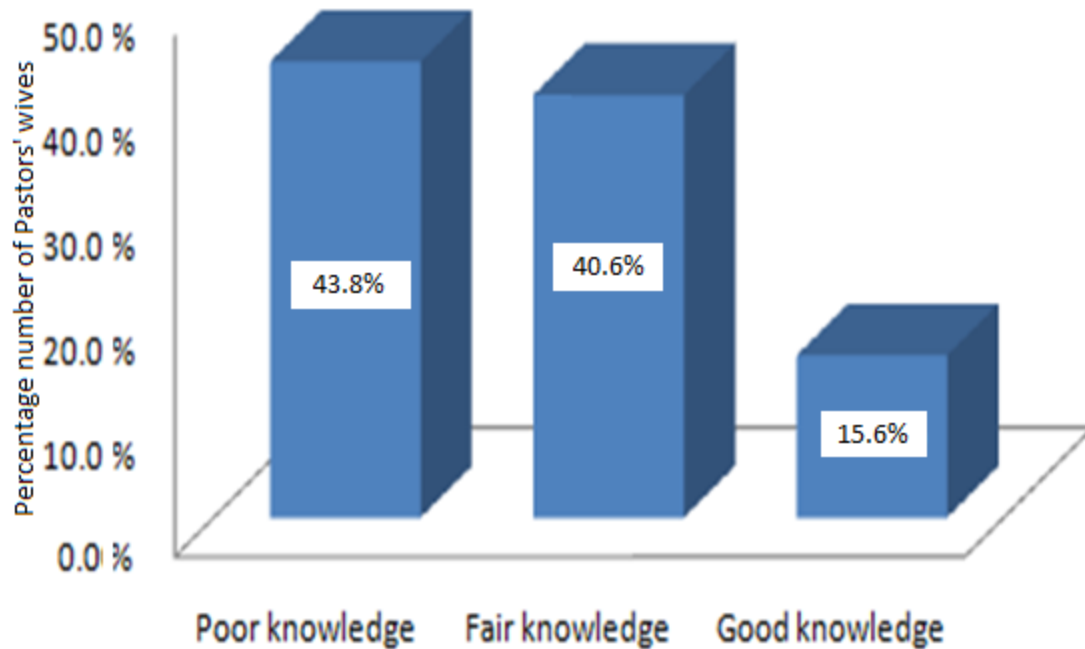


Figure 4.4. Categorisation of the level of knowledge of pastors' wives on child survival strategy

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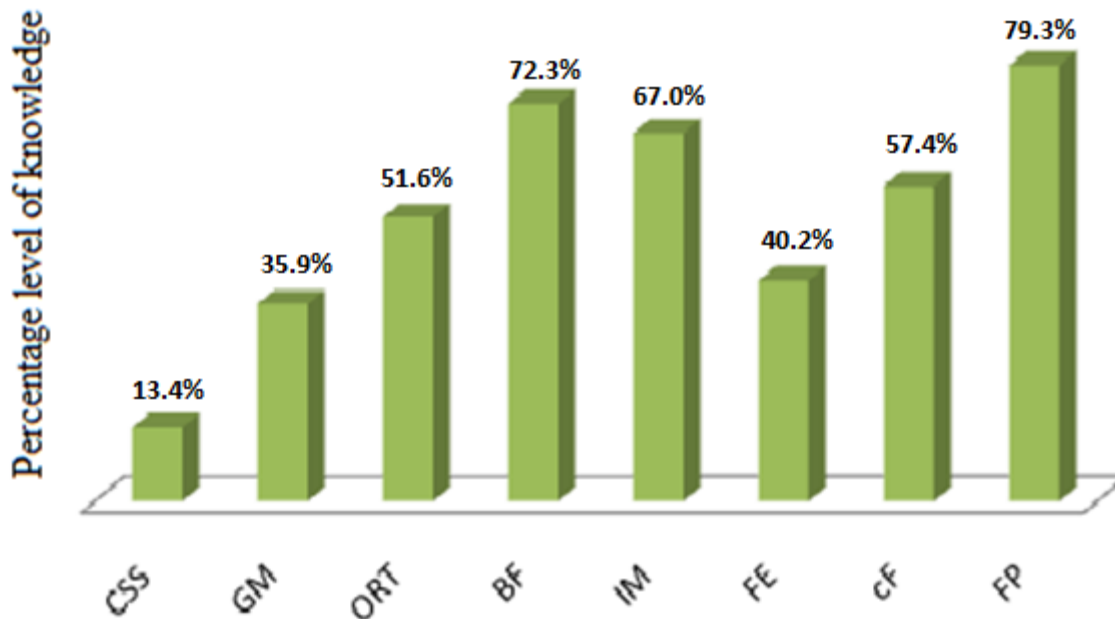


Figure 4.5. Percentage level of knowledge on the components of child survival strategy by the Pastors' wives

Key

CSS= Child Survival Strategy

GM = Growth monitoring

ORT = Oral rehydration therapy

BF = Breastfeeding

IM = Immunization

FE = Female education

cF = Complementary feeding

FP = Family Planning

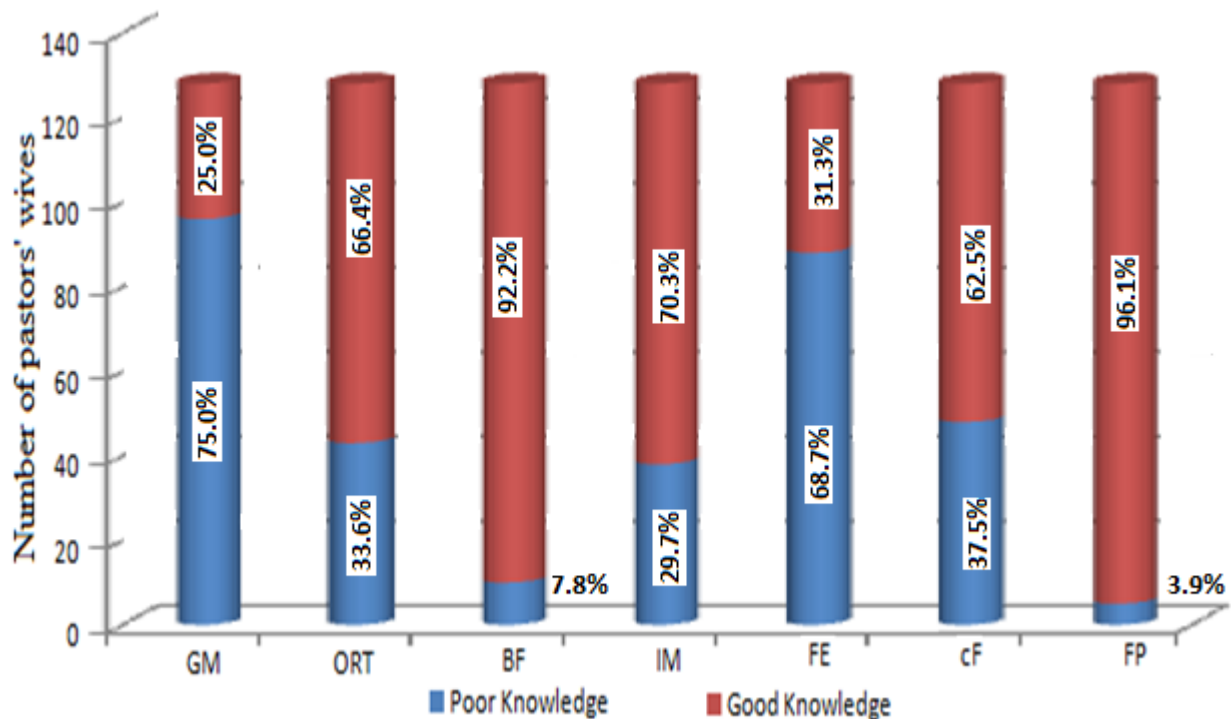


Figure 4.6. Categorisation of the Pastors' wives on the good and poor level of knowledge of the strategies in CSS

Key

CSS= Child Survival Strategy

GM = Growth monitoring (with 7 points scale; < 3.5 = poor; ≥3.5 = good)

ORT = Oral rehydration therapy (with 8 points scale; < 4.0 = poor; ≥4.0 = good)

BF = Breastfeeding (with 7 points scale; < 3.5 = poor; ≥3.5 = good)

IM = Immunization (with 6 points scale; < 3.0 = poor; ≥3.0 = good)

FE = Female education (with 5 points scale; < 2.5 = poor; ≥2.5 = good)

cF = Complementary feeding (with 5 points scale; < 2.5 = poor; ≥2.5 = good)

FP = Family Planning (with 7 points scale; < 3.5 = poor; ≥3.5 = good)

4.4 Methods Pastors' wives used in communication with mothers in the church

Table 4.5 indicates the methods of communication between pastors' wives and mothers in the church. It was observed that all except 0.8% (n=1) pastor's wife reported to visit church women when they give birth and 92.2% (n=118) reported church women and mothers discussing with them on matter/issues related to health. The most reported health issue/matter on which pastors' wives and mothers communicate is on issues of child care and nutrition (84.4%; n= 108). This was followed by issues on maternal health (32.0%; n=41), childhood illnesses (25.8%; n=33) and family affairs and health (14.1%; n=10).

