NIGERIAN JOURNAL OF SOCIAL AND DEVELOPMENT ISSUES

VOL. 4. NO. 1, JANUARY 2004 ISSN 1596 - 2288

CONTENTS

Deregulation and Productivity Improvements in Developing Economies: The Nigerian Case
- **JOHN E. U. NDEBBIO and UWEM ESSIA** 1

Beyond Social Class and Crime: Linking Political Patronage of Agaba Boys with Crime in Calabar Metropolis
- **JOSEPH O. CHARLES and MOSES U. IKOH** 21

Child Labour and Africa's Development: An Overview
- **GABRIEL S. UMOH and NDEM A. NDIYO** 43

Exchange Rate Policy and Inflation in Nigeria: A Causal Analysis
- **A. N. BASSEY, OLUMIDE S. AYODELE, FRANCES N. OBAFEMI AND FRIDAY S. EBONG** 59

The Role of Churches in Health Education in Rural Communities of Nigeria: A Case Study of Abak L.G. A. of Akwa Ibom State
- **JOHN O. UMOH** 75

Nation - Building and the Failure of the Nigerian Youth: The Necessity of Primary Education.
- **UNO IJIM AGBOR** 87

The Role of Human Resources Development in Societal Transformation in Nigeria
- **UGUMANIM B. OBO and WALTER A. MBOTO** 99

Elites and Personal Social Responsibility: Contemporary Welfare Investment Challenges in Nigeria
- **UMOR C. AGUNDU** 113

Current Cost Profit Measurement As It Affects Corporate Capital
- **SUNDAY A. EFFIONG** 121

Rainfall Climatology and Hydro Electric Power Generation: A case Study of Kainji Hydro Electric Power Station, Nigeria.
- **EKANEM M. EKANEM, EMMANUEL P. UDOFIA and ASUQUO I. AFANGIDEH** 135

15

A PUBLICATION OF THE FACULTY OF SOCIAL SCIENCES
UNIVERSITY OF CALABAR, CALABAR - NIGERIA

Nigerian Journal of Social Issues and Development Issues, Vol. 4. No. I January, 2004
ISSN 1596-2288 © Copyright Faculty of Social Sciences, University of Calabar, Printed in Nigeria.

THE ROLE OF CHURCHES IN HEALTH EDUCATIONAL IN RURAL COMMUNITIES OF NIGERIA: A CASE STUDY OF ABAK LOCAL GOVERNMENT AREA OF AKWA IBOM STATE.

John O. Umoh
Department of Sociology/Anthropology
University of Uyo - Uyo,
Nigeria

Abstract
The study examines the degree of involvement of churches in health education in rural communities using Abak Local Government Area of Akwa Ibom State as a case study. Using the simple random sampling technique, 120 Pastors and 100 Lay faithful were drawn for interview from the five clans of the local government area. With the help of a questionnaire and an interview guide, the study observed a rather low level of pastors' involvement in the promotion of health education. A high percentage rate of 91.7 of these pastors never considered health issue in their weekly homilies, while as many as 32.7percent of them would turn down requests by health personnel to address the congregation. The study recommends that along with raising the educational level of the local pastors, which was found to be generally low in this sample, rural churches through their pastors should rise to the social responsibility of promoting health consciousness through health education.

1 Introduction

The importance of health for national development has now been taken for granted. This awareness has motivated the developed nations and lately, many of the developing countries to constantly propose, and actually embark on, various strategies oftentimes experimental, in order to improve the health indices of their nations (Umoh 1994). The renewed awareness on the importance of health in the national scheme of things induced Nigeria to be part of the global race for National Health Improvement in the 1980's. Under that Scheme, Nigeria proposed the "Health for all by the year 2000" fifteen years ago. Sadly enough, the laudable goal never materialized by the target date. Presently this goal is yet to be achieved.

