Available online at www.mchandaids.org

INTERNATIONAL JOURNAL of
MATERNAL and CHILD HEALTH and AIDS
ISSN 2161-864X (Online)
ISSN 2161-8674 (Print)
DOI: 10.21106/ijma.326

ORIGINAL ARTICLE

# Mitigating Gender and Maternal and Child Health Injustices through Faith Community-Led Initiatives

**Ikenna J. Nwakamma,** MPH;[1✉] **Amber Erinmwinhe,** BSc;[1] **Arinzechukwu Ajogwu,** BSc;[1]
**Aniekan Udoh,** MPH;[2] **Anne Ada-Ogoh,** MD[2]

[1]INERELA+ Nigeria, 71 Citec Villa, Gwarinpa Abuja, Nigeria; [2]Christian Aid UK, Nigeria, Plot 802, Off Ebitu Ukiwe St, Jabi, Abuja, Nigeria

✉Corresponding author email: ike.nwakamma@gmail.com

## ABSTRACT

**Background and Objective:** Congregational Health Empowerment and Social Safety Advocates (CHESS-Advocates) initiative, a project aimed at mitigating maternal and child health (MCH) and gender injustices in religiously pluralistic societies, was implemented in two Northern Nigerian states of Benue and Kaduna between September 2018 and July 2019. The objective of this study was to assess the effectiveness, sustainability and factors of success in the CHESS-Advocates model as a faith community approach to mitigating gender and MCH injustices in Northern Nigeria.

**Methods:** Data were from desk review of monthly project reports which were documented monthly all through the 10-month project life, and qualitative assessment conducted in July 2019 at the end of project. The assessments involved focus group discussions, key informant interviews, and in-depth interviews conducted in four randomly selected communities in each of the project states. The variables of interest were sustainability, effectiveness of initiative, and the factors that contributed to the success of the program.

**Results:** The CHESS-Advocate model was effective in the mobilization of community response that improved uptake and acceptance of antenatal care (ANC), immunization, and uptake of human immunodeficiency virus (HIV) testing services. The model was cost-effective and able to instigate change in harmful practices, particularly in highly religious communities. The model showed promise of sustainability and identified some factors that led to its success in the different communities.

**Conclusion and Global Health Implications:** The CHESS advocates model showed promises of efficacy in engaging faith communities as important actors in promoting MCH practices and mitigating gender injustices particularly in rural and underserved communities. Like other faith based models, the CHESS-Advocates model provided opportunities in faith congregations for building sustainable development in health and social justice. The model helped to improve MCH seeking behavior, influenced change in harmful gender norms and in community response against gender based violence in rural communities.

**Key words:** MCH • Gender justice • HIV • CHESS-Advocates • Faith • Northern Nigeria • Nigeria

*Copyright © 2019 Nwakamma et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.*

© 2019 Global Health and Education Projects, Inc.

# 1. Introduction

## *1.1. Background of the Study*

The Alma-Ata declaration recognized community participation as a key component in addressing essential healthcare needs of the population.[1] Community participation entails active involvement of target populations in decision-making, implementation, management and evaluation of policies, programs and services.[2] Involving communities in the design, implementation and evaluation of programs may increase efficacy and sustainability of interventions.[3]

Over the years, poor maternal and child health have been major public health challenges in Nigeria,[4,5] with the country recording one of the highest rates of maternal and child mortality and morbidity.[6] According to Nigeria's 2018 Demographic and Health Survey (NDHS), under-5 mortality rate was estimated to be 132 deaths per 1,000 live births, while maternal mortality ratio for the 7-year period before the 2018 NDHS was estimated at 512 maternal deaths per 100,000 live births.[7] The Joint United Nations Programme on HIV and AIDS (UNAIDS) 2014 gap report stated that among 21 identified sub-Saharan African Global Plan priority countries, Nigeria recorded the lowest Prevention of Mother to Child Transmission of HIV (PMTCT) coverage rates and highest PMTCT service delivery gap, with the country contributing 25% of the global PMTCT gap and having approximately 190000 HIV+ women giving birth yearly.[8]