On the means of communication (Figure 4.7), it was observed that the most method of communication between the pastors' wives and mothers on health related issues was through counseling (n=116). This was followed by teaching (n=68), preaching (n=38) and phone calls (n=24) with books (n=3), bulletin (n=2) and posters (n=1) being the least mode of communication. However, 68.0% (n=87) reported counseling to be their most preferred method of communication while 22.7% (n=29) and 10.2% (n=13) reported teaching and preaching respectively as their most preferred method of communication (see Table 4.5).

Table 4.5. Methods of communication between pastors' wives and nursing mothers in the church

N=128

Questions	Variables	Frequency (%)
Visit church women when they give birth	Yes	127 (99.2%)
	No	1 (0.8%)
Mother consulting pastor's wife on health related issue	Yes	118 (92.2%)
	No	10 (7.9%)
*Health matters mothers and pastors' wives communicate on	Maternal health related	41 (32.0%)
	Child care/ nutrition	108 (84.4%)
	Childhood illnesses	33 (25.8%)
	Family affairs and health	18 (14.1%)
Most preferred method of communication	Teaching	29 (22.7%)
	Preaching	13 (10.2%)
	Counseling	87 (68.0%)

*Multiple responses apply

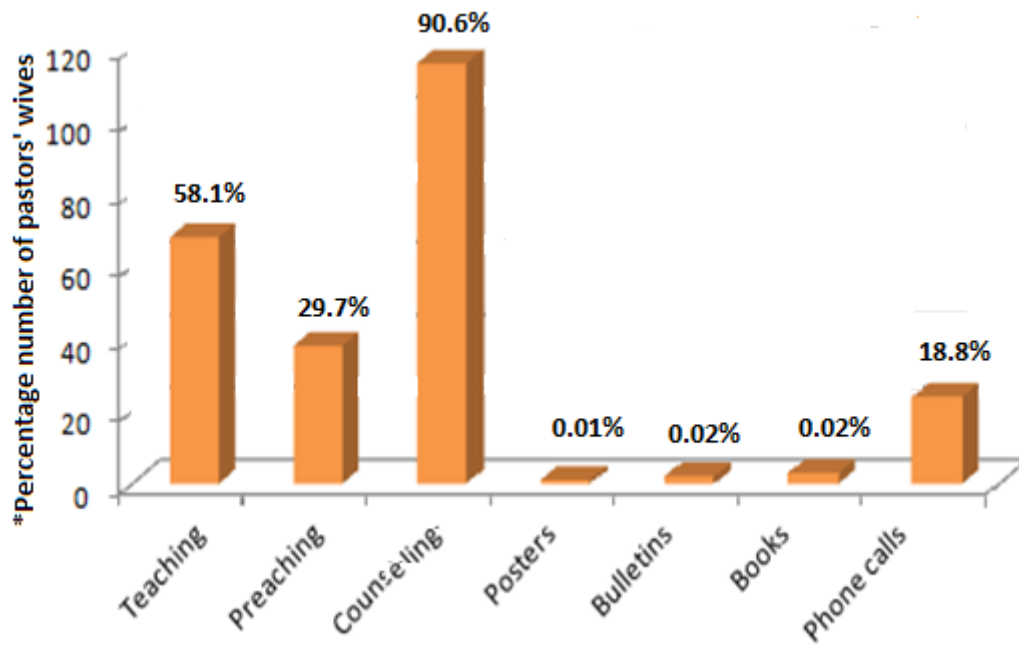


Figure 4.7. Methods of communication of health related issues/matters between pastors' wives and nursing mothers in the church (*Multiple responses apply).

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4.5 Pastors' wives challenges in the delivery of health related information to mothers

Table 4.6 showed that 96.9% (n=124) of pastors' wives are willing and eager to discuss with women in the church and 85.9% (n=110) reported to have done it before. Majority of the pastors' wives (97.7%; n=127) reported willing to organise health related programmes for women and mothers in the church. However, some of the pastors wives (58.6%; n= 75) reported they are limited and face several challenges and constraints to organise health related programmes for women and mothers in the church.

Figure 4.8 indicates the constraints reported by pastors' wives to limit their involvement in providing health related programmes to mothers and women in the church. Majority (n=32) reported the lack of correct and adequate information on the matter to discuss. Also, pastors' wives reported that lack of time (n=27), materials (n=19), funds (n=17), availability of women/ mothers (n=16), lack of opportunity/chance for women to preach in the church (n=9), language (n=4) and communication skills (n=2).

Table 4.6. Pastors' wife eagerness to discuss and organised health programmes for women/mothers in the church

N=128

Variables		Frequency (%)
Eager to discuss with mothers in the church	Yes	124 (96.9%)
	No	4 (3.1%)
Have discussed with mothers in the church in the past	Yes	110 (85.9%)
	No	14 (10.9%)
Willing to organise health related programmes for women and mothers in the church	Yes	125 (97.7%)
	No	3 (2.3%)
Constrained to organise health related programmes for mothers in the church	Yes	75 (58.6%)
	No	53 (41.4%)

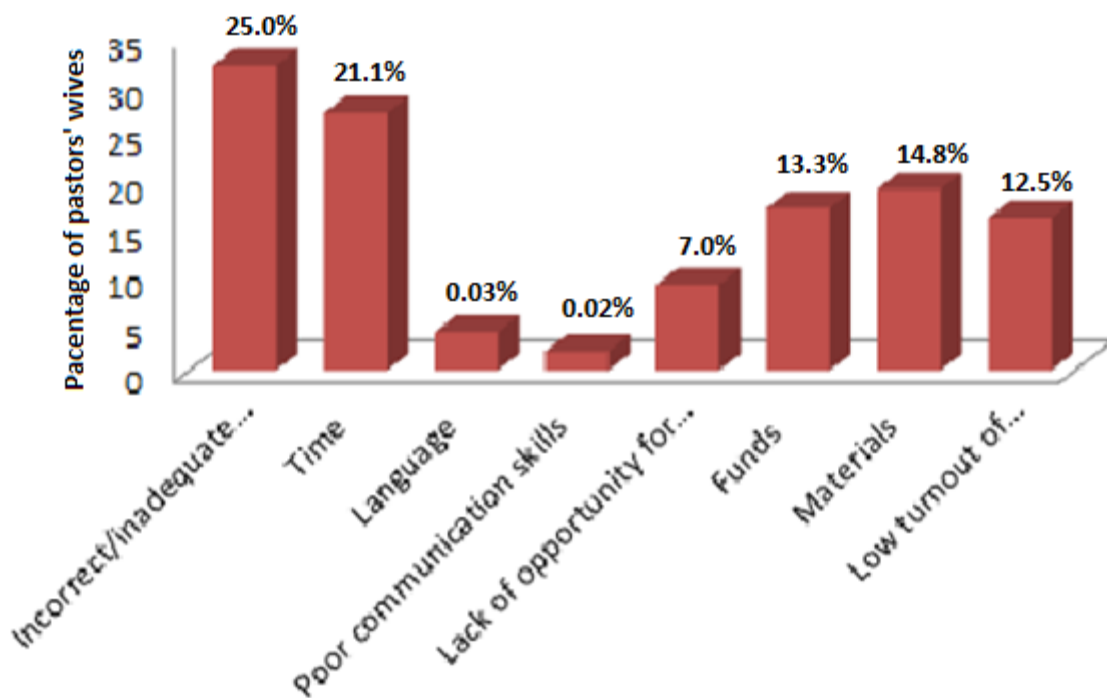


Figure 4.8. Pastors' wives challenges in delivering health related information to mothers (*multiple response apply)

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4.6 Ways Pastors' wives can be assisted to be more active in promoting maternal and child health

Although some pastors' wife (28.1%; n=37) reported to have received supports to carry out a health related programme in the church before, majority of the supports were said to be provided by the church (n=24), members of the church (n=3) and health workers and professionals in the church (n=9).