It is obvious that given Nigeria's high population government cannot single-handedly provide health for all Nigerians. Therefore, government at all levels, voluntary agencies, corporate and professional organizations and, even, individuals are considered partners and indispensable instruments for the achievement of national health. This implies that the battle against disease must be fought, not only by hospitals and other medical establishments but also jointly by all social institutions that are interested in the elimination of human problems – the family, the school and the church, among others. This realization demands greater

knowledge and understanding of the intricacies and dynamics of health and illness by individuals and public institutions through education.

Of the institutions and agencies that can offer useful information on health matters, outside of the health institution itself, the church stands in a unique vantage position. This is so because of its closeness to the grassroots. In the past, the role of the church in this regard was seen as unusual because, until recently, the church was known only to perform the limited role of catering for the spiritual welfare of its members. Today fortunately, not only public expectation but also the church's understanding of her mission have been enlarged to include a sense of mission for the overall well being of the human person (Odey, 1999). Studies have shown that not only has the church made tremendous social strides in modern settings, but that it has always intervened positively in moments of crises and human sufferings (Berger and Neuhaus, 1981; Troeltsch, 1931; Wilmore and Cone, 1979; Umoh, 1994). In matters of health, there is no better time than now when the health index of Sub-Saharan Africa, which Nigeria occupies a prominent part, is placed below average in health service availability and HIV/AIDS prevalence (World Development Indicators, 2002).

Health utilization, it is assumed, depends partly on the level of literacy and partly on the availability of the service. This paper focuses on the involvement of the church in creating awareness and sensitizing the rural people on the need for health service utilization, using Abak Local Government Area of Akwa Ibom State as a case study. The choice of a rural setting is justified by the observation by Dillman and Hobbs (1982) that rural habitants have not produced, contrary to popular belief, a healthier population than have the cities. In fact, it is their contention that rural people have a lower self-reported health status than their urban counterparts.

The study also challenges churches to greater commitment to health information dissemination in the face of increasing morbidity rate in the rural society. It is the contention of this paper that the church can make its impact more positively felt in the area of health, not only by dotting health centres around but also by actively embarking upon intensive health awareness campaign to educate the masses. As observed long ago, good health is a composite of nutritional, environmental, behavioural, socioeconomic and, to an unknown extent, professional health care contributions (Mckeown, 1976). Rural people can lag behind their urban counterparts in health matters as a result of poverty, ignorance, high illiteracy rate and lack of exposure to modern trends due to locational disadvantage.

Although Akwa Ibom State is made up of thirty-one Local Government Areas, the choice of Abak is deliberate. Abak Local Government Area is made up of the five clans of Afaha Obong, Abak Midim, Otoro and Ediene. Abak is uniquely qualified, as the setting for this study, because of its increasing popularity

in the area of the New Religious Movements (NRMs). Referring to the concentration of churches in Akwa Ibom State in general, Mbon (1984) noted that the phenomenon of the NRMs is so evident in Abak that people sometimes refer to them (the NRMs) as the local industries of the people. Another study on Abak town in particular, observed that although the population of the area is not more than 6000 inhabitants, the town is the seedbed or harbinger of all type of religious movements (Udoette, 2002). The same author notes further that literally all classrooms in primary schools, open spaces in filling stations, some lockup stores, public buildings, bus stops, mechanic shades, drinking parlours and, in some cases, even palours and rooms in private houses have been turned into churches. From whatever angle one looks at it, those descriptions indicate the central role that the church could play in matters of education, communication and information dissemination in Abak.

In reference to the Good News Community (still in Abak), Udoette (2002) contends that this religious body has provided a lot of support, both spiritual and material, to the residents. In her judgment, the Good News Community has stepped in where the nation had failed and offered practical help to those with the least access to the nation's patronage. It is certainly of interest to find out the extent to which such a claim on the church's support can be said to apply to the entire clans in the important area of health care delivery.

2. Conceptual Clarification

Two concepts need brief clarifications before the study can be properly focused: the Church and Health Education.

2.1 The Church

Following Troeltch's (1931) general definition, this study conceives of the church as any type of religious organization, claiming a unique legitimacy, and having a positive relationship with the social environment. As opposed to sects and cults, a church endorses existing political and economic arrangements. Because of its potentiality to enhance the social wellbeing of its members and promote social progress, it has been described as a "life – encompassing" organization (Bassis, Gells & Levine, 1980). Since the study does not dwell on elements of faith nor individual religiously, issues on denominational differences have been purposefully overlooked.