Within Nigeria, there are intra-country variations in maternal mortality rates (MMR), with the highest rates in Northern Nigeria.[9] According to a report,[10] women from the northern part of Nigeria are at higher risk of maternal deaths compared to those from the south of the country. Similarly, there are lower neonatal and infant survival rates in the Northern region when compared to Southern part of Nigeria,[11] and a lower likelihood of an infant born to a Northern mother receiving full immunization compared to children born to Southern mothers.[12]

Gender injustice in Northern Nigeria has been documented in different studies, manifesting in forms of gender discrimination and deliberate prohibition of women from exploiting economic, political and social opportunities.[13,14] Practices like forced and child marriage is common in Northern Nigeria,[15] and these have been implicated as drivers of the high cases of Vesico Vaginal Fistula[16] and maternal health risky behaviors, such as delay in seeking medical care, restricted access to MCH services, and pregnancy complications.[17] The resultant gender-based violence due to unequal power relationships has also been reported to be high in the Northern region of Nigeria.[18,19]

Religion has been identified as an important factor in community health outcomes.[20] Two theories: (1) particularized theology hypothesis, and (2) selectivity hypothesis associate doctrinal stances, belief systems, religious norms, and values with health-related behaviors and attitudes that may be detrimental to maternal and child health and influence access to healthcare.[21] The study by Antai and Antai on the differentials by religious affiliation of the mother as an individual-and contextual-level determinants of social inequities in under-five mortality in Nigeria reported significant association between religion and under-five mortality influenced by contextual-level characteristics of the community.[22]

The Sustainable Development Goal 3 targets the reduction of global maternal mortality ratio to less than 70 per 100,000 live births by 2030.[23] To achieve this target in Nigeria, there is need to reduce the country's maternal mortality rate by 7.5% every year,[24] hence the need to mobilize and leverage the most important, sustainable and influential actors in the communities to ensure improved access and uptake of maternal and child health services and promote gender justice.

## *1.2. Overview of the CHESS-Advocates Project*

**C**ongregational **H**ealth **E**mpowerment and **S**ocial **S**afety **A**dvocates (CHESS-Advocates) initiative was conceived to leverage faith platforms and the opportunities they provide to mitigate health and gender injustices in two Northern Nigerian states of Kaduna and Benue. The project locations were Igabi and Chikun Local Government Areas (LGAs) in Kaduna State; and Konshisha and Kwande LGAs in Benue State.

© 2019 Global Health and Education Projects, Inc.

CHESS-Advocates is an innovation of Christian Aid UK, Nigeria and Nigerian Network of Religious Leaders Living with or personally Affected by HIV/ AIDS (NINERELA+). It was the first attempt of implementing the model in any Nigerian community. The initiative was part of a 10-month project targeting faith leaders and congregations as advocates of community health and social justice. The initiative passed through a participatory planning cycle of assessment, sharing experiences, planning, implementation and reassessment.

In this initiative, religious leaders as influencers were engaged to leverage their faith platforms and promote community participation in health through advocacy, sensitization and mobilization to promote positive healthcare seeking behaviors and dialogues for the eradication of harmful practices and norms that violate the rights of women and girls. Religious leaders from the selected congregations were trained on communication for health, positive masculinity, demand creation, and advocacy. At the end of the training, the religious leaders nominated two persons (a male and a female) from their congregations who were trained, and set up CHESS-Advocates movement in their congregations.

The different groups developed strategies including tele-counselling, Mom's fellowship and support group for pregnant women/nursing mothers for participatory learning sessions, and support to the pregnant women. Each congregation's CHESS-Advocates group was supported with 10,000 Naira ($28.6/£22.4) per month to organize targeted engagements in their congregations and 2,000 Naira ($5.7/£4.5) for telephone calls. One-hour interactive radio programs for eight weeks were financed for the CHESS-Advocates in Kaduna and Benue states to further engage the public on transformational roles of faith in health and social justice, particularly on MCH and gender justice.

The project locations were selected from among four states (Anambra, Benue, Federal Capital Territory, and Kaduna) initially supported by the donor. The choices of the two selected states were based on evidence from Nigeria's 2013 Demographic and Health Survey with regards to child birth in health facility and women's ability to take decision independently on their health. According to Nigeria's DHS 2013, the lowest ranking on the selection criteria from among the four states were Benue and Kaduna.[25]

In summary, the CHESS Advocates initiative was expected to: (1) set up sustainable faith community mechanisms for mitigating community health and gender justice in the target communities; (2) create a network of religious leaders who work as gender and MCH champions in the target communities; (3) leverage the authority of faith leaders to challenge harmful norms and practices that affect gender and MCH justice; and (4) mitigate knowledge gaps that affect uptake of MCH services and instigate gender injustice.

