The Islamic Religious Leaders as Health Promoters: Improving Maternal Health in Selected Communities of Zamfara State, Nigeria

Abdullahi Mohammed Maiwada, Nor Azlina A. Rahman, Suzannah Abdurrahaman, Nik Mazlan Mamat and Judith Ann-Walker

Department of Biomedical Sciences, Kulliyah of Allied Health Sciences, International Islamic University Malaysia (IIUM)

Development Research and Projects Center, (dRPC) Kano, Nigeria

Abstract: Context: The project targeted Islamic religious leaders (ISOLs) through transformative interventions such as leadership development forums, health promotion and education training activities to the Islamic religious leader, who in return informed and educated their followership including men and women of reproductive age groups in order to help improve the maternal health situation and reduce maternal mortality in Zamfara states. Methods: a total of 100 Islamic religious leaders were engaged and exposed to health promotion and education trainings and community mobilization activities through the (IIUM/HPPMM) which was implemented in some selected intervention urban and rural communities of Zamfara State to women in reproductive age groups. Results revealed that there was an increase in some key output indicators such as antenatal care (ANC) attendance and contraceptive use among these women, delivery at the health facility also increased when compared with the control communities where no such interventions were carried out by the Islamic religious leaders and the project. The intervention rural facilities experienced an uptake in contraceptive use, ANC attendance and facility deliveries while the control sites saw no increase in uptake. Findings of particular significance in the rural facilities include the sharp increase in contraceptive use in the intervention compared to the control community facility. In the overall there is increase in ANC attendance in all the intervention rural and urban facilities compared to control sites. In conclusions: The findings of this analysis suggest that the (IIUM/HPPMM) Health Promotion and Prevention of Maternal Mortality Research and Leadership Development Project which assumes a health communication role for Islamic religious leaders has indeed contributed to the uptake of FP/RH services.

Key words: Islamic Religious Leaders • Antenatal Care • Contraceptive Use • Maternal Health

INTRODUCTION

Decades of intensive funding for reproductive health programs in Northern of Nigeria has yielded little change in health indices. Maternal mortality and morbidity ratios remain high, uptake of family planning services remain relatively low and high rates of early marriage continues to characterize the region. While studies on faith and faith base organizations (FBOs) clearly map out a role for faith communities and FBOs in public health interventions, the precise role of Islamic religious leaders is less clear. The literature focusing on the faith leader often makes little distinction amongst community leaders of faith, traditional leaders and indeed Islamic religious leaders in the northern Nigeria [1].

To the extent that these broad categories of faith actors are perceived to have influence over the health seeking behavior of adult men and women of free choice from the standpoint of superior knowledge of religious precepts on health, Muslim religious leaders as members of social networks are intimately involved in the everyday lives of their congregation this group can loosely be defined as Religious leaders. Invariably, much of the literature focuses on male Islamic religious leaders.
Studies which view Islamic religious leaders through supply side lenses tend to see them as a potential adversary to be neutralized through behavioral change communication by health professionals on issues concerning HIV/AIDS, reproductive health and gender interventions [2].

Also there are limitations of the methodology of most of the reviewed articles. For instance, for primary data most of them rely on interviews with key stakeholders like individuals from the health sector or programme beneficiaries rather than religious leaders [3]. Religious leaders, Imams or preachers are primary source of guidance and advice. When religious leaders are properly trained and briefed by trusted health workers, they become powerful agents of social change and therefore able to change their followers and community’s behavior [4]. However, these Islamic religious leaders that have great influence on communities live are rarely involved most and similar reproductive and maternal health projects in developing countries [5].

On the demand side, however, a more pro-active role is mapped out for Islamic religious leaders who are seen to have a key role as health communicators to strategic audiences of the faithful as well as to official government structures to whom they communicate advocacy messages. The term health communicator is fundamental to making sense of the Islamic religious leaders on the demand side. Health communication is a broad concept defined as “a multifaceted and multidisciplinary approach to reach different audiences and share health related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt or sustain a behavior, practice or policy that will ultimately improve health outcomes”. The role of Islamic religious leaders as health communicators can be viewed as evidence of the multifaceted and multidisciplinary approach of health communication. Health communication is an eclectic discipline in which flexible decisions are made on the most effective approach and strategies needed to transform and modify the behavior of a discerning and interactive target audience [6].

