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The influence of religious leaders on use of antenatal and delivery care in sub-Saharan Africa: a systematic review

Basambo Fabrics Vernyuy[a], Heather Sipsma[b]

[a] DDS, MPH, Faculty of Medicine and Biomedical Sciences, University of Yaoundé 1, Cameroon
[b] PhD, Associate Professor of Public Health, School of Science, Technology and Health, Gordon College, Massachusetts, USA

Abstract

Background: Maternal health remains a critical public health concern in sub-Saharan Africa, and use of antenatal care (ANC) and delivery care can reduce mortality and improve health outcomes. Religious leaders are greatly regarded as influential figures in shaping health behaviors, though many of the recommendations to involve religious leaders in promoting maternal health are based on indirect evidence. To better understand the degree and nature of this influence, we aim to review existing evidence describing the influence of religious leaders on use of antenatal and delivery care in sub-Saharan Africa.

Methods: A systematic literature review was conducted using PubMed and ScienceDirect, and hand searches were conducted using Google Scholar. References of included studies were also reviewed. Studies were included if they reported religious leaders' influences on ANC and/or delivery care among women in sub-Saharan Africa and were published between 2000 and June 2025 in English. We assessed risk of bias with the Mixed Methods Appraisal Tool (MMAT) and present our findings using a narrative summary and analysis. This report was guided by the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) protocol.

Results: Five studies met our inclusion criteria and were conducted in Ethiopia, Ghana, and Nigeria. These studies generally included comparisons between intervention and control communities and demonstrated positive effects of involving religious leaders—often in partnership with other community leaders—on ANC and delivery care. Risk of bias assessments varied widely.

Discussion: Overall, evidence from this review, though limited**,** supports the integration of religious leaders into maternal health promotion strategies. We recommend engaging religious leaders who are well respected by the community, have undergone formal training, and work alongside others in the community to participate in community- and individual-level outreach. Future efforts should focus on expanding trainings and opportunities for religious leaders to leverage their influence for improving maternal and neonatal outcomes.

Keywords: religious leaders, maternal care, antenatal care, delivery care, systematic review

Introduction

Maternal health remains a critical public health concern in sub-Saharan Africa as this region accounts for approximately 70% of global maternal mortality.[1] The health and well-being of expectant mothers and their unborn children depends heavily upon the utilization of healthcare services, particularly antenatal care (ANC) and delivery care.[2] The World Health Organization recommends pregnant women initiate ANC within the first trimester and visit their healthcare provider at least four times throughout pregnancy.[3] This standard of care has been associated with lower maternal and neonatal mortality as well as lower rates of neonatal infections, low birth weight, and preterm birth.[2] Additionally, facility-based delivery and/or delivery with a skilled birth attendant generally ensures better birth outcomes, infection prevention, and management of birth complications when compared with home births and/or those attended by traditional birth attendants.[4] However, despite increased efforts, ANC utilization and delivery care remain suboptimal in many parts of the region, putting mothers and babies at risk for preventable morbidity and mortality.[5]

Religious leaders are greatly regarded as influential figures in defining social norms and shaping community health behaviors, including decisions to seek health care. Evidence suggests that religious leaders can directly impact behavior, such as increasing uptake of polio vaccines in Northern Nigeria[6] and contraception in Tanzania[7] and decreasing intimate partner violence in Uganda.[8] Evidence of their direct impact on ANC and delivery care, however, remains unclear. For example, recommendations to involve religious leaders in promoting maternal health are commonly found throughout the literature,[9,10,11,12,13,14,15,16,17,18] though these suggestions are often based on quantitative associations found between religion and maternal care utilization[9,10,14,16,17] or qualitative feedback from women regarding religious beliefs and practices[13,15] or from religious leaders regarding healthcare practices.[12,18] Thus, the direct impact of religious leaders—and not merely religion or religious beliefs—on the use of ANC and delivery care remains unclear.

Given this gap, a systematic review of existing evidence is needed to better understand the nature and the extent to which religious leaders influence the use of ANC and delivery care, particularly in sub-Saharan Africa, where rates of maternal mortality remain high.[19] Understanding this potential impact is essential for designing culturally-sensitive interventions that leverage faith-based networks to improve maternal care and outcomes. Such insights can inform targeted strategies within this region to reduce preventable maternal and neonatal deaths.

