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Research Article

Involvement of Pastors' Wives in Educating Nursing Mothers on Childcare Practices in Ibadan North Local Government Area, Nigeria

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ABSTRACT

Poor childcare practices among nursing mothers have been implicated as one of the factors influencing high child morbidity and mortality in many developing countries including Nigeria. Many health promotion and education approaches have been used in previous studies to improve childcare practices but very few have considered the inherent potentials of using faith-based strategy as one of the acceptable means of health promotion in many developing countries. This descriptive cross-sectional study was aimed at investigating the involvement of Pastors' wives as change agents in educating nursing mothers on childcare practices in Ibadan North Local Government Area. Multi-stage sampling technique was used to select pastors' wives from all the registered churches in the Local Government Area. A pre-tested interviewer-administered questionnaire was used for data collection. Data were analysed using descriptive and inferential statistics. One hundred and twenty-eight (N=128) pastors' wives with age of 46.1±9.3 years were interviewed. Overall, 9.4% had never taught or preached on childcare practices or other health-related matters to mothers/women in the church before. Analysis showed that 42.2%, 26.6% and 31.3% of Pastor's wives had good, fair and poor level of basic communication techniques, respectively. Age and educational status of Pastors' wives significantly affect the level of communication between Pastors' wives and mothers in the church ($p<0.05$). Involvement of Pastors' wives with the mothers on childcare practices was through counselling (90.6%), teaching (53.1%), preaching (29.7%) and phone calls (18.8%). Counselling was the most preferred method (68.0%) of communication. This study establishes the fact that Pastors' wives and nursing mothers have been communicating health matters through counselling, which can be used as an opportunity for improving child care through faith-based setting.

Keywords: *Child health care practices, Pastors' wife involvement, Faith-based approach, Nursing mothers*

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INTRODUCTION

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). Nigeria, which constitutes just 1% of the world population, accounts for 10% of the world maternal and under-five mortality rates (Ogunjimi, Ibe and Ikorok, 2012). Infant and child mortality rates are exceedingly high in the country; in fact, the UNICEF report has it that Nigeria rank 15th highest in the world among countries with high under-five mortality (UNICEF, 2001). This indicates that the rate of decline in under-5 mortality is still grossly insufficient to reach the 5th Sustainable Development Goals targets. 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 (National Population Commission (NPC) [Nigeria] and ICF International, 2014), a baby born in Nigeria is still 30 times more likely to die before age five than one born in an industrialised country (NPC/UNICEF, 2001). The reported reduction in under-5 mortality in Nigeria between 1999 and 2013 is 30.81% reduction in 13 years as against the proposed 65.41% reduction for 15 years. The difference of over 30% within these MDGs periods is still high considering the

population of Nigeria. These figures are in the light of the wealth of human and natural resources in the country.

Interestingly, 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 (Sutherland, Hale and Harris, 1995). Thus, developing strong partnerships between Faith Based Organisations (FBOs) and the broader public health community may be a potential strategy for reducing maternal and child mortality in high-burden countries as previously reported by Gill and Carlough (2008). Considering therefore that 'the clear majority of people in sub-Saharan Africa identify as adherents of Christianity or Islam (Pew-Templeton Global Religious Futures Project, 2010) coupled with evidence that showed that approximately 75% of Africans to trust their religious leaders (Ferrett, 2005), the faith-based approach might be beneficial in reducing the high infant and child mortality in the country. 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.

Egbert, Mickley and Coeling (2004), showed the linkage between religion, spirituality and health decision making is consequential in health communication and should be factors considered when targeting specific segments of the population. Support and social connectedness, in any form, can be effective in contributing to happiness and contentment, as well as the social and psychological well-being of people in general (Biemans van Dijk, Dadlani and van Halteren, 2009). Studies showed that mothers of both preterm and full-term infants who had more social support showed less stress and were more positive in attitude over the months following birth (Crnic Greenberg, Ragozin, Robinson, & Basham, 1983; Eward, 1979). Studies identified various communication types used by parents who had more successfully coped with preterm experiences (Farnham, Cheng, Stone, Zaner-Godsey, Hibbeln, Syrjala and Abrams, 2002) and a correlation between effective communication and improved physiologic status, functional outcomes, mental health and symptom resolution (Stewar, 1995). African Americans, in particular, have been known to subscribe to a religious lifestyle and maintain a strong belief in a higher power. For example, Asante and Asante (1985) and Lincoln and Mamiya (2001) had shown that in the African American community, the church is a trusted organization and many African Americans look to church leaders for not only spiritual guidance but for counselling and direction in other areas of life that include social and civic engagement, financial, educational, health or other personal needs. It is, therefore, the aim of this study to investigate the involvement of Pastors' wives as change agents in educating nursing mothers on childcare practices via assessing the level, methods and child health issues communicated between Pastors' wives and nursing mothers in Ibadan North Local Government Area, Nigeria.