### *1.3. Objectives of the Study*

The objective of this study was to assess the effectiveness, sustainability and success factors of CHESS-Advocates model as a faith community approach to transforming behaviours, norms and practices that affect gender and MCH justice in Northern Nigeria.

## 2. Methods

The data were based on desk review of the project reports which were documented monthly all through the project life, and the end of project qualitative assessment conducted in July 2019. The assessments were carried out in four randomly-selected communities in each of the two project states.

The project was implemented from September 2018 to July 2019. In the monthly reporting, the state project officers followed up on the activities of the different congregational CHESS-Advocates groups and ensured they reported accurately on their activities. At the end of every month, reports from the various project communities were collected by the national monitoring and evaluation officer. The monthly data captured the reach of the CHESS-Advocates with the various innovative approaches for mobilizing and sensitizing the congregants on the key issues. In particular, the monthly figures on number of pregnant women, under 5 children and

 © 2019 Global Health and Education Projects, Inc.

nursing mother reached were reported, as well as their participation in the learning sessions and utilization of MCH services. The trained religious leaders and CHESS-Advocates reported the patronage of their tele-counselling sessions and utilization of the tele-platform for reporting sexual and gender based violence. At the end of the project, there was an assessment of the level to which the model influenced MCH health seeking behavior and change in harmful gender norms and practices in the communities.

### *2.1. Qualitative Assessment*

The assessment involved 8 key informant interviews (KIIs) with men and women leaders in the congregation, 8 focus group discussions (FGDs) with congregational and community members and 8 in-depth interviews (IDI) were held with 12 religious leaders trained in the project and CHESS-Advocates in the selected faith communities.

In the KII, 4 Christians were interviewed in Benue State, while in Kaduna, 2 Muslims and 2 Christian women leaders were interviewed. Also, 3 and 5 FGDs were conducted in Benue and Kaduna, respectively, with all 3 in Benue being in Christian congregations and 2 Christian congregations in Kaduna. The FGDs were held separately for males and females in the Muslim communities (2 FGDs for females and 1 for males). More respondents were selected for the IDI in Kaduna; 4 each were selected from the Muslim and Christian congregations, while 4 Christian respondents were interviewed in Benue (Table 1).

The FGDs, KII and IDI were guided by semi-structured questionnaires and the facilitation comprised of trained moderator, a co-moderator, and an observer documenting key emergent issues and nonverbal cues. Sessions were conducted in English and/or the local language (Hausa and Tiv whichever is the dominant language of the study communities). An interpreter was used in communities where the facilitators did not speak the local language. Each FGD, KII and IDI was audio-recorded and lasted between 60–90 minutes.

### *2.1. Study Variables: Our study variables were*

(1) effectiveness of CHESS Advocates model; (2) factors that contributed to the success of the model; and (3) sustainability of CHESS-Advocates model.

### *2.2. Statistical Analysis*

Audio recordings were transcribed verbatim; local languages, were transcribed into English independently by two people, before the two transcripts were harmonized with the principal investigator. Audio transcripts were independently hand-coded by two people by reviewing each line, phrase, and paragraph to identify the initial key themes. After going through two transcripts each, the two persons later reviewed and harmonized their codes to develop the general codes and themes. This process was followed by validation, codes and themes were examined for content analysis of the transcripts thematically and in relation to the overall interview guide. The data were put together into one matrix of the words and phrases that represented the themes that emanated from the analysis. The primary findings were then synthesized and summarized in narrative forms. Important quotes from the transcripts were extracted and used to complement the analyzed data, particularly the excerpts where the views were expressed by the majority of the discussants.

**Table 1: Distribution of participants in the end of project qualitative assessments in Kaduna and Benue States**

| Method of assessment | Kaduna | | Benue | | Total |
|---|---|---|---|---|---|
| | Male | Female | Male | Female | |
| Focus Group Discussions | 26 | 27 | 24 | 24 | 101 |
| Indepth Interviews | 4 | 4 | 3 | 1 | 12 |
| Key Informant Interviews | 2 | 2 | 2 | 2 | 8 |
| Total | 32 | 33 | 29 | 27 | 121 |

© 2019 Global Health and Education Projects, Inc.