2.2 Health Education

Health, according to the World Health Organization (WHO) is the state of complete physical, mental, emotional and social wellbeing of the individual. Understanding the full ramification of the above definition is the task of education. This can best be done formally through extension education and informally through information dissemination. This study examines extension education since it is most suitable to rural condition. Like its counterpart in agriculture, the aim of extension education is to upgrade rural competence or skill in specific areas such as health or home management (Ekong, 1988:229). Just as the Ministry of Agriculture hires and trains agricultural extension agents for extension work with rural farmers, it is felt that the church should, from time to time, embark on similar measures in order to help in the promotion of rural health. Through health extension, sometimes referred to as "health promotion" such services as group health education classes, health counseling, dietary and nutritional information are provided to local residents at minimum cost and discomfort. Such services not only improve the health indices of rural people but also have the potential of minimizing visits to emergency hospital rooms.

3 Church's Perception of its Role in Health Education

As noted earlier until recently, the involvement of the church in secular matters was considered an intrusion. It was well-known caveat that the church should steer clear of worldly affairs especially politics. At presently, in some of the developed countries, for example the United States, debates are still on over the separation of church and state. The debates are on the church's place and relevance in the modern society (Umoh, 2002; Horton and Leslie, 1970). Theoretically however, the controversy the social relevance of religion is as old as the social and behavioural sciences, with strong adherents on each side of the controversy divide. Presently, the debate centres on the church as a social institution and her ability to contribute toward development. Now, the wall of separation between the church and secular institutions is gradually dissipating, giving way to what could rightly be called a memorandum of understanding in the interest of the human person. For example, today political caucuses open with prayers for divine guidance and churches are seen to manage large economic conglomerates to ensure the survival of its structures into the future.

As expressed by the Fathers of the Second Vatican Council thirty-nine years ago, true religion, whether traditional or revealed, cannot separate the spiritual from the temporal, or remain silent in the face of social, political and economic threats, inflicted upon its adherents (Vat II Document, Gandium et Spes, No. 4). This conception suggests that the church is undergoing a critical self-awareness in search of relevance in modern society. In this new light, she accepts

her existence in the world as a reality, which imposes on her the obligation to work for the transformation of the world of which she is part. As Odey (1997:42) explains, the church has no excuse to shift from the world only to hope for eternal happiness in heaven. Therefore, for role, or lack of it, in the health sector can authenticate her true position in matters of development, especially in the rural community. It is, therefore, in the interest of the church and her enhanced credibility that she be called upon to supply the needed quota in the area of health and well being of those she evangelizes. Her advocacy against social ills, such as murder, theft, injustice, economic exploitation and other forms of fraudulent business practices remain unanchored if she neglects a basic social responsibility like involvement in health promotion. Embracing this responsibility will further testify to, and strengthen her commitment to human development.

Further justification for this social gospel approach is that unless social institutions are improved, they are capable of posing as obstacles to genuine Christian life. What the foregoing discussions show is that the church can promote health education along with its religious chores. Whether the church has, in fact, promoted health education in this regard, especially in the rural areas, is the next point of interest.

4 Brief Overview of the Church's Involvement in Health Education

When Christianity arrived the southern part of Nigeria through the effort of the Portuguese missionaries about 200 years ago, it focused exclusively on the spiritual conversion of souls almost to the complete neglect of other areas of human concern. Education was a means of consolidating the religious gains made and achieving more conversion. The instrumental use of education for the above purpose in the early part of the 20th century is seen in the following statement by Shanahan: "If we go from town to town talking about God, we know from experience that much of our efforts brings no result. But no one is opposed to schools" (2003 Catholic Dictionary: a Publication of the Catholic Secretariat of Nigeria, p. 3). This shows that Christianity, like Islam before it also turned its attention away from the provision of social amenities for the welfare of its converts. When the area of health later attracted attention, it was in favour of the foreign missionaries themselves in order to prepare them for their aggressive drive for souls.