MATERIALS AND METHODS

Study Design: This study was a descriptive cross-sectional study. The study was conducted in Ibadan North Local Government Area of Ibadan, located in the State capital of Oyo State, in the South West geo-political zone of Nigeria. The Area comprises of 12 wards with a population of 306,763 (153,039 male and 153,756 female), 132,500 Km^2 land mass and a population density of 2,626 persons per Km^2 (National Bureau of Statistics, 2006). The study was targeted at Pastors' wives of registered churches in the Local Government Area (LGA). All Pastors' wives of churches registered with the Christian Association of Nigeria (CAN) in the study area were eligible to participate in the study. The organization is made up of five blocks and they are: Christian Council of Nigeria (CCN), Catholic Secretariat of Nigeria (CSN), Christian Pentecostal Fellowship of Nigeria (CPFN)/Pentecostal Fellowship of Nigeria (PFN), Organization of African Instituted Churches (OAIC) and Evangelical Church Winning All (ECWA) and Tarayya Ekilisiyoyin Kristi A Nigeriya (TEKAN). However, the Roman Catholic Church was excluded because her Pastors/Priests are officially forbidden from getting married and other churches not registered with CAN in the LGA were also excluded. Four blocks of churches participated in the study.

Sample Size Determination and Sampling Procedures: Sample size was determined using the formula described by Araoye (2008) $N = \{Z^2 p (1-p)/ d^2\}$ 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 National Population Commission (NPC) [Nigeria] and ICF International, (2014); d = absolute deviation from true value or degree of accuracy =5% =0.05. This resulted into a minimum sample size of 126.

The multi-stage sampling technique involving three stages was used to select respondents. In the first stage, the LGA was stratified into the 12 wards and 6 wards were randomly selected by balloting. Chairmen and representatives of each of the selected 4 blocks of registered churches in the selected wards were visited and invited to a meeting during the second stage of sampling. In the third stage, Pastors' wives resident in the selected 4 blocks of churches from the 6 selected wards were invited and those present were sampled. This sampling procedure was adopted based on the problem of having the entire population of pastors' wives at the same time in the same place.

Ethical Consideration: Approval to conduct the study was obtained from the Oyo State Ministry of Health Ethics Review Committee (AD 13/479). The research participants were provided with information on the study and consent was obtained after the provision of adequate, clear and complete information. The study was conducted in compliance with the Declaration on the Right of the subject/participant (World Medical Association, 2000).

Data Collection Procedure: A semi-structured questionnaire was developed after reviewing existing literature and was used for data collection. The questionnaire was pre-tested and

tested for validity and reliability. The corrected tool consisted of 3 sections: Pastors' wives' socio-demographic characteristics (Section A), levels and methods of communication between Pastors' wives and mothers (Section B) and the health issues discussed (section C). This instrument was used for data collection.

The questionnaire was interviewer-administered, and data were collected by the researchers with the assistance from 4 public health postgraduate students who had received training and had previous experience in data collection. On the day of data collection, all the Pastors' wives present and gave their consent were interviewed.

Table 1:
Socio-demographic characteristics of Pastors' wives that participated in the study

Demographic characteristics	Frequency (%)	Mean
Age (years)		
27-42	48 (37.5)	
43-57	62 (48.4)	46.1±9.3
58-72	18 (14.1)	
Marital status		
Married	122 (95.3%)	*
Widow	6 (4.7%)	
Ethnicity		
Hausa	1 (0.8%)	
Igbo	8 (6.3%)	
Yoruba	112 (87.5%)	*
Others	7(5.5%)	
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	38 (29.7%)	
Business/Trading	28 (21.9%)	
Teaching/Lecturing	22 (17.2%)	
Civil servants	7 (5.5%)	
Retired	2 (1.6%)	
Fashion designer	4 (3.1%)	*
Management	8 (6.3%)	
Full housewife	10 (7.8%)	
Health workers	9 (7.0%)	
Female clergy		
Number of biological children		
0-2	27 (21.1)	
3-5	90 (70.3)	3.6±1.5
6-8	11 (8.6)	
Denominations/Blocks	35 (27.3%)	
CCN	66 (51.6%)	
PFN/CPFN	23 (18.0%)	*
OAIC	4	
ECWA/TEKAN	(3.1%)	

Data Analysis: The level of communication was assessed based on the frequency of teaching or preaching to nursing mother/women in the church by the Pastors' wives. In a bid to determine this, Pastor's wives who said they had never and occasionally preach/teach women/nursing mothers were classified as poor communication level, while those who said they preach/teach once a month and once a week were classified as fair and those who said they teach and preach twice, three times or more were classified as high level of communication. Analysis consisted of frequencies, central tendencies and Chi-square test using Fisher's Exact Test where applicable.