Because the target audience is not perceived as passive and communication is defined as a two-way interactive process, analysis of the intended audience determines the communication strategy, the message and indeed the choice of communication channels. Thus if the intended audience is community based, traditional and faith inspired, the communication strategy should reinforce the audience’s value base and the communication channel or ‘pathway’ should be around a legitimate and influential communicator such as the Islamic religious leaders and the message should equally resonate with value base of the audience.

The audience centered approach in health communication views Islamic religious leaders (ISOLs) as important actors at the leadership level of the audience who must engage in a persuasive dialogue and exchange of knowledge with the rank and file of the audience to modify their behavior. The most influential ISOLs may neither be ‘innovators nor early adopters’ willing to participate in development interventions and to become health communicators. Indeed, the most influential ISOLs may be members of the ‘late majority and laggards’ reluctant to change [7].

How to catalyze influential ISOLs to take up a global health leadership role and become effect health communicators and agents of change? This is the question that the leadership development in global health literature seeks to address. Global health communication calls for ISOLs to have a leadership role with adult men and women of the faith through interpersonal communications; with faith communities through social and community mobilization and with political decision makers as well as medical personnel through advocacy [6]. Despite the central role for ISOLs were expected to play in public health interventions in the early 2000s few projects incorporated health promotion and leadership capacity building activities to prepare the ISOLs to fulfill their role. Indeed, ISOLs seemed to be expected to be willing to participate and to be ready to look for maternal health guiding principles in religious contexts [2,8].

Zamfara State is one of the states in Northern Nigeria, located in the northwest geopolitical zone. It has a population about 3.4 million people. According to CBN report of 2006 the state has a poverty rate of about 75-80% and is one of the educationally less advantaged states in Nigeria. Zamfara State has a total fertility rate of 7.5 and maternal mortality rate of 1049/100,000 live birth [9] as compared to the national average of 545/100,000 live birth [10]. The current use of any modern family planning method in Zamfara (among married women aged 15-49) is 2% and the percentage of women who gave birth in the last 5 years who received antenatal care from a skilled provider is only 18% and those with a skilled attendant delivery stood at 8% [11].

The centrality of Islam, tradition, patriarchy in social relations and an agricultural economic base are the predominant characteristics which define the Zamfara...
Muslim-majority state. The social structure in the northern Nigeria especially in Zamfara State is one in which male influential Islamic religious leaders are invariably at the top hierarchies. These religious leaders who straddle in most cases both traditional and religious leadership roles influence the behavior of men and women in every aspect of life through power of public pronouncements. In the Northern Nigeria setting public pronouncements ranges from the guiding utterances and commentaries of Islamic religious leaders on special occasions, to Friday sermon-Juma’at-hut bat and preaching by the regular Imams of mosque.

While studies have found a generally low engagement of Faith based Organizations especially the Islamic faith in development projects, in Nigeria this has particularly been so in Northern Nigeria [12, 13]. In the past, public health interventions have engaged Islamic religious leaders as leading health communicators in good reproductive and maternal health seeking behavior [14].

MATERIALS AND METHODS

Aim of the Study: Given the significance of the northern region, international development partners in public health have taken up the challenge of designing innovative pilot projects to improve reproductive health outcomes. One such research pilot intervention was the IIUM/KAHS HPPMM project which is an operational research intervention that worked with both Traditional and Religious Leaders in some selected communities of Zamfara States.

Setting: The setting was selected urban and rural, intervention and control communities in Gusau Local Government Area of Zamfara State, Nigeria.

Participant Size: In this intervention study, a total of 100 ISOLs were engaged and exposed to trainings and community mobilization activities for IIUM/KAHS Health Promotion and Prevention of Maternal Mortality Project which were implemented to women in reproductive age groups in some selected urban and rural communities of Zamfara States.

Intended Beneficiaries: The project targeted Religious Opinion Leaders through transformative interventions such as Health Promotion trainings and leadership development forums to catalyze a process by which they were to become community based champions, disseminating correct behavior change communication and information on maternal health and maternal mortality to the Ummah, members of their communities and advocating to community structures to accept maternal health program and for decision makers to support and increase investment in maternal health issues. Making Public pronouncements on maternal health and maternal mortality was as the main instrument used by Islamic religious leaders to change opinions of community members in the Ummah on maternal health.

Evaluation Approach: Health facility statistics in the intervention and control communities were compared for with previous service statistic of the previous years before the intervention and that of the one year period of the project implementation.