### 2.2. *Ethical Approval*

Comprehensive information was provided to participants in this study, and their consents were sought and obtained verbally. Confidentiality was maintained by excluding names of respondents; option to opt out of the study and to ignore any question was allowed and communicated to the participants. Approvals were also obtained from the local authorities of the congregations where the assessments were conducted.

## 3. Results

The reach of the project in the 20 partner congregations was assessed based on the review of the monthly data reported from the project communities.

A total of 242 pregnant women were identified and enrolled into the learning sessions, 65% were in Kaduna. Among them, 133 (84%) and 55 (63%) participated in the weekly learning sessions for at least 8 weeks in Kaduna and Benue respectively. In Kaduna, 97% of the women willingly accessed HIV screening, will 88 (100%) of them in Benue accessed HIV testing service in the community or health facility (Table 2).

The number of mothers and their under-5 infants reached with information on vaccination was 305 (195 in Kaduna). Six months after the sensitization, 94% and 96% in Kaduna and Benue respectively reported compliance with the vaccination schedule of their infants. From the project congregations, 363 congregants utilized tele-counselling services provided by the CHESS-Advocates, 99 people from the states called back after the radio programs for more information on the issues discussed and 26 people utilized the hotline services for reporting cases of GBV (Table 3).

### 3.1. *Effectiveness of CHESS-Advocates Model*

The effectiveness of the initiative and approaches adopted in the project were extensively discussed. In Muslim communities, for instance, there is the practice of restricting women from the public for any reason including for healthcare service uptake. The female CHESS-Advocates were able to cross the barriers and reached their fellow women who were pregnant or had children with vaccination needs. The men did not frown at the approach as they felt comfortable that the mentoring processes were done by respected female members of their congregations. Some of the female CHESS-Advocates were healthcare professionals and experienced mothers; thus they created safe spaces for the women to comfortably share experiences and participate actively in the community learning sessions.

> *"Hajia Aisha (the leader of the CHESS-Advocates) has been helping us. Everybody knows her and when she calls us to come together even our husbands will not complain because we respect her, and we learn lot of things from the things they teach us" [Female Muslim, FGD Kaduna].*

All the congregations reported that their Pastors or Imams had called for men to support their wives and ensure they attended ANC. Through the support groups formed for pregnant women, the women motivated each other to attended ANC. Where some women reported resistance from their husbands, they collectively approached their Imam to speak on their behalf. The Imams intervened by exerting some pressure on the men to comply or supported him financially, in some cases, to aid the man meet his responsibility.

> *"It is easier for us as women to meet the pregnant women in their homes without fear. Also, we have the support of our Imam, sometimes when we receive complain that any man is not supporting his wife to either go for ANC or participate in the support group, we talk to the Imam and he will talk to the man and that is it" [Muslim CHESS-Advocate, IDI, Kaduna].*

In the Christian communities, the introduction of fellowship or prayer meetings with the pregnant women was very effective in mobilizing them and for linking/follow-up into ANC. In one church, the Pastor indicated his plan of requesting evidence of vaccination from couples planning for child dedication.

In terms of cost effectiveness, we inferred that given the number of engagements conducted by the CHESS-Advocates, it would have cost a lot more if outsiders were to come and conduct those activities.

 © 2019 Global Health and Education Projects, Inc.

> *"You know when you come from far to conduct this activity here, people will gather not because of what you have come to talk about but to know or get what they expect you will give them and you will definitely spend on them, but when we gather them, whoever is there has the interest to learn and we give nothing because they do not expect me to give them transport or refreshments. Even if they are just 10, they are committed 10" [Trained Pastor, IDI Benue].*

A high point of the model was the endorsement and involvement of the religious leaders. In some cases, the religious leaders led the congregational engagement on HIV testing by first testing with their wives. That gave a sense of ownership of the model. An Imam in Kaduna reported that he was impressed with the result he was seeing.