RESULTS

One hundred and twenty-eight (N=128) Pastors' wives and women leaders with a mean age of 46.1±9.3 years participated in the study. Except for 4.7% who reported to be widows, they were all married and currently living with husbands (95.3%; n=122). They were mainly Yoruba (87.5%; n= 112), business women (29.7%; n=38) and all had a form of formal education with a university degree (35.9%; n=46) as the highest. The number of biological children by the pastors' wives ranged from 0 to 8 with a mean of 3.6±1.5. The Pentecostal Fellowship of Nigeria/Christian Pentecostal Fellowship of Nigeria block formed the bulk (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).

Table 2:
Duration of service as a Pastor's wife or women leaders, the frequency of preaching or teaching as a Pastor's wife

Pastor's wife service duration and preaching frequency	Frequency (%)	Mean
Duration of service as Pastor's wife/women leader per years		13.0±9.2
1-10	65 (50.8%)	
11-20	46 (35.9%)	
21-30	9 (7.0%)	
31-40	6 (4.7%)	
41-46	2 (1.6%)	
The frequency of teaching/preaching slot allotted to women in the church		*
	12 (9.4%)	
Not at all	4 (3.1%)	
Once a month	28 (21.9%)	
Occasional	30 (23.4%)	
Once a week	5 (3.9%)	
Twice a week	1 (0.8%)	
3 times a week	48 (37.5%)	
As many times as possible		

* Not applicable

Table 2 shows the duration of service as a Pastors' wife or women leaders and frequency of preaching or teaching to nursing mothers/women in the church. The mean duration of serving as a Pastors' wife or women leader was 13.0±9.3 years. Except for 9.4% (n=12) of the Pastors' wives who reported not to have taught or preached to nursing mothers/women in the church before, others reported teaching and/or preaching in different degrees. Analysis showed that 31.3% (n=40) Pastors' wives had a poor level of communication while 26.6% (n = 34) and 42.2% (n=54) were in the categories of fair and high level of communication, respectively (Figure 1).

On the factors that affected the level of communication between Pastors' wives and nursing mothers/women in the church, it was shown that the age of Pastors' wives and highest educational status significantly affected the level of

communication between Pastors' wives and mothers in the church. Specifically, there was a positive association (Fisher's Exact Test = 16.018; p = 0.027) between the age of the Pastors' wives and the level of communication with nursing mothers in the church; that is, the older the Pastors' wives, the higher the level of communication with nursing mothers in the church. The level of education was significantly associated with the Pastors' wives level of communication with nursing mothers in the church (Fisher's Exact Test = 24.073; p = 0.002). On the other hand, the Pastors' wives' occupation, number of children and types of the church they belong did not significantly affect the level of communication between Pastors' wives and nursing mothers (Table 3).

Table 4 showed the approaches to communication with nursing mothers/women by Pastors' wives. It was observed that all except 0.8% (n=1) Pastor's wife reported to visit church women when they were delivered of a baby and 92.2% (n=118) said nursing mothers/women discussed child health matter/issues with them. The most common method of communication between pastors' wives and nursing mothers (Figure 2) was through counselling (n=116). This was followed by teaching 58.1% (n=68), preaching 29.7% (n=38) and phone calls 18.8% (n=24) with books 0.03% (n=3), bulletin 0.02% (n=2) and posters 0.01% (n=1) being the least mode of communication

Data presented in Table 5 showed the most reported health issues/matters, which Pastors' wives and nursing mothers have been communicating together. These included child care and nutrition (84.4%; n= 108), issues on maternal health (32.0%; n=41), childhood illnesses (25.8%; n=33) and family health matters (14.1%; n=10). The majority (68.0%; n=87) of the Pastor's wives mostly preferred counselling as the method of communication while 22.7% (n=29) and 10.2% (n=13) preferred teaching and preaching, respectively