The history of church participation in health provision in Akwa Ibom State should not be expected to wear a different outlook from the above sketchy outline until recently. What should be noted rather is that it would be wrong to draw a common conclusion concerning the various denominations in terms of social commitments due in part to the varying religious orientations and ideologies and the differentials in the individual arrival time of the churches. Also, certain periods of nation's history witness greater health problems than others, making a

cross-temporal analysis a necessity. In fact, up to the period of the outbreak of the smallpox in the 1950's, foreign missions still preferred sending their missionaries abroad for treatment due to the poor state of medical technology in rural Nigeria. This behaviour only helped to increase the degree of neglect of the Church's involvement in the sector. It is obvious that without any interest in health issues, health education can be said to have attracted little or no attention at all.

In analyzing the role of the Church in health education, the place of African Traditional Religion (ATR) should not be overlooked. Before the advent of the Christian church, African Traditional Religion had been developed enough to embrace all aspects of life, physical, spiritual and psychological. Due to its pervasive characteristic, African religion had assumed a central position in African thought. It was considered responsible not only for individual spiritual welfare but also for the social well being of the individual and groups. This understanding raised the position of the African religious practitioners to religious specialists and accredited medical authorities. As noted by Nwanunobi, (1992:177) "the combination of religious expertise and medical proficiency in given personalities… greatly facilitates the simultaneous search for both material and spiritual items which make healing possible in the traditional contexts". Such a prominent position occupied by the traditionalists would evidently lessen the development and need for health education in the formal sense.

5 Methodology

With the use of the survey method, a total of 120 pastors and 100 lay persons, that is 24 pastors and 20 lay persons respectively from each of the five clan of the Abak Local Government, were randomly chosen for the study. The open-ended questionnaire used for the study centred on such issues as:

- The frequency of health discussion in homilies and special sessions;
- Occasional invitations of health specialists to enlighten members of the congregation through seminars;
- The number of health service centers within a mile radius of the centre of worship;
- The most pressing health problems in the area (e.g. HIV/AIDS, infants mortality, maternal mortality, sexually transmitted diseases etc.)
- Incidence of any of the six killers diseases – polio, measles, tuberculosis, diptheria, tetanus, pethusis;
- The extent of involvement of the churches in matters of health generally
- Illness behaviour of the members of the congregation generally (i.e. inclination towards orthodox or traditional therapy).

A sample of 120 pastors and 100 lay persons was considered reasonable, given the size of Abak with an overall population of 108,833 (Local Government Census News, 1991). This is relatively small compared to the neigbouring Local

Governments like Essien Udim and Oruk Anam with populations of 130,215 and 126,726 respectively. Furthermore, a larger sample was capable of posing as obstacle to effective survey due to problems resulting from poor road network in Abak.

6 Findings

The following brief discussion discloses some knowledge concerning the degree of church involvement in health issues relative to this rural sample.

Table 1: Pastor's Attitude towards Health Education in Abak

		No. of Pastors	Percentage
1	Pastors' initiative to invite health workers for enlightenment of congregations	55	45.8
2.	Pastors' rejection of offer for health talk by health officials	33	32.7
3.	Frequent discussion of health matters in homilies	10	8.3

On the initiative of Pastors to invite health personnel for discussion on health matters, only 55 (45.8percent) of the 120 Pastors as shown in table 1 admitted they have ever taken the initiative to do so. 101 (84.2percent) of them admitted that medical teams (over the previous twenty months) had served notices of readiness to discuss health with their congregations. However, 33 (32.7percent) in this group (of 101) said they were unable to welcome them due to "other more pressing items" on the local programmes. Asked about the frequency that health reflected in their weekly sermons, 91.7 percent confessed that they hardly talk about health. These revelations point to a lack of commitment by churches in the health status of their members. The other 8.3 percent accepted that they emphasize the importance of good health in their sermons especially since the HIV/AIDS scourge. Among the 110 ministers who rarely discuss health, 69 (62.7percent) however claim they have often encouraged pregnant women to undertake regular visits to maternity centers. "Medical experts", they said, "are more reliable than the untrained local traditional birth attendants whom the residents tend to patronize rather heavily due to some cultural biases."