### *3.2. Personal and Community Benefits*

The benefits of the project to the community emerged in two forms: first, individual/personal-level benefits, and second, community level benefits. The benefits acknowledged spanned change in behavior, improved knowledge, shift in practices, and improved access to services. Those that participated in the training acknowledged personal benefits from the CHESS- Advocates initiative.

> *"Honestly, the training helped me to see clearly the direction my ministry will move to. I have a doctor in my Church who used to treat me and my family for free. But I have come to see that there are people in my Church that need that free service more than me" [Trained Pastor, IDI Benue].*
> *"I remember when we were asked a question during our training about how many men among us knew about how their daughters buy sanitary pad every month. Ha, do you know before that time, I never considered it as something I should bother about, but since that time, I personally give my daughter money every month to buy pads, that is gender equity. Even my daughter is surprised" [CHESS-Advocate, IDI Benue].*

At the community level, some of the benefits showed in addressing stigma associated with HIV, fear of testing for HIV, and in the promotion of gender-friendly communities. For instance, it may not have been easy to individually ask that women be allowed to go for ANC in the Muslim communities, but with the collective efforts of women, through the support group of pregnant women and advocacies of the CHESS-Advocates to the religious leaders, community supports were mobilized by the religious leaders to address the issues.

### *3.3. Factors Contributing to the Success of the Model*

The recorded success stories were based on some factors in the different communities that aided the initiative to yield results. In some communities, there were organized structures that the groups leveraged to engage the community members more effectively. For instance, in the Christian congregations, there were different groups for the men, the women, the youths and welfare groups in the churches. Some of the activities were keyed into the programs of these groups making mobilization of the congregants easy.

The involvement of male religious leaders in both the Christian and Muslim communities was very advantageous. Through their sermons and participation in the weekly radio programs, they sustained the call for gender justice and need for community actions to promote MCH. The Muslim Imams played important roles in reconstructing the narratives about women empowerment, acceptance of vaccination and allowing women to meet and learn about their health. In some instances, they intervened in favor of the women on issues affecting women or their children.

The involvement of the clergy's wives either as a member or leader of the CHESS-Advocates gave the group stronger legitimacy and support from the church leaderships. Being a symbol of motherhood in the congregations, they played important roles in the congregational learning sessions and in mobilizing the support of the church.

Some churches developed innovations like tele-counselling and hotline approaches, in which telephone numbers were published in the churches for anonymous calls for counselling or reporting cases in the communities. More still, inter-congregation

© 2019 Global Health and Education Projects, Inc.

collaboration between two mosques in Kaduna yielded great result by joining forces to engage with the community members and in advocacy efforts to the community leaders.

### 3.4. Sustainability of the Model

The sustainability of the initiative was an interesting theme. The project emphasized faith community ownership of the initiative through asset-based community-led development approach. Many of the respondents acknowledged that the initiative had come to stay with potentials for expansion, though there was need for support in same areas.

> *"As you can see this year we had our first health week and it is going to be annual. We, as a church, have realized the need to make these issues bothering our people our collective problem and we will continually devise means of using this group to address them [Pastor, KII Kaduna].*
> *"This support group for pregnant women we have set up is interesting. I think it will grow from strength to strength because the women have seen the need to support each other" [Female Muslim, FGD Kaduna]* (Tables 2 and 3).

## 4. Discussion

The World Health Organization (WHO) Guideline Development Group (GDG) has recommended antenatal care model with a minimum of eight contacts to reduce perinatal mortality and improve women's experience of care, as against the focused antenatal care (FANC) model developed in the 1990s which was associated with more perinatal deaths,[26] and further clarified that "contact" can be adapted to local contexts through community

**Table 2: Uptake of MCH related services by pregnant women in project congregations**

| Variables | Kaduna No. (%) | Benue No. (%) | Total No. (%) |
|---|---|---|---|
| Pregnant women identified in the congregations | 154 (65) | 88 (35) | 242 |
| Pregnant women who completed weekly sessions for at least 8 weeks | 133 (84) | 55 (63) | 188 |
| Pregnant women reached who tested for HIV in the facility or community after sensitization | 149 (97) | 88 (100) | 237 |
| Pregnant women reached who kept to the WHO ANC schedule* | 128 (81) | 73 (83) | 201 |
| Pregnant women reached who delivered under the care of a trained healthcare worker in due time | 121 (77) | 82 (93) | 203 |
| Women with under- 5 infants reached with information on with vaccination schedules | 195 | 110 | 305 |
| Mothers reached with under-5 infants who confirmed vaccination schedule compliance 6 months after sensitization | 184 (94) | 106 (96) | 290 |