Interestingly, all the pastors wives except 0.8% (n=1), are willing to carryout child care practice programmes in the church. However, 99.2% (n=127) reported they will require assistance to do so (see table 4.7). The most reported assistance required by the pastors' wives was materials (n=87) as shown in Figure 4.9. This was followed by financial assistance (n=85), training (n=70), health care professional/ human resources (n=52) and lastly information on the matter (n=25) (see Figure 4.9).

Table 4.7. Supports received and required by pastors' wives to carry child care practice programmes in the church

Variables		Frequency (%)
Received support to organise a health programme in the past	Yes	37 (28.1%)
	No	92 (71.9%)
Types of supports received	Given by church	24
	Provided by church member(s)	2
	Provided by Health professionals in the church	9
Willing to carry out child care programmes in the church	Yes	127 (99.2%)
	No	1 (0.8%)
Requires assistance/ support to be able to carry out child care programme in the church	Yes	127 (99.2%)
	No	1 (0.8%)

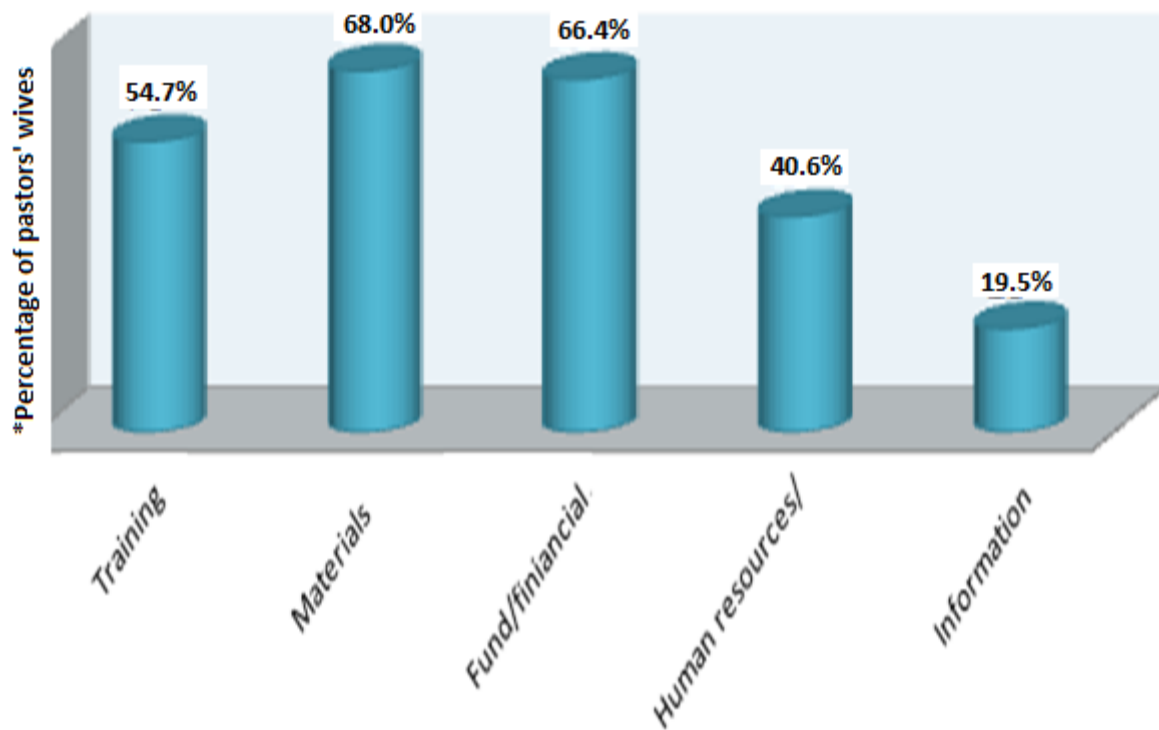


Figure 4.9. Types of supports required by pastors' wives to carry out child care programmes in the church

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4.7 Null Hypotheses

Hypothesis 1: There is no significant relationship between pastors' wives educational status and level of knowledge of child care practices.

Analysis showed that pastors' wives educational status correlates positively with their level of knowledge of child survival strategy. In fact, pastors' wives with high educational status are 2.4 times more likely to have high and good knowledge of child care practices in child survival strategy.

The Chi Square test analysis (Table 4.8) showed that educational status of Pastors' wives significantly correlates ($X^2 = 38.612$; $df = 8$; $p \text{ value} = 0.000$; $p < 0.05$) with the level of knowledge of child survival strategy. Thus, the null hypothesis that there is no significant relationship between pastors' wives educational status and level of knowledge of child care practices was rejected.

Table 4.9 showed the ANOVA analysis of the mean score knowledge of Pastors' wives with their educational status. The difference in the mean score of knowledge of child survival strategy was statistically significant ($p < 0.05$) in pastors' wives with HND and university degree compared to pastors wives with OND/NCE, secondary and primary education.

Table 4.8. Chi-square test analysis to investigate the relationship between pastors' wives educational status and level of knowledge of child survival strategy

Pastors' wives Educational status	Level of knowledge of child survival strategy			Total	OR	X ²	p value
	Poor	Fair	Good				
Primary	11	3	1	15			
Secondary	14	6	1	21			
OND/NCE	18	11	2	31		38.612	0.000
HND	1	13	1	15	2.4		
Tertiary	12	19	15	46		df=8	p<0.05
Total	56	52	20	128			

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Table 4.9. ANOVA analysis of the mean knowledge of child survival strategy with educational status

Pastors' wives		Mean	Percentage	F	P value
Educational status	N	knowledge	level of knowledge		
Primary	15	22.7±5.4 ^a	45.5%		
Secondary	21	24.34±5.8 ^a	48.8%		0.00
OND/NCE	31	23.3±6.7 ^a	46.6%		
HND	15	29.0±5.0 ^b	58.0%*	7.201	
Tertiary	46	30.4±8.6 ^b	60.8%*		P<0.05
Total	128	26.6±7.7	53.3%		

Values are mean ± standard deviation; mean in a column having different superscripts are significantly different at p<0.05. * indicates significant difference compared with primary education value at p<0.05.

Hypothesis 2: There is no significant relationship between Pastors' wives previous attendance in any health related programmes and knowledge of child care practices

Chi-square test analysis showed positive correlation between pastors' wives previous attendance at any health related programmes and knowledge of child survival strategy (Table 4.10). Pastors' wives who have not attended any health related programme in the past are 9.3 times more likely to have poor knowledge of child survival strategy compared to pastors' wives who had attended a health related programme in the past. However, the difference was statistically not significant ($p>0.05$). Thus, we accept the null hypothesis that "there is no significant relationship between Pastors' wives attendance in any health related programmes and knowledge of child care practices".

Table 10.11 showed the t-test analysis of mean knowledge of Pastors' wives on child survival strategy and their previous attendance/presence in health related programmes. The mean knowledge score of Pastors' wives who had previously attended any health related programme was compared with those who has not attended any health programme in the past (Table 4.11). Although the mean knowledge score on child survival strategy was higher in Pastors' wives who had attended a health related programme(s) in the past (27.7 ± 8.4), it was not statistically significant ($p>0.05$) compared to the mean score for Pastors' wives who has not attended any health related programme in the past (25.6 ± 6.8).

Table 4.10. Chi-square test analysis to investigate the relationship between pastors' wives educational status and level of knowledge of child survival strategy

		Level of knowledge of child survival strategy				OR	X ²	p value
		Poor	Fair	Good	Total			
Attended any health programme in the past as a Pastor's wife	Yes	26	23	14	63	9.3	4.148	0.126
	No	30	29	6	65			
Total		56	52	20	128			

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Table 4.11. Independent samples t-test analysis of the mean knowledge of child survival strategy with previous presence (attendance) in health related programme(s)

Presence in any health programme in the past				
	N	Mean	T	p value
Yes	63	27.7±8.4	1.577	0.117
No	65	25.6±6.8		p>0.05

Values are mean ± standard deviation; there was no significant different in means.