Inclusion Criteria: Imams, Islamic preachers, Islamic scholars, Islamiyyah teachers, leaders and administrators of Islamic Organizations in the intervention communities who participated in the Health Promotion and Leadership trainings.

Exclusion Criteria: Those Islamic religious leaders who did not participate in the intervention trainings and those from the control site excluded in this study.

RESULTS

It was found that in the intervention health facilities (both rural and urban areas) there was a growing increase in ANC attendance and about a three-fold increase in contraceptive use and uptake, while hospital deliveries also increased.

In the above graph it can be seen that the Contraceptives uptake was higher in the intervention than control facilities when compared to the pre-intervention years of 2011 to 2013. The marked difference in the uptake of contraceptive is clearly indicating a sharp increase especially in the year 2014 when the project activities and intervention by Islamic religious was optimum.

Attendance in antenatal care ANC among pregnant women increased in intervention urban facilities where the ISOLs made pronouncements and remained stable in control sites were ISOLs were least active, thus showing a correlation in the activities of the Islamic religious leaders in the project the positive performance in the output indicator of antenatal care in the intervention community health facilities as compared to the nonintervention sites.
Fig. 1: The graph above shows the Health services statistics at one of the rural intervention primary health center (PHC) indicating the sharp rises in the three key indicators between the year 2013 and 2014 when compared to previous years 2011 to 2013 before intervention.

Fig. 2: The graph shows the Contraceptives Uptake

Fig. 3: The diagram shows the ANC Attendance at the Clinic

Fig. 4: The diagram shows the Delivery at the Clinic

The study found differential correlations also doubled in the intervention site in Mada. While between control and intervention sites in each indicator and for all the intervention sites health facility deliveries increased about five-fold (in one of the rural primary health center-PHC) in Mada community and three fold in another (Shemori). Contraceptive use also doubled in the intervention site in Mada. While ANC attendance increased significantly in all the intervention facilities around which ISOLs were preaching and engaged their community members and followers in health promotion activities compared to the control sites.
DISCUSSION

While studies on faith and FBOs clearly map out a role for faith communities and FBOs in public health interventions, the precise role of Islamic religious leaders is less clear. The literature focusing on the faith leader often makes little distinction amongst community leaders of faith, traditional leaders and indeed religious opinion leaders.

To the extent that these broad categories of faith actors are perceived to have influence over the health seeking behavior of adult men and women of free choice from the standpoint of superior knowledge of religious precepts on health, this group can loosely be defined as Islamic religious leaders. Invariably, much of the literature focuses on male ISOLs. Studies which view ISOLs through supply side lenses tend to see them as a potential adversary to be neutralized through behavioral change communication by health professionals on issues concerning HIV/AIDS, reproductive health and gender interventions. For example, the UNFPA hallmark work on Communities and FBOs referred to above sets out the core recommendation that “Before designing advocacy work for grass-roots communities, it is important to ensure that leaders of these communities are approached, sensitized and ‘neutralized’ or ‘won’ “ [15]. The article goes on to recommend that providing hard data on maternal mortality and other health related areas are the ‘best advocacy tools to win over a faith-based partner’.

On the demand side, however, a more pro-active role is mapped out for ROLs who are seen to have a key role as health communicators to strategic audiences of the faithful as well as to official government structures to whom they communicate advocacy messages. The term health communicator is fundamental to making sense of the ISOLs on the demand side. Health communication is a broad concept defined as “a multifaceted and multidisciplinary approach to reach different audiences and share health related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt or sustain a behavior, practice or policy that will ultimately improve health outcomes” [15, 17].

The role of ROLs as health communicators can be viewed as evidence of the multifaceted and multidisciplinary approach of health communication. Health communication is an eclectic discipline in which flexible decisions are made on the most effective approach and strategies needed to transform and modify the behavior of a discerning and interactive target audience. Because the target audience is not perceived as passive and communication is defined as a two-way interactive process, analysis of the intended audience determines the communication strategy, the message and indeed the choice of communication channels. Thus if the intended audience is community based, traditional and faith inspired, the communication strategy should reinforce the audience’s value base and the communication channel or ‘pathway’ should be around a legitimate and influential communicator and the message should equally resonate with value base of the audience.