*WHO guideline development group (GDG) recommends 8 "contact" that can be adapted to local contexts through health facility services, community outreach programmes and lay health worker involvement.[24]

**Table 3: Utilization of supports and different innovative outreach models offered by the CHESS-Advocates**

| Variables | Kaduna No. (%) | Benue No. (%) | Total |
|---|---|---|---|
| Congregants who utilized tele-counselling services offered by CHESS-advocates between April and June 2019 | 221 (61) | 142 (39) | 363 |
| Persons who called back for more information on HIV, MCH or SGBV after an episode of the radio program | 71 (72) | 28 (28) | 99 |
| Persons who utilized the hotlines for reporting, or requesting for more information on SGBV between April and June 2019 | 19 (73) | 7 (27) | 26 |
| Pregnant women who obtained support from their spouses to attend ANC based on intervention of their religious leaders/CHESS-Advocates | 42 (89) | 5 (11) | 47 |
| Total | 353 | 182 | 535 |


© 2019 Global Health and Education Projects, Inc.

outreach and lay health workers involvements. With maternal and child health and gender injustice being major topical issues in Northern Nigeria, a community participatory approach to the problems is advantageous.[27] The CHESS-Advocates model has shown some promise in helping communities develop local strategies that are culturally and socially appropriate, acceptable, and sustainable.

A key success of the initiative was the ability to identify and link pregnant women into MCH services through mentoring and learning sessions delivered in the faith congregations and the faith leaders' confrontation of the gender norms that limit women's ability to take decisions on issues related to their health and those of their children. Empowering a woman in the context of her household and relations with her partner can positively influence a woman's likelihood to have birth in a health facility and with a skilled attendant.[28]

The programmatic cost effectiveness of this model is worthy of note. The major investments at the community level were in the training of the religious leaders and CHESS-Advocates, and a total monthly support of about $34/£26.9 (12,000 Naira) for each congregation. The CHESS-Advocates were able to mobilize volunteers who committed their time and skills solely as their contribution to their faith communities. Equally, the weekly/monthly activities were all at little or no cost to the project. Like a respondent in the IDI pointed out, it would have cost lot more if the activities were organized directly by an external organization and yet, the same level of commitment may not have been achieved.

The pregnant women and mothers with under-5 children reached in this project showed greater compliance to uptake of ANC, perinatal services, and vaccination coverage compared to documented low coverage and uptake in the region.[29,30] Though this study did not have a baseline data on MCH seeking behaviors of the women reached or their prior practices or beliefs, however, given the high participation in the weekly activities, the reported increase in support from the spouses, the reported increase in attendance of ANC, and acceptance/ demand of HIV services and immunization for infants, it can be inferred that there was a change in behavior and attitude in the communities based on the engagements and activities of the CHESS-Advocates in their congregations.

The religious bodies in Nigeria have multi-denominations with the potential channels to reach people with right messages for improved health seeking behaviors, stigma reduction and demand creation for other health services using approaches sensitive to the peculiarities of the denominations. Being in constant contact with policy makers as well as community members, religious leaders could play a key role in demanding for policy change/ implementation while also sensitizing community members on the need to seek and access health services.

### *4.1. Limitations*

The project duration was short, and this assessment was based on the recorded achievements within the short period of time. While 4 locations were randomly selected for the assessment, the reports may not necessarily represent those of the other communities as all have different demographic characteristics. A cluster randomized trial will be interesting to study this model in different communities to have stronger empirical evidence to support the model.

## 5. Conclusion and Global Health Implications

Community participatory approach to development has been proven to be effective in different development areas. This study has shown the promising efficacy of engaging faith communities as important actors in promoting MCH and gender justice particularly in rural and underserved communities. The CHESS-Advocates model, as an example of a community led development initiative, showed effectiveness in breaking some of the barriers in traditional Muslim and Christian communities that limit access to health, optimal health seeking behavior and hinder equal access to opportunities. This study has reinforced the assertion that faith communities and leaders can play transformational roles toward attaining sustainable development in health and social justice.