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Hypothesis 3: There is no significant difference in the level of knowledge of child survival strategy between Pastors' wives who had ever discussed child care issue with mothers and women of child bearing age and those who has not

Table 4.12 is a cross tabulation of Pastors' wives response on ever discussed child care with mothers and women of child bearing age and level of knowledge of child survival strategy. There was a negative correlation between ever discussed child care and pastors wives level of knowledge of child survival strategy. It was observed that Pastors' wives who had ever discussed child care with mothers and women of child bearing age are more likely to have poor knowledge of child survival strategy compared to Pastors' wives who has never discussed child care with mothers and the association ($X^2 = 6.541$; $df=2$; p value 0.038) was observed to be statistically significant ($p<0.05$)

Table 4.13 compares the mean knowledge of child survival strategy of pastors' wives who had ever discuss child care with mother and women of child bearing age and those who has not. It was observed that Pastors' wives who reported not to had ever discussed child care with mother and women of child bearing age has a higher mean knowledge on child survival strategy (27.5 ± 7.5) compare to pastors' wives who reported to had discussed child care with mothers (25.7 ± 7.8). However, the difference in the mean knowledge between the two groups was statistically not significance ($P>0.05$).

Table 4.12. Chi-square test analysis to investigate the relationship between pastors' wives ever discussion of child care with women in the church and level of knowledge of child survival strategy

		level of knowledge of child survival				OR	X ²	p value
		Poor	Fair	Good	Total			
Ever discussed child care issues with women of child bearing age	Yes	34	19	11	64	-0.132	6.541	0.038
	No	22	33	9	64			
Total		56	52	20	128		df=2	P<0.05

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Table 4.13. Independent samples t-test analysis of the mean knowledge of child survival strategy with ever discuss child care

		N	Mean	T	p value
Pastors wives who had ever discussed child care issues with women of child bearing age in the church	Yes	64	25.7±7.8	-1.327	0.187
	No	64	27.5±7.5		p>0.05

Values are mean ± standard deviation; there was no significant different in means

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CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Discussion

Recent data from 24 countries in sub-Saharan Africa show that 42% of children who took antimalarial medicines received treatment at home (UNICEF and Roll Back Malaria, 2007). Across the region, fewer than 40% of women give birth with the assistance of a skilled attendant (Save the Children, 2006). In Nigerian for example, only about 38% of births are delivered by a skilled health provider and a similar proportion of deliveries (36%) take place in health facilities (NDHS 2013). By implication, the household can be said to be the front line of health care and treatment of childhood illness and maternal health care. Thus, empowering households and communities to participate in the nutrition and health care of newborns, children and mothers, is a logical and practical way to enhance the provision of care –especially in countries and communities where basic primary health care and environmental services are lacking as well as in marginalized and impoverished areas. In this regards, community participation can be crucial for households and families to obtain the food, health and caregiving needed by mothers and children to ensure improved nutritional status and health. In view of these facts, it is essential to assess the suitability of faith-based approach to promote child care practice through the pastors' wives. This will then enable the implementation of appropriate programs to improve the health of under-five children and women; the MDGs 4 and 5.

5.1.1 Socio-demographic profile of Pastors' wives in Ibadan North LGA

The data collected has shown that Pastors' wives in Ibadan North LGA are within the age group 27-72 years. Majority of the pastors wives in this study are Yoruba. This is expected considering that Ibadan-the capital of Oyo State; where the study was conducted is in the South Western part of Nigeria, where Yoruba is the major ethnic group. Also a finding of this study, it was observed that Pastors' wives are educated, with most of them having a university degree. Interestingly, the entire Pastors' wives had formal education. This finding disagrees with the report where more than one third of women (38%) are reported not to have education (NDHS, 2013). According to the NDHS (2013), only 9.1% of women are reported

to have more than a secondary education. This is very low compared to 71.9% of Pastors' wives observed to have more than a secondary education in this study. This finding correlates with the previously reported qualities of the Pastors' wives as highly influential, esteemed, public modeling and recognised figures. These powerful qualities of the "Pastors' wives" are no doubt related to their formal educational attainment as compared to the general public.

Except for 6.3% of the Pastors wives who reported to be full house wives, they all are involved in one occupation or the other. This is high compared to 62% of women reported to be currently employed (NDHS, 2014). Although employment is highest in the South West zone, especially in Ogun, where 80 percent of women are currently employed (NDHS, 2014). The observed high employment status of Pastors wives in this study can be due to their high educational status. This is based on the fact that the likelihood that a woman is employed increases with her education (NDHS, 2014).

While about 47% were employed (teachers/lecturers, civil servants, and health workers), about 31% were self-employed and 7% and 3% were ministries/prophetesses and managers respectively. This distribution is similar compared to the report by NDHS (2014) that 7% of women are employed in professional, technical, or managerial positions while about 61% are engaged in sales and services with the remaining working in agriculture (16%), in skilled manual jobs (14%), and in unskilled manual jobs (1%).

On the mean number of children by Pastors wives, this study observed that the average number of children by Pastors wives was 3.6 ± 1.5 . This is lower than the total fertility rate of 5.5 (NDHS, 2013) reported per woman in Nigeria. This lower number of children by Pastors wives may be due to the influence of education considering the fact that over 71% of the Pastors wives had more than a secondary education. This assertion is based on the fact that education may have propped their age at marriage and may have provided them with information on pregnancy, family planning and contraceptives.

5.1.2 Health related programmes that the Pastors' wives have been involved in

Studies on the suitability of adoption of faith-based approach through the pastors' wives in the promotion of child care practices have not been previously investigated in Nigeria and environs. This study revealed that pastors' wives are involved and interested in attending a health related programme and organising a health programme in the future.

Although previous attendance of health related programmes in the past does not significantly influences ($p>0.05$) the knowledge of pastors' wives on child care practices in child survival strategy, pastors' wives who have attended a health related programme in the past were more likely to have better knowledge. The non-significant influence of previous attendance in health related programme on knowledge of child care practices in child survival strategy may be due to programme differences. This assertion is based on the observation that the most attended programmes in the past by pastors' wives were nutritional, family planning, maternal and HIV/AIDS programmes. Moreover, the most organised health programmes in the past by pastors' wives were family planning, maternal and HIV/AIDS programmes.

Specifically, the pastors' wives were most interested in attending and organizing programmes targeted at improving child health. While studies on pastors' wives involvement in health related programmes are limited, the high attendance of health related programmes by pastors' wives (49.2%) in this study is expected. This high attendance in health related programmes may be due to the several health institutions in the study area, as Ibadan North LGA host the University College Hospital and several health institutions known for health programmes.

5.1.3 Level of knowledge of Pastors' wives on child survival strategy

Also a finding of this study, pastors' wives were unaware of child survival strategy; however, they have knowledge of the components in child survival strategy. Although only 15.6% percent showed good knowledge of child care practice in child survival strategy, 40.6% showed fair knowledge and 43.8% showed poor knowledge, education was observed to correlate positively ($X^2 = 38.612$; $df = 8$; $p \text{ value} = 0.000$; $p < 0.05$) and has significant influence ($p < 0.05$) pastors' wives knowledge of child care practices in child survival strategy. The most known components of child survival strategy by the pastors wives were family planning, breastfeeding and immunization while complementary feeding and growth monitoring being the least known components. The high knowledge of the pastors' wives on several components of child survival strategy may be due to their educational level status as all the pastors' wives that participated in this study had a form of formal education with those with university education forming the majority.

Also, their higher knowledge on family planning, breastfeeding and immunization may be the influence of their previous involvement in health related programmes. This assertion is based on the fact that the most attended programmes by pastors wives in the past were nutritional health programmes (22.7%), family planning (21.1%), maternal health (20.3%) and HIV/AIDs (19.5%). These programmes may have influenced their knowledge of child survival strategy components. Moreover, considering that they were majorly mothers (99.2%) with at least a child, it is expected they had utilized antenatal care in the past considering their level of education. Their utilization of antenatal services may also be a contributory factor to the high knowledge of some of the child care practices in the child survival strategy.