Methods

A systematic literature review was conducted using PubMed and ScienceDirect, accompanied by hand searches through Google Scholar, to identify peer-reviewed empirical studies examining the influence of religious leaders on use of antenatal and delivery care in Sub-Saharan Africa. Google Scholar was included in our search methodology to ensure our search was not limited by access to journals indexed for PubMed and ScienceDirect. This approach reduces publication bias by allowing a more comprehensive review of scholarly work that is relevant for our understanding of the impact of religious leaders on ANC and delivery care. We searched for combinations of the following terms within the title or abstract, where possible: "religious leaders," "spiritual leaders," "faith leaders" or "faith-based leaders" along with "prenatal care," "antenatal care," "maternal care," "maternal health*," "pregnan*," delivery or birth. Our search was limited to articles published in the English language between January 2000 and June 2025, and our report was guided by the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) protocol.[20] Studies were included if they reported qualitative or/and quantitative empirical research conducted in sub-Saharan Africa that examined the influence of religious leaders on use of antenatal or delivery care. Religious leaders were defined by the articles themselves; we did not otherwise

establish criteria for qualifying individuals as such. The authors screened titles and abstracts for relevance, followed by full-text review as needed to assess eligibility. Inclusion was based on our predefined criteria, including the following: 1) study participants must be comprised of pregnant women or women of reproductive age, 2) the exposure included the direct engagement or influence of religious leaders, and 3) the outcome included ANC (including initiation, frequency, or adherence to WHO recommendations) and/or delivery care (including facility-based delivery or presence of a skilled birth attendant). We excluded commentaries, editorials, conference abstracts, and feasibility-only pilot studies. We also excluded studies that did not directly involve religious leaders as an exposure variable (e.g., religious leaders as study participants) or antenatal or delivery care as an outcome variable. Any discrepancies between the two reviewers were resolved through discussion and consensus. Additionally, references of included articles were hand searched to identify further relevant articles.

Data from eligible studies were extracted using a template capturing the article's title and authors along with the study's country, objectives, design, participants, sample size, definition and recruitment of religious leaders and their training, the intervention for ANC and delivery care outcomes, and unadjusted and adjusted findings. We used the Mixed Methods Appraisal Tool (MMAT; version 2018)[21] to assess methodological quality. Both authors reviewed each study independently and then discussed any discrepancies to resolve disagreements. Results are reported as a narrative summary and analysis.

Results

The initial search yielded 221 articles from PubMed and ScienceDirect. After reviewing titles, abstracts, and full-texts as needed, we excluded 219 articles. Among these, 203 articles were excluded due to the study outcome, and 16 articles were excluded due to study participants (i.e., religious leaders were participants, not women); no studies were excluded due to geography. Only two articles met all inclusion criteria for the review. Further hand searches using Google Scholar identified two additional articles. Reviewing references among the selected articles identified one further article that met our inclusion criteria. Thus, we identified a total of five articles for our review (Table 1).[22-26]

Table 1. Description of included studies

Study	Country	Study Design	Data Source	Sample Size	Religious Leaders	Intervention	Results
Hembling, et al.[22]	Ghana	Quasi-experimental design	Mothers of children ages 0-23 months	Intervention: 484 at baseline and 510 at follow up Comparison: 466 at baseline and 510 at follow up	Protestant ministers, traditional African religious leaders, Islamic imams	Village-level councils comprised of religious leaders, village chiefs, traditional medical practitioners, and female community leaders, were trained to assess a problem, analyze its causes, and act to address the issues. They then led community dialogues to discuss overcoming barriers to engaging in maternal health care. They also conducted home visits to engage heads of households (often the primary decision-makers) and promote practices during religious services	Unadjusted Early ANC: 45.9% increase ≥ 4 ANC visits: 61.3% increase Adjusted Early ANC: β = 2.30 ($p < 0.001$) ≥ 4 ANC visits: β = 2.24 ($p < 0.001$)
Sadore, et al.[23]	Ethiopia	Cluster randomized controlled trial	Pregnant women < 20 weeks gestation	Intervention: 292 women Control: 301 women	Local leaders representing faith-based organizations, chosen based on their religious training, standing and influence, and the endorsement of community leaders, healthcare workers, and local authorities	Religious leaders, trained to support and encourage pregnant women to use recommended healthcare services, conducted four sessions on maternal health topics for their congregations, four group training sessions for pregnant women, and home visits to each pregnant woman to provide additional support and counseling	Unadjusted ≥ 4 ANC visits: 21.4% increase Institutional delivery: 20.0% increase Adjusted ≥ 4 ANC visits: AOR = 2.09 (95% CI: 1.69, 2.57) Facility delivery: AOR = 2.36 (95% CI: 1.94, 2.87)
Guthrie, et al.[24]	Ethiopia	Cluster randomized controlled trial	Facility-level statistics from pregnant women attending health centers over 12 months	Intervention: 6 facilities Control: 12 facilities	Ethiopian Orthodox priests	Religious leaders and community health workers, trained on maternal health, community outreach and counseling, conducted outreach and education within communities, including in homes and places of worship, and provided referrals and counsel to pregnant women to help overcome barriers to care	Unadjusted None reported Adjusted 1st ANC visits: RR = 1.14 ($p < 0.001$) 4th ANC visits: RR = 1.26 ($p < 0.001$) Facility deliveries: RR = 1.10 ($p < 0.001$)