The audience centered approach in health communication views ISOLs as important actors at the leadership level of the audience who must engage in a persuasive dialogue and exchange of knowledge with the rank and file of the audience to modify their behavior. The most influential ISOLs may neither be ‘innovators nor early adopters’ willing to participate in development interventions and to become health communicators. Indeed, the most influential ISOLs may be members of the ‘late majority and laggards’ reluctant to change. How to catalyze influential ISOLs to take up a global health leadership role and become effect health communicators and agents of change? This is the question that the leadership development in global health literature seeks to address. Global health communication calls for ISOLs to have a leadership role with adult men and women of the faith through interpersonal communications; with faith communities through social and community mobilization and with political decision makers and medical personnel through advocacy [6, 16 and 17].

Despite the central role for ISOLs were expected to play in public health interventions in the early 2000s few projects incorporated leadership capacity building activities to prepare ISOLs for to fulfill their role. Indeed, ISOLs seemed to be expected to be willing to participate and to be ready to look for RH guiding principles in religious texts. Thus the UNFPA work referred to above speaks in passive terms of the project’s involvement of “religious scholars, in a series of participatory meetings involving religious leaders at various levels studies specific reproductive health messages and related them to Koranic text” [2,16].

This paper therefore set out to explore the extent to which there is an association between the activities of ISOLs and changes in services statistics. The operational research design was used to generate robust data from
the health facilities on differential correlations between intervention and control sites. The analysis found important associations between facility deliveries and the activities of Islamic religious leaders in urban intervention community health facilities. The increase in uptake was particularly significant for facilities covered by activities of the Islamic religious leaders in rural areas and less significant in urban facilities.

In a real sense the paper’s most significant finding is the strong, sustained and comprehensive differential correlation in all the rural intervention health facilities assessed. All the intervention rural facilities experienced an uptake in contraceptive use, ANC attendance and facility deliveries in the state while the control sites saw no increase uptake. Findings of particular significance in the rural intervention health facility include the sharp increase in contraceptive use in the intervention compared to the control facility (Figure 2).

Also there is significant increase in facility deliveries in the intervention facility in both rural and urban communities compared to the control facility (Figure 4). But perhaps the most important finding is the increase in ANC attendance in all the intervention facilities in both rural and urban compared to control sites (Figure 3). The findings of this paper suggest that the IIUM/HPPMM research intervention project which used the health communication role approach for the Islamic religious leaders has indeed contributed to the uptake of maternal health and Family Planning/Reproductive Health services in both rural and urban communities of the projects’ intervention. The research suggests that the outcome has been particularly significant in rural areas where differential correlations were established between improved service statistics in the intervention sites and static or negative service statistics in control sites.

While the study does not venture to explain unexpected findings in other urban facilities it is conceivable that the general improvement that may be seen is due to the intermediating variables of improved maternal and FP/RH service delivery of other interventions. Therefore, investment in engaging ISOLs as public health promoters or communicator for improved maternal health in communities is a sustainable and cost effective strategy for demand creation and acceptance. Islamic religious leaders can therefore play an important role by being health educators and communicators in the development of contemporary Muslim societies. They can also help bridge the gap where other conventional mediums are not effective due to lack of media reach and non-availability of community level health workers.

CONCLUSION

There was an improved service statistics related to maternal and reproductive health in the intervention area as compared to the nonintervention or control site. Faith-based organizations and groups especially the ISOLs have an important role in promoting acceptability of critical health interventions to save lives and improve maternal health as was witnessed in the IIUM HPPMM project. Support for ISOLs will reduce the information gaps and operational support between communities and the health system managers provided they are sufficiently informed and mobilized to perform their roles as health educators or promoters. The ISOLs public pronouncements correlate with uptake of MNH/FP/RH services especially in rural areas. This is particularly so for ANC attendance and hospital delivery.

ACKNOWLEDGEMENT

The authors wish to acknowledge the support of Dr. Yahya Hashim and Development Research and Project Center (dRPC), Kano for their support and encouragement. The Officials of Zamfara State Ministry of Health especially the Director PHC, Medical Officers in-charge of the Health facilities in Mada, Wanke, Shagari Clinic, King Fahd Women and Children Hospital, Yariman Bakura Specialist Hospital, Dr. Karima PHC Tudun Wada and Federal Medical Center, Gusau, are worthy of acknowledgement. Also the Islamic religious leaders who participated in this study are indeed appreciated for their time and cooperation as well as the community leaders who also granted permission for the intervention.

REFERENCES

13. Tribune, 2011. Muslim Clerics urged to be vanguards for family planning, Nigerian Urban reproductive Health Initiative NURHI.