Specifically, pastors' wives high knowledge on family planning agrees with several studies conducted within Nigeria where married women were reported to have high and good knowledge on family planning. For example, the study by Osifo, Akpamu and Shelu (2015) among married women in Ekpoma, South-South Nigeria, by Anyebe et al. (2014) among married women in Zaria, Northwest Nigeria, and the South-West geo-political zone where contraceptive used is said to be highest (NDHS, 2013). According to Olawepo and Okedare (2006), the issue of family planning attracted attention in Nigeria due to its importance in population growth and development. Interestingly, a study has also reported high knowledge of contraceptive among married men (Akpamu, Nwaopara, Otamere, Osifo, Adisa, Okhiai and Akpamu, 2011), thus, the high level of knowledge among married women and specifically pastors wives in this study is in accordance.

5.1.4 Methods Pastors' wives use in the communication of health related information to mothers

This study revealed that pastors' wives and mothers and women of child bearing age communicate health related issues in faith-based setting using several method and means of communication. This finding is in agreement with the study by Clay et al. (2005) who revealed that lay church women rely on the pastor's wife for direction and insight regarding a variety of issues including beauty and image, job-related matters, and family dynamics. In fact the regarding sources for health education in the church, the study by Clay et al. (2005) reported that nearly 95% of study participants reported that they get ideas regarding health

from other women in the church and that over 80% indicated that they take advice about health care and screening from the pastor's wife. In line with this, the present study revealed that on the health related issues pastors' wives and women in the church communicate on, child care and nutrition (84.4%), maternal health (32.0%), childhood illnesses (25.8%) and family affairs and health/matters (14.1%) were the most communicated health issues between pastors' wives and mothers and women of child bearing age. These therefore indicate that the pastors' wives and women in the church share experiences on health related issues concerning their self and children. Imagine therefore if the pastors' wives were aware and highly knowledgeable of child survival strategy and all the child care practices in it. This relationship between mothers and women in the church indicates offering opportunity for health practice in church setting.

Indeed approach to health promotion has been previously advocated as offering opportunities to position practice in its social context, optimize interventions and influencing behavior, as well as renders settings more health enhancing (Frohlich and Poland, 2007; Poland et al., 2000; Whitelaw, Baxendale and Bryce, 2001; Leger, 1997; Baric, 1993). Thus, the observed communication relationship between pastor's wife and women in this study, point toward the suitability of the pastor's wives in enhancing and promoting child care practice in church setting. Moreover, considering that the pastors' wives have influence on women and mothers in the church, this relationship can be leverage to communicated child care practice to mothers in the church. A faith-based, six-month pilot study designed to increase the capacity of faith-based institutions and faith leaders to address HIV/AIDS and sexually transmitted infections (STIs) in 11- to 19-year-old African Americans has previously included pastors' wives and ministers' wives, and the findings were positive (Griffith, Campbell, Allen, Robinson and Stewart, 2010).

5.1.5 Challenges encountered by Pastors' wives in the delivery of health related information to mothers

On the challenges encountered by pastors' wives in communicating health related information to women in the church, this study revealed that although pastors' wives are willing and eager (96.9%) to discuss health related issues and organise programmes (97.7%) for with women in the church and organise, only 85.9% claimed to have tried to discussed

with women in the past. The major challenges and constraints observed to limit pastors' wives in communicating and organising health related programmes to mothers and women were lack of correct and adequate information on the matter to discuss (25.0%), time (21.1%), materials (14.8%), funds (13.3%), availability of women/ mothers (12.5%), lack of opportunity/chance for women to preach in the church (7.0%), language (3.1%) and communication skills (1.6%).

5.1.6 The ways Pastors' wives can be assisted to be more active in promoting maternal and child health

Interestingly, this study indicated that 99.2% of the pastors wives were willing to carryout child care practice programmes in the church and 28.1% had received supports from the church, members of church and health professionals in the church to conduct an health related programmes in the church in the past. This finding revealed that the church can be a setting for health promotion and education through the pastors' wives. In line with this assertion, studies have previously showed positive observation on FBOs settings in health promotion in areas such as health education (Wilson, 2000), screening and management of high blood pressure (Smith, Merritt and Patel, 1997), heart health in stroke (Butler-Ajibade, Booth and Burwell, 2012), diabetes (McNabb, Quinn, Kerver, Cook and Karrison, 1997), cancer prevention and awareness (Duan, Fox, Derosé and Carson, 2000; Earp and Flax, 1999; Davis, Bustamante and Brown, 1994), nutritional guidance (Barnhart, Mossavar-Rahmani, Nelson, Raiford and Wylie-Rosett, 1998) and weight loss (Kumanyika and Charleston, 1992) as well as in the provision of education, water, sanitation, health, food, spiritual and other services (Moyo and Keir, 2014) to the needy. Thus, the willingness of pastors' wives to carryout child care practice despite low awareness and knowledge on child survival strategy, indicate the pastors' wives will need assistance to carry out such programmes and be proactive.

The need of assistance was showed by 99.2% of pastors' wives in this study. Interestingly, the assistance required by the pastors' wives in this study were materials (68.0%), financial assistance (66.4%), training (54.7%), health care professional/ human resources (40.6%) and information on the matter (19.5%). This therefore calls for collaborative endeavor between pastor's wives and authorities concern with child care. In

support of this fact, evidence from over 1,200 studies and 400 reviews has shown strong associations between faith-based setting and a number of positive health benefits, including protection from disease, coping with illness, and faster recovery from it (Bunn and Randall, 2011). By implication, using the pastors' wives in this regards to promote child care may be the missing association between the sluggish movements towards realization of the 4th MDG in Nigeria. Indeed a study has suggested that pastors' wives may serve as an effective conduit for generating program interest and involvement, particularly among Black women (Clay, Newlin, and Leeks, 2005). Thus, the findings of the present study support the fact that pastors' wives can serve effective in child care programmes. While engagement of pastors have showed positive finding (Taylor et al., 2000; Levin, 1986), engaging the pastors alone, without recognizing the significant influence of pastors' wives, may result in missed opportunities for intervention targeted at women and children in Nigerian in particular and in African at large; where women are limited by cultural norms and practices that do not favour some discussion with opposite sexes. The role of the pastor's wife in this regards cannot be overemphasized.

In support of this fact, Clay et al. (2005) reported that the role of the pastors' wives remain unrecognized despite the centrality of pastors' wives as change agents. The role of the pastors' wives in programme intervention and implementation has not been investigated in Nigeria despite the severity of health disparities among women and children. However, the present study has shown that that role and function of the pastors' wives extends beyond the church building and spiritual ministry but is multifaceted as she was seen suitable for the promotion of child and maternal health. Considering that pastors' wives can reach women and their families, there is need to take opportunity of their potential and begin to involve them in programme planning and implementation especially in programmes targeted toward women and children.

In another line of thought, considering the highly influential, esteemed, and recognised figures of pastors' wives in their church settings and communities, involving them in programmes such as child care programmes can go a long way to improving child survival. In addition, training of the pastors' wives on programmes targeted to women and children including provision of human and materials resource are expected to cultivate health relationships between the women congregants and the pastors' wives and connect for gender

bonding as well as spiritual guidance. Considering the public modeling of the pastor's wife as the "first lady of the church", partnering with her in health promotion and education may provide be the missing gap toward the attainment of the millennium development goals 4 and 5 and by implication improving child care practices and promoting the nation's child and maternal indexes. A potential strategy for reducing maternal and child mortality in high-burden countries like Nigeria and other sub-Sahara countries could be the development of strong partnerships with pastors' wives in faith-based setting.

5.2 How suitable the Pastors' wives will be in the promotion of child care practices

This study was conducted to determine how suitable the Pastors' wives will be in the promotion of child care practices. The finding that Pastors' wives are highly educated as compared to the general population of women add to the reason why they can serve as "mentor" and "role model" for women and nursing mothers in the church, especially in Nigeria and developing countries where women illiteracy is reported to be high.

The observed high attendance level of health related programmes by Pastors' wives (49.2%) in this study showed that the pastors' wives have had previous experiences on health programmes in the past. This finding indicates that the pastors' wives can be suitable in the promotion of child care practice. In addition, the observed finding that all the pastors wives are interested in attending at least a health related programme, and majority (66.4%) are interested in attending child care programmes, couple with the 68.0% with future interest in organizing child care programmes in the church, point to the fact that the Pastors' wives are suitable in the promotion of child care practices in the community.