Study	Country	Study Design	Data Source	Sample Size	Religious Leaders	Intervention	Results
Maiwada, et al.[25]	Nigeria	Quasi-experimental design	Facility-level statistics from health centers before and after the intervention	Unspecified number of facilities in urban and rural communities	Imams, Islamic preachers and scholars, Islamiyyah teachers, leaders and administrators of Islamic organizations	Religious leaders, exposed to health promotion, education, and community mobilization activities, were primarily expected to make public pronouncements to change community opinion and improve maternal health	Unadjusted ANC attendance and facility-based delivery significantly increased Adjusted None reported
Nasiru[26]	Nigeria	Mixed methods study; (presumably) pre-test/post-test design to assess impact of intervention	Community surveys with unspecified number of pregnant women	200	Islamic leaders	A radio drama, created with religious leaders, healthcare providers, and community members, encouraged maternal health service utilization	Unadjusted 35% increase in ANC attendance Adjusted None reported

Among the studies included in our review, two were conducted in Ethiopia,[23,24] two were conducted in Nigeria,[25,26] and one was conducted in Ghana[22]; all were published within the last 10 years. Study designs varied and included two cluster randomized controlled trials,[23,24] two quasi-experimental (non-randomized) designs,[22,25] and a quantitative, presumably pre/post study.[26] Two studies included large samples of pregnant women as participants (approximately 500 participants in Ghana[22] and 300 participants in Ethiopia[23]) in each of the intervention and control communities. Two other studies used records from healthcare facilities in periods prior to and after implementing the intervention.[24,25] The fifth study analyzed data from 200 community surveys, but the number of pregnant or postpartum women within the sample is unclear.[26]

The MMAT was used to assess the methodological quality of our included studies based on five criteria specific to each study design (Table 2). Articles were evaluated based on whether or not criteria were met using "Yes" (low risk of bias), "No" (high risk of bias), or "Can't tell" (insufficient information). The study by Sadore, et al.[23] was the strongest study, indicating the lowest risk of bias, whereas the study by Nasiru[26] was potentially the weakest, as little information was available to evaluate its methodological quality. Ultimately, the two Nigerian studies[25,26] were most difficult to evaluate; insufficient information was common. The other studies appeared to demonstrate lower risk of bias and thus greater assurance of their findings' validity.

Table 2. Risk of bias assessment of included studies using the Mixed Methods Assessment Tool (MMAT)

Study	Study Type	Criteria				
		1	2	3	4	5
Hembling, et al.[22]	Non-randomized study[a]	Yes	Yes	Can't tell	Yes	Yes
Sadore, et al.[23]	Randomized controlled trial[b]	Yes	Yes	Yes	Yes	Yes
Guthrie, et al.[24]	Randomized controlled trial[b]	Yes	No	Yes	Can't tell	Yes
Maiwada, et al.[25]	Non-randomized study[a]	Yes	Yes	Can't tell	No	Can't tell
Nasiru[26]	Quantitative descriptive study[c,d]	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell

a. Criteria for non-randomized studies include the following: 1. Are the participants representative of the target population? 2. Are measurements appropriate regarding both the outcome and intervention (or exposure)? 3. Are there complete outcome data? 4. Are the confounders accounted for in the design and analysis? 5. During the study period, is the intervention administered (or exposure occurred) as intended?

b. Criteria for randomized controlled trials include the following: 1. Is randomization appropriately performed? 2. Are the groups comparable at baseline? 3. Are there complete outcome data? 4. Are outcome assessors blinded to the intervention provided? 5 Did the participants adhere to the assigned intervention?

c. Criteria for quantitative descriptive studies include the following: 1. Is the sampling strategy relevant to address the research question? 2. Is the sample representative of the target population? 3. Are the measurements appropriate? 4. Is the risk of nonresponse bias low? 5. Is the statistical analysis appropriate to answer the research question?

d. The quantitative descriptive study section was used to assess risk of bias in the article by Nasiru based on the surveys employed to evaluate the influence of religious leaders on maternal health. Qualitative research was implemented in formative pre-intervention phase to identify key socioreligious barriers to maternal health.