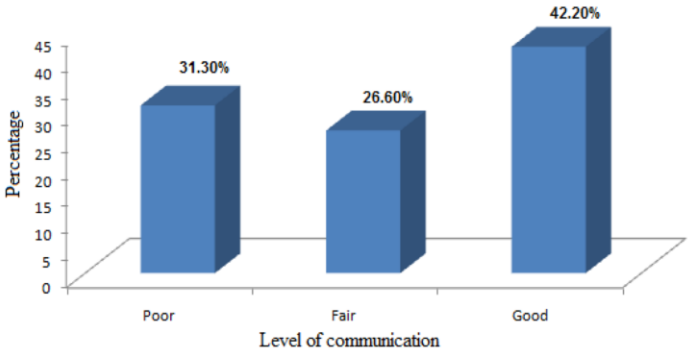

Figure 1:
Level of communication between Pastor's wives and nursing mother/women

Table 3:
Association between Pastor's wife socio-demographic profile and level of communication with mothers/ women in the church

Variables	Level of communication			Fisher's Exact Test	P- value
	Poor	Fair	Good		
Age (Years)	6 (33.3%)	7 (38.9%)	5 (27.8%)		
27-36	22 (41.5%)	15 (28.3%)	16 (30.2%)		
37-46	10 (28.6%)	6 (17.1%)	19 (54.3%)		
47-56	2 (10.5%)	4 (21.1%)	13 (68.4%)	16.018	0.027
57-66	0 (0.0%)	2 (66.7%)	1 (33.3%)		
67 and above					
Highest education status	0 (0.0%)	2 (13.3%)	13 (86.7%)		
Primary education	5 (23.8%)	5 (23.8%)	11 (52.4%)		
Secondary education	11 (35.5%)	7 (22.6%)	13 (41.9%)	24.073	0.002
OND/NCE Certificate	6 (40.0%)	2 (13.3%)	7 (46.7%)		
HND	18 (39.1%)	18 (39.1%)	10 (21.7%)		
University degree					
Occupation	13 (34.2%)	10 (26.3%	15 (39.5%)		
Businesswoman/ Trading	10 (35.7%)	7(25.0%)	11 (39.3%)		
Teaching/ Lecturing/	10 (45.5%)	6 (27.3%)	6 (27.3%)		
Civil servants	1 (14.3%)	3 (42.9%)	3 (42.9%)		
Retired	2 (100.0%)	0 (0.0%)	0 (0.0%)	19.963	0.203
Fashion designer	1 (25.0%)	0 (0.0%)	3 (75.0%)		
Manager of a company/school	1 (12.5%)	3 (37.5%)	4 (50.0%)		
Full-time housewife	2 (20.0%)	4 (40.0%)	4 (40.0%)		
Health workers/ Nurses	0 (0.0%)	1 (11.1%)	8 (88.9%)		
Female clergy					
Number of children					
No child	1(33.3%)	0(0.0%)	2(66.7%)		
1 - 2	9(37.5%)	7(29.2%)	8(33.3%)	10.605	0.177
3-4	25(36.2%)	20(29.0%)	24(34.8%)		
5-6	5(20.0%)	6(24.0%)	14(56.0%)		
7 and above	0(0.0%)	1(14.3%)	6(85.7%)		
Denominations/	15(42.9%)	7 (20.0%)	13 (37.1%)	9.396	
CCN	21(31.8%)	20 (30.3%)	25 (37.9%)		0.121
PFN/CPFN	3(13.0%)	5 (21.7%)	15 (65.2%)		
OAIC	1(25.0%)	2 (50.0%)	1 (25.0%)		
ECWA/TEKAN					

Table 4:
Approaches and Methods of communication between Pastors' wives and women/nursing mothers in the church (N=128)

Approaches and Methods of Communication	Frequency (%)
Visit church women when they give birth	
Yes	127 (99.2%)
No	1 (0.01%)
Nursing mothers consulting Pastor's wife on a health-related issue	118 (92.2%)
Yes	10 (7.8%)
No	
***Pastor's wife methods of communicating health issues**	68 (53.1%)
Teaching	38 (29.7%)
Preaching	116 (90.6%)
Counselling	1 (0.01%)
Posters	2 (0.02%)
Bulletins	3 (0.03%)
Books	24 (18.8%)
Phone calls	

***Multiple responses apply

Table 5:
Health issues Pastors' wives and women/nursing mothers in the church discussed on (N=128)

Health issues discussed by Pastors' Wives	Frequency (%)
***Health matters nursing mothers and Pastors' wives communicate on**	41 (32.0%)
Maternal health-related	108 (84.4%)
Childcare/ nutrition	33 (25.8%)
Childhood illnesses	18 (14.1%)
Family affairs and health	
Most preferred method of communication	
Teaching	29 (22.7%)
Preaching	13 (10.2%)
Counselling	87 (68.0%)