In another line of thought, although the low level of knowledge of child survival strategy by the pastors' wives (13.4%) maybe a limiting factors, however, their high level of knowledge on some components of child survival strategy such as family planning (79.3%), breastfeeding (72.3%) and immunization (67.0%), point to the suitability of the Pastors' wives in health programmes targeted towards improving child health and survival, especially in areas with high child morbidity and mortality rates like Nigeria and other sub-Sahara countries.

Similarly, the observations that the pastors' wives visit women in their church when they give birth (99.2%) and mothers consult and communicated health related information

with them (92.20%) showed the suitability of the pastors' wives. Moreover, that some of the pastors' wives communicate health issues with mothers and women via counseling (90.6%; n=116), teaching (53.1%; n=68) and preaching (29.7%; n=38) further indicate their suitability in relating health care issues to nursing mothers in particular and women at large. Although the pastors' wives acknowledged some challenges and constraints might hinder them in the provision of child care practice to mothers and women in the church and community, that they require assistance such as training and information, materials and human resources are positive towards their suitability in the promotion of child care practices.

5.3 Implication for health promotion and education

Health promotion is the process of enabling people to increase control over, and to improve, their health. There is no doubt the findings of this study had shown that the Pastors' wives are suitable for the promotion of child care practice within the community using the setting approach. This showed that the church is an important site for health promotion and education for nursing mothers and women especially through the Pastor's wife. By implication, the findings of this study can have influence on programme planning, implementation and evaluation of health promotion and education intervention targeted at improving child care and survival in Nigeria. In line with this, the World Development Report has previously called for the greater use FBOs, to improve service quality and fill existing gaps in healthcare services (Gill and Carlough, 2008; World Bank, 1993). Also, the Centers for Disease Control and National Institutes of Health have recommended collaborative model of comprehensive educational programme, highlighting the importance of addressing cultural factors, such as religion, faith and spirituality, in the provision of care to improve health endpoints in ethnic/racial minority populations (CDC, 2007; CDC 2010).

From the reviewed literatures, it was established that child morbidity and mortality are higher in Nigeria and meeting the MGD-4 by the end of year 2015 is not fixable. This mean that Nigeria still face challenges of meeting the promises made to children and women 15 years ago. With the limited resources for health care in Nigeria, there is therefore need to employ health promotion and education strategies to tackle the challenges identified by Pastors' wives in this study. Thus, the adoption of faith-based setting in the promotion of

child care practices through the Pastors' wives is an innovative and welcome strategy for Nigeria.

The key implication of this study for health promotion and education is the need for training of Pastors' wives on child survival strategy and the implementation of programmes and interventions that target improving child survival and maternal health in faith-based settings. Also, this study call for the need for the governments, politicians, community stakeholders, local and public leaders, and care providers to partnership with Pastors' wives in faith-based organisations to address public health challenges facing children and mothers. The importance of the involvement of Pastors' wives in the planning, implementation and evaluation of programmes in this regards cannot be underestimated.

5.4 Conclusion

This study showed that pastors' wives are educated and have been involve in health related programmes, communicate health-related issues with nursing mothers and women in the church and are interested in child care programmes. Although it was also shown that the Pastors' wives may have some constraints, interesting, they reported to require assistance that ranges from human and material resources.

In conclusion, the findings of this study indicate that the pastors' wives can be suitable in the promotion of child care practices and child survival strategy. Thus, harnessing the influence of the pastor's wife could be an effective means of addressing the poor child indexes in the country and a way forward in the realisation of the 4th Millennium Development Goal.

5.5 Recommendations

Based on the findings of this study, the following recommendations are anticipated;

1. There is need for organisations and agencies concerned to build strong partnerships and collaborations with faith-based organisations and the pastors' wives in particular, in programmes targeted toward health child care practices. This will no doubt bring about a speedily attainment of the 4th Millennium development goal which will also influences the 5th millennium development goal which both seek to reducing child mortality and improving maternal health respectively. By implication, if Nigeria is to have meaningful improvement

in her 4th and 5th MDGs, the partnership with faith-based organisations and development of faith-based setting programmes are two very important strategies to employ and utilise.

2. There is need for training of pastors' wives and women leaders in faith-based organisations on child care practices; such as the simple and cheap child survival strategy, proposed for sub-Sahara Africa countries with high child and maternal morbidities and mortalities. Training of pastors' wives; who are usually observed by mothers and women, communicate with mothers in the church, and recognised as "Mama", on the child survival strategy will promote and popularised the strategies in child survival strategy. This is expected to promote knowledge and the practice of child survival strategy in the community through observational learning and thus promote child health in the community and in the nation as proposed in the framework on the pastor's wife and improve child health through child survival strategy in figure 2.2. This assertion is indicated in the fact that over 75% of Africans (especially women) trust their religious leaders.

3. When considering training of Pastors' wives on child survival strategy, attention and much importance should be placed on the growth monitoring and female education components; which in this study were observed to presence very high poor knowledge. Also, complementary feeding, oral rehydration therapy and immunization may also receive similar attention as about 29.7 to 37.5% were observed to have poor knowledge in these components.

4. Because Nigerians trust and believe their religious leader, the utilization of community directed intervention; in this case faith-based setting directed intervention, targeted at child health through the pastors' wives will be a more suitable intervention strategy. Thus, this supports the training of pastors' wives on child survival strategy; recommended cheap and effective intervention for child health promotion.

5. Lastly but not the least, the importance of more researches in the areas of faith-based settings and organisations on their suitability in promotion of health for all and towards health equity particularly of child care enhancement and maternal health care cannot be overemphasized.

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APPENDIX I

Ethical approval from the Oyo State Ministry of Health

TELEGRAMS..... TELEPHONE.....



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Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan.
Attention: Akpamu Uwaifoh

**ETHICAL APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE**

This is to acknowledge that your Research Proposal titled: "Suitability of Faith-Based Approach in the Promotion of Child Care Practice Through the Pastor's Wives in Ibadan North Local Government Area." has been reviewed by the Oyo state Review Ethical Committees.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.
3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.
4. Wishing you all the best.


Sali Alade (Dr)
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee

APPENDIX II

List of register churches from the Ibadan North LGA CAN

CHRISTIAN ASSOCIATION OF NIGERIA
IBADAN NORTH LOCAL GOVERNMENT

VEN C.O. ADAGBADA
Chairman L.G.
08055267644


PASTOR J.K. AYETAN
1st Vice Chairman
08056152051

REV. S. ADEKOLA
2nd Vice Chairman
08034041388

GMSAP K. S. AKINWALE
Secretary
08033766895

REV. T.O. MORAKINYO
Treasurer
08032267224

Our Ref: _____
Your Ref: _____
Date: _____



Secretariat
c/o St Stephen's
Anglican Church
P.O. Box, 125 Dugbe P.C
Nalende

**LIST OF CHURCHES REGISTERED AND ACTIVE IN IBADAN
NORTH LOCAL GOVERNMENT CHRISTIAN ASSOCIATION
OF NIGERIA OYO STATE**

A. CCN BLOC:

1. St. Paul's Anglican Church, Yemetu
2. St. Stephen Anglican Church, Nalende
3. Methodist Church, Bodija
4. Bodija Estate Baptist Church, Adeyi, old Bodija
5. St. David's Anglican Church, Ijokodo
6. Immanuel Anglican Church, Ashi, Ibadan.
7. Mokola Baptist Church, Mokola
8. Methodist Church, Agodi Gate, Ibadan.
9. Gateway Baptist Church, Sango.
10. African Church, Polytechnic Road, Sango
11. First United African Baptist Church, Oke Aran, Ibadan
12. Nazareth Baptist Church, Iyana Bodija, Ibadan.
13. El- Shaddai Baptist Church, Agbowo.

B. PFN/CPFN BLOC:

1. Winners Chapel - Basorun
2. Christ Apostolic Church - Oke Iyanu, Sango
3. Christ Apostolic Church - Oke Ibukun, Ikolaba
4. Redeem Church - Christ Palace - Ikolaba
5. The Apostolic Church - Ikolaba
6. Christ Life Church - Ikolaba
7. Christ Apostolic Church - Oke Agbara, Ashi
8. Christ Apostolic Church - Idi Odo, Yemetu
9. The Apostolic Church Agbowo
10. Christ Apostolic Church - Power of Restoration, Agbaje
11. Overcomer Church of Christ - Ikolaba
12. C.A.C. Oniyanrin, Ibadan.