Outcomes varied across studies and were focused on key maternal health services utilization indicators, including any ANC, early ANC (ANC initiation within the first trimester), completion of four or more ANC visits, and facility-based delivery.

Each study explored the effect of an intervention that included religious leaders. Generally, these individuals were regarded as holding formal or informal authority within local faith communities or within the general community. Leaders who participated in these studies included Protestant ministers, Islamic imams, and Orthodox priests. In each intervention, they were trained to make an impact in their communities, often alongside others of influence. For example, in the study carried out by Hembling, et al. in Ghana,[22] religious leaders were trained alongside village chiefs, traditional medical practitioners, and female community leaders, as part of a "Council of Champions," to collectively work together and implement community-based solutions. In the study by Sadore, et al. in Ethiopia,[23] religious leaders were recruited purposively based on their recognized religious training, social standing, and influence within the community. They were then trained on how to deliver health education, specifically to encourage pregnant women to use recommended healthcare services.[23] In the study by Guthrie, et al. in Ethiopia,[24] the religious leaders were Orthodox priests who worked in close collaboration with community health workers. They were trained on maternal health, counseling, and community outreach.[24] In the pilot study by Maiwada, et al. in Nigeria,[25] religious leaders were not intentionally trained but exposed to training through the IIUM/KAHS Health Promotion and Prevention of Maternal Mortality Project.[25] No training was specified for the religious leaders in the Nigerian study by Nasiru.[26]

Interventions generally consisted of religious leaders engaging in some type of education and/or outreach. Education included integrating maternal health information in their messages at their houses of worship, hosting community dialogues, and conducting educational sessions for their congregations, and outreach generally included home visits with pregnant women and their families. Three of the studies required religious leaders to be involved in both education and outreach,[22,23,24] whereas the two studies from Nigeria focused solely on community education.[25,26] Specifically, in the study from Ghana, religious leaders organized community dialogues, integrated maternal health messages into religious services, and conducted home visits to household heads.[22] Similarly, in the study by Sadore, et al. in Ethiopia, local faith leaders provided congregation-based, teaching sessions, group training for pregnant women, and supportive home visits to increase the use of both ANC and facility delivery.[23] The other study by Guthrie, et al., also in Ethiopia, trained orthodox priests with community health workers to conduct community education and outreach, including home-based counseling and referrals; however, specific details and examples of community events were not described in the manuscript.[24] In Nigeria, religious leaders engaged primarily in community-level messaging and education; in Maiwada, et al., imams and Islamic preachers sought to influence maternal health behaviors by making public pronouncements to shift community opinion, while in the study by Nasiru, religious leaders co-developed a radio program with health professionals to influence on the uptake of ANC.[25,26]

In all studies, the intervention demonstrated positive effects on ANC and delivery care. In Ghana, Hembling, et al.,[22] a quasi-experimental study found that mobilizing village councils including religious leaders resulted in a 45.9% increase in initiation of ANC within the first trimester ($\beta = 2.30$, $p < 0.001$) and a 61.3% increase in women attending four or more ANC visits compared to controlled communities ($\beta = 2.24$, $p < 0.001$).[22] In Ethiopia, Guthrie, et al.[24] showed in their cluster randomized trial across 18 health facilities, that there was a 14% increase in first ANC visits (RR = 1.44), a 26% increase in completion of fourth ANC visits (RR = 1.26), and a 10% (RR = 1.10) increase in facility deliveries (all p-values < 0.001), following the pairing of community health workers with Ethiopian Orthodox priests.[24] And the cluster-randomized trial conducted by Sadore, et al.,[23] also in Ethiopia, demonstrated that training religious leaders to deliver health education resulted in a 21.4% increase in women completing at least 4 ANC visits (AOR = 2.09) and a 20.0% increase in institutional delivery (AOR = 2.36).[23] The data measurement and analysis strategies employed in both Nigerian studies were unclear, though they too claim an increase in ANC attendance and facility-based delivery.[25,26]

Discussion

The studies included in this review show evidence that religious leaders can act as powerful agents of change with the potential to shift community norms and address sociocultural barriers that hinder the utilization of essential maternal health services. Though limited, the findings consistently demonstrate that involving religious leaders in health education and outreach, particularly after formal training and in collaboration with other community leaders, significantly improves ANC and delivery care. This work contributes to the growing literature on faith-based approaches in public health by providing context-specific insights from sub-Saharan Africa.