*Multiple responses apply

DISCUSSION

This study has revealed the possible interactions between Pastors' wives and nursing mothers in a faith-based setting. The level of interaction was observed in the percentage of Pastors' wives involved in congregational preaching/teaching with nursing mothers/women, visit nursing mothers in the situation of being delivered of a baby and nursing mothers' consultation of Pastors' wives on a health-related issue. These implied that Pastors' wives actually interact with nursing mothers and could be a veritable tool in health promotion using this channel. These findings were in agreement with the study by Clay *et al*. (2005) who reported that church women rely on the Pastor's wife for direction and insight regarding a variety of issues including beauty and image, job-related and family matters. In fact, the study by Clay *et al*. (2005) reported that nearly 95% of study participants in their study reported that they get ideas regarding health from other women in the church and over 80% indicated they take advice about health care and screening from the Pastor's wife. The leadership role Pastors' wives played for reason that they are the wife of the Pastor, has a positive impact on the high level of communication in this study and might have influenced the acceptance or change in behaviours that will impact positively on their health. In support of this assertion, Lumpkins *et al*. (2013) had previously documented that most clergies see their leadership role in the church as part of this communication. This has a positive influence by impacting on health-promoting behaviours among not only the congregation but the surrounding community. Considering the level of communication that exists between Pastors' wives and nursing mothers in this study, they constitute untapped resources that can be used in health promotion activities when trained on basic health communication that will promote child health in faith-based settings.

Various methods of communication by Pastors' wives have been identified. This finding consolidates the fact that faith-based setting can be a suitable setting for influencing positive maternal and child health-positive behaviours, using the Pastors' wives. A similar study by Lumpkins *et al*. (2013), have previously reported that sometimes Pastors see themselves as health promoters and could discuss health issues more frequently from the pulpit. Many Pastors believe spirituality linked with religion is translatable into successful health promotion program planning and could be part of the church and faith-based information materials. Thus, the faith-based health promotional approach may positively set Nigeria in the right direction towards curbing the high child morbidity and mortality. In fact, approach to health promotion has previously advocated offering opportunities to position practice in its social context, optimize interventions and influencing behaviour, as well as renders settings more health-enhancing (Frohlich and Poland, 2007; Poland, Green and Rootman, 2000; Whitelaw, Baxendale, Bryce, Machardy, Young and Witney, 2001; Leger, 1997; Baric, 1993).

In the present study, the observed communicated health matters; such as child care and nutrition, maternal health, childhood illnesses, family affairs and other health/matters, between Pastors' wives and nursing mothers indicated that the role of being a Pastor's wife extends beyond religious and spiritual responsibilities. This assertion is in line with the report by Aholou, Gale and Slater (2009) and Watson, Bisesi, Tanamaly, Branch, Novgrod, Sim and Williams (2006) who both documented that the leadership role of the pastor often extends beyond spiritual and religious communication and includes health advice. Thus, our findings on Pastors' wives in the present study showed that Pastors' wives can serve as a change agent and health promoter; especially in matters of maternal and child health.

Moreover, considering that the Pastors' wives may have a high influence on women/nursing mothers in the church, their involvement in communicating health issue to nursing mothers can be leverage on to improve child care practices. Involvement of Pastors' wives in a six-month pilot study designed to increase the capacity of faith-based institutions and faith leaders in addressing HIV/AIDS and sexually transmitted infections (STIs) in 11- to 19-year-old African Americans had previously included Pastors' and church Ministers' wives with a successful outcome (Griffith *et al*., 2010). Thus, the observed level of communication on health issues between Pastors' wives and nursing mothers in this

study supports the suitability of Pastor's wives in enhancing and promoting childcare practice and as such agent of change. Considering that the communication component is critical for the success of the programme, Berhnhardt in 2004 observed communication as one part of many factors public health personnel should consider in developing health promotion programs targeted at improving the poor child health indices in the country. Moreover, when involving communication in health promotion, it is expected that it should be appealing to the targeted population for there to be a success.

In conclusion, majority of Pastors' wives was involved in teaching and preaching, coupled with the fact that nursing mothers consult Pastor's wife on their child health. It, therefore, means that nursing mothers trust and rely on Pastors' wives for assistance on health-related issues. As such, they can relay healthy child behaviour and practice information to all mothers including nursing mothers in the congregation. Therefore, Pastor's wife may serve as a critical part of the health communication process in relaying basic child health information using the principles of Child Survival Strategies to nursing mothers. Partnering with Pastors' wives as an agent of change requires consideration because of the innate potentials.

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