1

13. The Apostolic Church, Nalende
14. C.A.C. Oke Itunnu.
15. Voice of Christ Church, Oje-Igosun
16. Soul Harvester's Church, Ibadan.
17. Vineyard of Grace Alaro, Sango.
18. Rehoboth Living Church, Sango, Rail line

C. CSN BLOC:

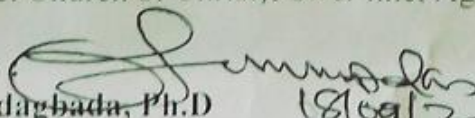
1. St. Patrick Catholic Church, Basorun
2. St. Thomas Catholic Church, Agbowo, Ibadan
3. Catholic Church, Aare Avenue, Bodija
4. St. Michael Catholic Church, Yemetu
5. Catholic Church, Mokola
6. Sacred Heart Catholic Church, Iyana Bodija, Ibadan.

D. ECWA/TEKAN BLOC:

1. ECWA Church, Behind Cocacola, Obasa
2. ECWA Church, Bodija, behind Bodija Market

E. OAIC BLOC:

1. Celestial Church of Christ, Army Barrack Road, Mokola
2. New Eden Light of Jesus, Mokola
3. Celestial Church of Christ, Onala Parish
4. Ona Iwa Mimo Cherubim and Seraphim Church, Mokola.
5. C&S Oke-Anu Church, Alawada, Ibadan
6. Celestial Church of Christ, Yemetu, Ibadan.
7. C&S Olorunsogo, Agbowo, Ibadan.
8. Christ worker Gospel Mission, Mokola
9. C&S Gosheni Mokola, Ibadan
10. C&S Oluwajoba, Oke Igbala, Agbowo
11. Inspiration of God Church Int'l (a.k.a. Imisi Oluwa Spiritual Gospel Church of Christ) Power line, Agbaje, Ijokodo.

Prepared by 
Ven. C.O. Adagbada, Ph.D 18/09/2015
Chairman CAN, IBNLG OF OYO STATE.

APPENDIX III
INFORM CONSENT FORM

My name is Akpamu Uwaifoh. I am a student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am interviewing Pastor's wives in Ibadan North Local Government Area to find out the suitability of adoption of faith-based approach in promotion of child care practices through Pastors' wives. I will need to ask you some questions which you may find difficult to answer. Please note that your answers will be kept very confidential. You will be given a number and your name will not be written on the form so that your name will not be used in connection with any information you give. The information you and other Pastor's wives will give will be useful to help address the under-five mortality rate and improve maternal health.

During this exercise, you will be asked questions about yourself, health programmes you have been involved in, as well as questions to investigate your knowledge on child care practices, communication methods, challenges and ways you can be assisted in promoting maternal and child health. No medical examination will be carried out on you and no specimen will be collected or drug given. Thus no harm or injury will be cause to you by taking part in this study. I only require you time and honest answers to the questions as this will help to better understand interventions to promote child survival using faith-based setting approaches.

You are free to refuse to take part in the study. You have a right to withdraw at any given time if you choose to. I will greatly appreciate your help in responding to the study and taking part in the study.

Now that the study has been well explained to me and I fully understand the content of the process, I will be willing to take part in the study.

Signature and date of participant

Fun IFOWOSI kq

Oruko mi ni Akpamu Uwaifoh. Emi a akeko ti Sakaani ti Health Promotion ati Education, Oluko ti Public Health, College of Isegun, University of Ibadan. Mo n interviewing Aguntan ká aya ni agbegbe ijoba ibile Ariwa Ibadan Area lati wa jade awon ibójúmu ti olomo ti igbagbo-orisun ona ni igbega ti omọ itoju ise nipase Pastors 'aya. Mo ti yoo nilo lati beere ti o diẹ ninu awon ibeere eyi ti o le ri soro lati dahun. Jowo se akiyesi pe idahun re daradara wa ni pa gan igbekele. O yoo wa ni fun a nomba ati oruko re yio wa ko le se ko lori awon fofomu ki oruko re yio ko see lo ninu asopo pelu eyikeyi alaye ti o ti fi fun. Awon alaye ti o Aguntan ati awon miiran ka iyawo won yoo fun yoo je wulo lati ran koju awon labe-marun niyen osuwon ki o si mu ilera awon abiamo.

Nigba yi idaraya, o yoo wa ni beere ibeere nipa ara re, ilera eto ti o ti a ti lowo ninu, bi daradara bi lati se iwadi ibeere re imo lori itoju omọ ise, ibaraenisoro ona, italaya ati ona ti o le wa ni iranlowo awon ni igbega si si jeki ilera ati awon omọ. Ko si egbogi ibewo yoo wa ni ti gbe jade lori o ko si si aperere yoo gba tabi oogun fun. Bayi ko si ipalara tabi ipalara ti yoo je fa si o nipa mu apakan ninu iwadi yi. Mo nikan beere wipe ki o akoko ati ki o mo idahun si awon ibeere bi eyi yoo ran lati dara ni oye ilowosi lati se igbelaruge omọ iwalaaye lilo igbagbo-orisun eto yonuso si.

Ti o ba wa free lati ko lati ya apakan ninu iwadi. O ni a otun lati yo ni eyikeyi fi fun akoko ti o ba ti o ba yan lati. Mo ti yoo gidigidi riri re iranlowo ni fesi si awon iwadi ki o si mu apakan ninu iwadi.

Bayi wipe awon iwadi ti a ti daradara salaye si mi ati ki o Mo ni kikun ye awon akoonu ti awon ilana, Emi o je setan lati ya apakan ninu iwadi.

Ibuwolu ati o

APPENDIX IV

QUESTIONNAIRE ON THE SUITABILITY OF ADOPTION OF FAITH-BASED APPROACH IN PROMOTION OF CHILD CARE PRACTICES THROUGH PASTORS' WIVES IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE

Section A: Socio-demographic information

1. Age (in years) -----
2. Highest education status (i) Primary education (ii) secondary education (iii) OND/NCE Certificate (iv) HND (v) University degrees
3. Marital status (i) Married (ii) Widow
4. What is your occupation?
5. How many biological children do you have? -----
6. Ethnic group (i) Hausa (ii) Igbo (iii) Yoruba (iv) Others
7. Religious denomination that you belong. -----
8. How long have you been a pastor's wife? -----
9. As Pastor's wife, how frequently do you teach/preach/ talk to women in your church?
(i) Once a week (ii) Twice a week (iii) 3 times a week (iv) As many times as possible
(v) Not at all (vi) Occasional (vii) Everyday
10. Have you ever discussed child care issues with women of child bearing age in your church? 1. Yes [] 2. No []

Section B: The health related programmes that the Pastors' wives have been involved in

s/n	Questions	Answer
11	Have you attended any health programme before as a Pastor's wife?	Yes No
12	If yes, how long was this?	
13	What are the health related programme(s) you have attended before?	Cardiovascular health Family planning Cancers Nutritional health Mental health care Maternal health Child health Health/care for the elderly Health behaviour Adolescent health HIV/AIDs Diabetes Obesity/weight loss Dental care Eye care Sickle cell disease None Other (specify) ...

14	Have you organised any health related programme(s) before?	Yes No
15	If yes, who was/were the programme(s) targeted to?	Children Adults Youths Men Women All/general
16	What health related programme(s) have you organised before?	Cardiovascular health Family planning Cancers Nutritional health Mental health care Maternal health Child health Health/care for the elderly Health behaviour Adolescent health HIV/AIDs Diabetes Obesity/weight loss Dental care Eye care Sickle cell disease None Other (specify) ...
17	Will you be willing to attend any health related programme?	Yes No
18	If yes, what health related programme(s) will you be willing to attend?	Cardiovascular health Family planning Cancers Nutritional health Mental health care Maternal health Child health Health/care for the elderly Health behaviour Adolescent health HIV/AIDs Diabetes Obesity/weight loss Dental care Eye care Sickle cell disease None Other (specify) ...