Despite different interventions and sample populations across studies, results consistently demonstrated positive effects. Thus, the impact may be traceable to components consistent across interventions—particularly from those studies with the lowest risk of bias—including having religious leaders who are well respected and regarded by the community and generally who have undergone formal training in maternal health education and outreach. Interventions to improve maternal health outcomes also should likely include community-level education along

with individual-level outreach, particularly among pregnant women and their families. This approach inherently addresses multiple aspects of Theory of Planned Behavior, helping to shift attitudes, change subjective norms, and increase perceived behavioral control to impact one's intention and lead to behavior change. The community-level education influences attitudes by providing information and shaping beliefs about the benefit of ANC and delivery care. This approach further modifies subjective norms by demonstrating community and religious support of maternal health seeking behaviors, thereby, creating social expectations that support these practices. And last, the individual-level outreach enhances perceived behavioral control by addressing practical and logistical barriers, offering guidance, and empowering women and their families to confidently act on health-promoting decisions.[30] Thus, future efforts to leverage religious leaders as health advocates will likely be successful if these components are retained.

Results are consistent with the other literature supporting the effectiveness of religious leaders to drive meaningful behavioral change and improve health outcomes. In Nigeria, training religious leaders led to an increase in willingness to receive HIV-positive results and improved HIV knowledge and acceptance among people living with HIV.[31] Additional evidence from a study in Uganda underscores the impact of religious leaders in promoting abstinence and fidelity.[32] Other studies have demonstrated the positive effects that religious leaders can have on increased vaccination coverage[33,34] and increased use of family planning.[7,35,36] Thus, religious leaders have demonstrated effectiveness in their abilities to influence health outcomes, particularly in the areas related to family and reproductive health.

Importantly, this review highlights the ways in which the role of religious leaders has been overlooked among efforts to improve maternal health outcomes, such as ANC and delivery care utilization. The limited number of studies, of mixed methodological quality, suggests a lack of integration of faith-based actors in sub-Saharan Africa. Most programs here aim to improve maternal health by focusing on clinical interventions, health worker training, or community education, often excluding religious leaders, despite their influence. This gap is particularly notable among populations with extremely high religiosity, as in sub-Saharan Africa, where over 95% of the population identifies with a faith.[37] Thus, religious leaders are likely to be trusted authority figures with considerable power and influence over family decisions and health-seeking behaviors. Further, their absence in this work starkly contrasts that of faith-based organizations, that provide approximately 40-70% of health services in some countries.[38,39] The influence of religious leaders bridges biomedical care and cultural beliefs, making their exclusion from maternal health intervention strategies a missed opportunity to address an important determinant of maternal health behaviors in the region.

Despite the substantial evidence presented in this review, several unanswered questions persist. First, we have a limited understanding of the specific religious messages, teachings, or pastoral approaches that were effective in this body of evidence, though they likely vary across regions, religions, and cultures. Second, it is unclear the extent to which these outcomes may affect health-seeking behavior in maternal health more broadly since our reviewed studies focused on ANC and delivery care. Additionally, because interventions included multiple components, it is not clear which part might have been most effective and most important to implement in resource-constrained contexts. Furthermore, the long-term sustainability of behavior change following religious leader interventions remains unclear. More research is needed specifically within the area of maternal health to make stronger and more specific recommendations for future programs and strategies to alleviate the burden of maternal morbidity and mortality within this region.

Additional limitations of this review are important for consideration. First, we found only five studies within a somewhat restricted geographic and cultural scope, potentially limiting the capacity to generalize these

findings to other contexts. These results are also likely to have been affected by publication bias, wherein positive findings among interventions are more likely to be published than negative or null findings. Additionally, these studies were limited in methodological quality, as two of the studies were at high risk of bias or had insufficient evidence to evaluate. Most studies relied on self-reported data, which may introduce recall or social desirability bias, particularly in communities where religious leaders were actively involved in health seeking behaviors. Increasing the methodological rigor of these types of studies is key for ensuring strong evidence for behavior change and effective strategies for reducing maternal morbidity and mortality.

Conclusion

Overall, despite limited evidence, this review supports the integration of religious leaders into maternal health promotion strategies for ANC and delivery care. Given their moral authority and community influence, religious leaders are well positioned to address spiritual, cultural, and social barriers to accessing maternal health care, particularly in sub-Saharan Africa. Future efforts should focus on creating opportunities for religious leaders to integrate into current and new strategies for increasing utilization of ANC and delivery care in this region. These strategies should include expanded trainings and monitoring programs to better understand their influence and make more specific recommendations for future work. Further efforts to evaluate and ensure long-term effectiveness are also critical for impacting maternal and neonatal outcomes. Policy makers and public health practitioners should consider faith-based leaders and partnerships not as peripheral, but as central components of culturally-grounded, maternal health interventions in this region.

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