© 2019 Global Health and Education Projects, Inc.

### *Compliance with Ethical Standards*

***Conflicts of Interest:*** *The authors declare there are no conflict of interest to report.* ***Financial Disclosure:*** *The authors did not receive any financial compensation for this study other than salary received during project implementation.* ***Funding/Support:*** *The project and study was funded by Christian Aid UK.* ***Ethics Approval:*** *Comprehensive information was provided to participants in the study; participants' consent were sought and obtained verbally. Confidentiality was maintained by excluding names of respondents; participants were provided the option to opt out of the study and to ignore any questions posed during the program.* ***Acknowledgements:*** *The authors acknowledge the contribution of the CHESS-Advocates in Kaduna and Benue States, Nigeria.*

**Key Messages**

- Participatory faith community intervention is efficacious in building resilience in community health.
- Empowering rural women leaders as lay counsellors in MCH improves service uptake in rural communities.
- Religious leaders can change harmful norms and practices that promote gender injustice and negatively affect MCH among their congregants.

## References

1. World Health Organization. *Alma Ata Declaration. Geneva: World Health Organization; 1978. https://www.who.int/publications/almaata_declaration_en.pdf*. Accessed July 10, 2019.
2. Sachs JD. *Investing in Development: A Practical Plan to Achieve the UN Millennium Goals: A Report to the UN Director-General. London: Earthscan; 2005. http://web.worldbank.org/archive/website01021/WEB/IMAGES/TF1MAINR.PDF.* Accessed July 10, 2019.
3. Steyn PS, Cordero JP, Gichangi P, et al. Participatory approaches involving community and healthcare providers in family planning/contraceptive information and service provision: a scoping review. BMC *Reproductive Health*. 2016;13(1):88. doi:10.1186/s12978-016-0198-9.
4. Doctor HV. Variations in under-five mortality estimates in Nigeria: explanations and implications for program monitoring and evaluation. *Maternal Child Health Journal*. 2013;17(8):1355–1358. doi: 10.1007/s10995-012-1161-1.
5. WHO, UNICEF, UNFPA, The World Bank: *Trends in maternal mortality: 1990 to 2010. Geneva: World Health Organization; 2012. https://apps.who.int/iris/bitstream/handle/10665/44874/9789241503631_eng.pdf;jsessionid=63343CADE20D630CC32208DA4900C2C3?sequence=1*; Accessed July 20, 2019.
6. Bolarinwa OA, Ameen HA, Durowade KA, Akande TM. Mapping knowledge management resources of maternal, newborn and child health (MNCH) among people living in rural and urban settings of Ilorin, Nigeria. *The Pan African Medical Journal*. 2014;17:34. doi:10.11604/pamj.2014.17.34.2704.
7. Nigerian Ministry of Health. Demographic Health Survey Report 2018. Nigeria: Ministry of Health. https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf. Accessed November 10, 2019.
8. UNAIDS. The Gap Report, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva, Switzerland, 2014. http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf. Accessed July 2019.
9. Sharma V, Brown W, Kainuwa MA, Leight J, Nyqvist MB. High maternal mortality in Jigawa State, Northern Nigeria estimated using the sisterhood method. *BMC Pregnancy Childbirth*. 2017;17(1):163.
10. African Population and Health Research Center. *Maternal Health in Nigeria: Facts and Figures, June 2017. http://aphrc.org/wp-content/uploads/2017/06/APHRC-2017-fact-sheet-Maternal-Health-in-Nigeria-Facts-and-Figures.pdf*. Accessed July 2019.
11. Fagbamigbe AF, Akinyemi JO. Modelling the survivorship of Nigeria children in their first 10 years of life. *Nigerian Health Journal*. 2016; 16 (1);13.
12. Antai D. Inequitable Childhood immunisation in Nigeria: A multilevel analysis of individual contextual determinants. *BMC Infectious Disease*. 2009;9:181–5. doi: *10.1186/1471-2334-9-181*.
13. Bello G. Condition of Women in Nigeria: Issues and Challenges. *Arts and Social Science Journal*. 2017; 8:293. doi: 10.4172/2151-6200.1000293.