19	Will you be willing to organise any health related programme(s) in the future?	Yes No
20	If yes, what health related programme(s) are you will to organise?	Cardiovascular health Family planning Cancers Nutritional health Mental health care Maternal health Child health Health/care for the elderly Health behaviours Adolescent health HIV/AIDs Diabetes Obesity/weight loss Dental care Eye care Sickle cell disease None Other (specify) ...
21	Will you be willing to organise health programme(s) targeted towards improving child health?	Yes No

Section C: Level of knowledge of Pastors' wives on the child care practices in the child survival strategy

s/n	Question/ comments	Answers	Score	Code
22	What is child survival strategy?	Refers to practices aimed at improving survival of children 0 - 5 years	3 points	
23	Mention 2 components of child survival strategy?	Growth monitoring, Oral rehydration therapy, Breastfeeding, Immunization, Feeding/nutrition, Female education Family planning	2 points	
24	How can child growth be monitored?	Periodic checking of growth measurement among child 0 - 5 years OR By comparing pervious weight/height with present value and child age	3 points	
25	List 2 things to check out for when monitoring child growth?	Weight, Height, Age	2 points	
26	What is growth monitoring use for?	It is used to check the pattern of growth of children	2 points	
27	What is oral rehydration therapy (ORT)?	is a simple , cheap, and effective treatment for dehydration	3 points	
28	How is ORT prepared?	Water= 1 liter		

		Salt= ½ small spoon Sugar= 5 spoons or 10 cubes	3 points	
29	What is ORT used for?	Treating dehydration cause by diarrhea	2 points	
30	What is exclusive breast feeding?	Feeding a new born only on breast milk for the 1 st 6 months of life	2 points	
31	When should breast feeding begin and stopped for the new born?	1. Between the 1 st few minutes (10 – 45 minutes) of life 2. After the 1 st six months of life	1 point	
32	List 2 importance of exclusive breast feeding to the child?	reduce the severity /frequency of diseases improve mental function provide energy for the baby and contains all that the child needs including water, medicine, nutrients	2 points	
33	List 2 importance of exclusive breast feeding to the family?	save family money increase bond between mother and child	2 points	
34	What is immunization	Is a cost-effective ways of protecting children from diseases using vaccine protecting people from diseases by giving them a vaccine	2 points	
35	List 2 different childhood immunizations?	BCG DPT OPV Measles Yellow fever Hep B	2 points	
36	List 2 different periods to get a child immunized?	At birth 14 days after 3 months after 1 years	2 points	
37	What is complementary feeding?	Refers to food added to support breastfeeding child after 6 months of age	2 points	
38	Give 1 reason why a child should be fed on complementary food?	Because he/she is growing and requires more energy for growth	1 point	
39	List 2 content of complementary food for the child?	Continuing breast feeding Introduction of family diet to the child Soft fruits and vegetables	2 points	
40	What does female education mean?	Sending the girl child to school to have education Providing education for all girl child	1 point	
41	List 2 importance of female education	It empowers the female child It enlightens and or inform her It makes the female child creative It makes her resourceful	2 points	
42	Mention 2 ways how	It gives her the ability to differentiate a sick	2 points	

	female education does relate to child survival?	child and seek help when need arises It provides her with knowledge of nutrition, hygiene, healthy behavioural practices,		
43	What is family planning?	Refers to practices that control birth rate through the provision of birth preventive methods and services	3 points	
44	List 2 importance of family planning	It saves life of the mother It saves money for the family It promotes care for children and the family It enhances relationship between parents It enhances health of the family	2 points	
45	List 2 methods of family planning	Female method (Female condom, IUD, implant, tubectomy, pills, etc) Male method (Condom, Vasectomy) Couple co-operation (calendar method, withdrawer method)	2 points	

50 points knowledge scale; scores less than or equal to 25 points = poor level of knowledge; scores between >25 – 34 = fair level of knowledge; scores above >35 points = good level of knowledge.

Coding: poor level of knowledge = 1; fair level of knowledge = 2; good level of knowledge = 3

Section D: Methods Pastors' wives used in the communication of health related information to mothers

s/n	Questions	Answer
46	Do you as a pastor's wife visit your church women when they give birth to a new born?	Yes No
47	Do nursing mothers in your church come to you for health related issues/matters?	Yes No
48	Do you communicate with nursing mothers in the church?	Yes No
49	If yes, on what issues do you communicate with nursing mothers?	1. 2. 3. 4. 5.
50	What means of communication do you usually apply?	1= Teaching 2= Preaching 3= Counseling 4= Posters 5= Flyers 6= News letter/ bulletin 7= Books
51	Which communication method work best for you?	1= Teaching 2= Preaching

		3= Counseling 4= Posters 5= Flyers 6= News letter/ bulletin 7= Books
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Section E: Challenges encountered by Pastors' wives in delivering health related information to mothers

s/n	Questions	Answer
52	Are you eager to discuss/talk to women in your church on health related issue(s)?	Yes No
53	If yes, have you done it before?	Yes No
54	Will you be willing to organise healthy related programme(s) for women and mothers in your church?	Yes No
55	Are you constrained in providing health related programme(s) to nursing mothers in your church?	Yes No
56	Mention all the constraints that may limit you in providing health related programme(s) targeted at nursing mothers in your church?	1. 2. 3. 4. 5. 6. 7.

Section F: Ways Pastors' wives can be assisted to be more active in promoting maternal and child health.

s/n	Questions	Answer
57	Have you as a pastor's wife received support to carry out a health related programme in your church before?	Yes No
58	If yes, what are the types of support?	1. 2. 3. 4. 5.
59	Are you as a pastor's wife willing to carry out child care programme in your church?	Yes No
60	Do you require assistance/support to be able to carry out child care programme for nursing mothers in your church?	Yes No
61	If you are to organise a child care programme for nursing mothers in your church, what types of support will you request for?	1. 2. 3. 4. 5.

Appendix V

Pre-test Cronbach's Alpha coefficient

Reliability Statistics

Cronbach's Alpha	N of Items
0.803	16

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Have you ever discussed child care issues with women of child bearing age in your church?	19.47	9.552	.237	.808
Have you attended any health programme before as a Pastor's wife?	19.47	8.410	.641	.772
Have you attended any health related programme within the last 6 months?	19.20	8.886	.491	.785
Have you organised any health related programmes before?	19.07	9.495	.347	.796
Will you be willing to attend any health related programmes?	19.87	10.552	.000	.806
Will you be willing to organise any health related programmes in the future?	19.67	8.524	.768	.765
Will you be willing to organise health programmes targeted towards improving child health?	19.67	9.381	.394	.793

Do nursing mothers in your church come to you for anything or the other?	19.60	9.686	.231	.806
Do you communicate with nursing mothers in your church?	19.67	8.810	.639	.775
Are you eager to discuss/talk to women in your church on health related issue?	19.73	9.352	.500	.787
Will you be willing to organised healthy related programmes or talk to women and mothers in your church?	19.73	9.781	.294	.799
Are you constrained in providing health related programmes to nursing mothers in your church?	19.80	10.886	-.235	.821
Have you as a pastor's wife received support to carry out a health related programme in your church before?	19.07	9.352	.406	.792
Are you as a pastor's wife willing to organise or carry out child care programme in your church?	19.67	8.810	.639	.775
Do you require assistance/support to be able to organise child care programme for nursing mothers in your church?	19.80	10.029	.280	.800
Before or after dedication of a new born by the Pastors in your church, do you as a Pastor's wife have contact with the nursing mother?	19.53	8.838	.509	.784

APPENDIX VI

PICTURES



Meeting with PFN/CPFN block Pastors in Ibadan North Local Government Area at Sour Harvester Church in Yemetu



Interactive section between PFN/CPFN block Pastors and the researcher on the purpose and significant of the study in Sour Harvester Church, Yemetu



Preparatory meeting with prophets and prophetess of OAIC block in Ibadan North Government Area at Cherubim and Seraphim Church in Bodija



The researcher and a Prophetess interpreting the researcher's words to other prophetess during interactive section at Cherubim and Seraphim Church in Bodija



CCN block Pastors' wives signing inform consent form during data collection at El-Shadia Baptist Church



PFN/CPFN Pastors' wives going through and signing the inform consent form before data collection at Sour Harvester Church, Yemetu



The Researcher, Chairwoman and Vice Chairwoman of PFN/CPFN Pastors' wives during data collection at Sour Harvester Church, Yemetu



An interviewer with a PFN/CPFN Pastor's wife during data collection Sour Harvester Church, Yemetu



An interviewer with a PFN/CPFN Pastor's wife during data collection Sour Harvester Church, Yemetu



The researcher and a prophetess during interview (data collection) with other prophetesses and prophets' wives in waiting line



The researcher and a prophetess interpreting for another prophetess during data collection



An interviewer and a Prophet's wife during data collection