 © 2019 Global Health and Education Projects, Inc.

14. Abdulwasiu A, Gado MA. Cross-Sectional Analyses of Women Political Participation for Development in North western Nigeria: A Study of Sokoto, Kebbi and Zamfara States. *OSR Journal of Humanities and Social Science (IOSR-JHSS).* 2017; 22 (7): 23-29.

15. Adebusoye PM, Hidden: A Profile of Married Adolescents in Northern Nigeria. Yaba, Lagos, Action Health Incorporated, 2006. http://www.actionhealthinc.org/publications/docs/hidden.pdf, accessed November 30, 2019.

16. Onyido JA and Brambaifa AP. Girl-Child Marriage in the Nigerian Society, Causes, Impacts and Mitigating Strategies. *World Journal of Social Sciences and Humanities*. 2018; 4(2):104-110. doi: 10.12691/wjssh-4-2-6

17. Adedokun O, Adeyemi O, Dauda C. Child marriage and maternal health risks among young mothers in Gombi, Adamawa State, Nigeria: implications for mortality, entitlements and freedoms. *African Health Science*. 2016; 16(4):986–999. doi:10.4314/ahs.v16i4.15

18. Salaudeen AG, Akande TM, Musa OI, Bamidele JO, Oluwole FA. Assessment of violence against women in Kano metropolis, Nigeria. *Niger Postgraduate Medical Journal.* 2010; 17(3):218–222.

19. Audu O, Bako IA, Jogo AA et al. Prevalence of domestic violence against married women: A case study of Oiji Ward, a rural setting in North Central Nigeria. *Journal of Community Medicine and Primary Health Care.* 2015; 27(2), 20-29.

20. Antai D. Faith and Child Survival: The Role of Religion on Childhood Immunization in Nigeria. *Journal of Biosocial Science*. 2009; 41(1): 57-76. doi: 10.1017/S0021932008002861

21. Soura A., Pison G., Senderowicz L., & Rossier C. Religious differences in child vaccination rates in urban Africa: Comparison of population surveillance data from Ouagadougou, Burkina Faso. *Etude de La Population Africaine*, 2013; 27(2):174

22. Antai, D & Antai A. Individual- and contextual-level determinants of social inequities in under-five mortality in Nigeria: differentials by religious affiliation of the mother. *World Health and Population*. 2008;10(4), 38-52.

23. United Nations Organization. Transforming our world: the 2030 Agenda for Sustainable Development. Sustainable Development knowledge platform. 2015. https://sustainabledevelopment.un.org/index.php?page=view&type=400&nr=2125&menu=1515. Accessed July 15, 2019.

24. World Health Organization (WHO). Nigeria fights high maternal mortality through improved quality of care**.** June 20, 2018. https://www.afro.who.int/news/nigeria-fights-high-maternal-mortality-through-improved-quality-care. Accessed July 15, 2019.

25. Nigerian Ministry of Health. Demographic Health Survey Report 2013. Nigeria: Ministry of Health. https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf Accessed June 20, 2018.

26. WHO Reproductive Health Library. WHO recommendation on group antenatal care. (November 2016). The WHO Reproductive Health Library; Geneva: World Health Organization. https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-antenatal-care-contact-schedules. Accessed July 3, 2019.

27. Sule SS. Community participation in health and development. *Nigerian Journal of Medicine*. 2004; 13(3):276–281.

28. Corroon M, Speizer IS, Fotso JC et al. The Role of Gender Empowerment on Reproductive Health Outcomes in Urban Nigeria. *Maternal and Child Health Journal.* 2014; 18 (1) 307–315. https://doi.org/10.1007/s10995-013-1266-1

29. Maryam Al-Mujtaba M, Cornelius LJ, Galadanci H. et al. Evaluating Religious Influences on the Utilization of Maternal Health Services among Muslim and Christian Women in North-Central Nigeria. *BioMed Research International.* 2016; 2016; 3645415, https://doi.org/10.1155/2016/3645415.

30. Galandanci H, Ejembi C, Iliyasu Z, Alagh B, Umar U. Maternal health in Northern Nigeria – a far cry from ideal. *BJOG International Journal of Obstetrics and Gynaecology.* 2007; 114(4):448–452.


© 2019 Global Health and Education Projects, Inc. 