Table 2: Attitude of Lay Faithful towards Church involvement in Health Education

	Questions	No of lay faithful	Percentage
1.	Whether church should be involved in health education	85	85
2.	Preferring mission to government workers in health care delivery	88	88
3.	Whether church had done enough in area of health care delivery	63	63

Table 3: Educational level of Rural Pastors

S\n	Qualifications	No. of Pastors	Percent
1.	Above SSCE	27	22.5
2.	SSCE level	49	40.8
3.	Below SSCE	44	36.7
TOTAL		120	100

In an effort to obtain a more balanced view of the situation, interviews with lay members of selected churches in the local government were considered necessary. Consequently 20 lay faithful from each clan (total = 100) were randomly chosen for interviews among this group. The major question sought their opinion on what the church could do in order to assist the government in the area of health care delivery. Quite a large number, 85 (85percent) as shown in Table 3 suggested the establishment of more health centers to supplement the effort of government. The remaining 15 (15percent) called for more awareness among the rural people in order to derive maximum benefits from the existing facilities. Furthermore, neglect of health centres by government was identified as one of the many problems facing the health institutions in the rural areas. By their assessment, the existing structures are not maintained, the health workers are not faithful to duty and prescribed drugs are often not available for purchase. Although the issue of proprietorship of health institutions was not important, as many as 88 (88.3percent) of the lay faithful preferred health services provided by religious bodies for reasons of better quality, frequent supervision and regular maintenance of facilities. "Mission workers," as they call them, "are more faithful than government workers" they said. Lastly, 63 percent of the lay faithful agreed that the church has not done enough towards improvement of health conditions of the people, given their privileged position as grassroots institutions.

These findings are consistent with earlier ones on the issue in the Annang ethnic nationality in general. For example, speaking in reference to reproductive health education, Essien (1997) noted in a study of Annang communities that the general view of respondents was that issues of reproductive health are masked in churches. This again is a serious indictment on the church in respect to health education in rural communities.

7 Conclusion

For successful health care delivery in Nigeria's rural areas certain factors are considered crucial. Such factors as identified by respondents include: availability of health facilities – trained personnel, drugs and so on – accessibility of facilities, awareness, removal of cultural constraints (such as dependence on traditional harmful practices and quack patronage), cost implication and a healthy environment. It is obvious that in this set of sample, health care delivery is yet to reach a reasonable level despite government's increased effort in recent times to promote health through air-time advertisement, the use of posters, house-to-house immunization exercise, occasional free services and seminars, among others. The level of involvement in health education on the part of the religious bodies is quite low given their strategic position with the grassroots. This is so when one considers that only 45.8percent of the pastors interviewed find health education to be necessary. Some 32.7percent would even turn down the initiative of the health officials, while as many as 91.7percent of the pastors never consider health matters in their weekly homilies.

An explanation for low involvement of rural pastors in health education is their low level of enlightenment. In this sample, for example, it was discovered that only 27 (22.5percent) of those sampled read beyond the secondary school level. As many as 49 (40.8percent) had managed to reach SSCE level, The remaining 44 (36.7percent) of the pastors were below the secondary level of education. Certainly, one expects a longer time lag for an illiterate to appreciate the value of health education.

8 Recommendations

These findings point to an important fact: The health situation of rural communities needs more attention from all stakeholders – the government, the church and the individuals themselves. The church can supplement government effort in health provision because of their strategic social location. Accordingly, religious bodies in rural communities should ensure that:

(i) Pastors and ministers of religion see it as part of their sacred responsibility to enlighten their flock on the need to utilize available health provisions within their domains. Such enlightenment should be incorporated into their homilies and sermons as the needs arise;

(ii) Religious bodies should use medical personnel to arrange seminars to inform members and interested non-members of health facilities available in the community.

(iii) Religious bodies should step up their role in health care provision by supplementing government effort in the establishing of health posts in the rural communities;

(iv) Religious bodies should continue as before in the training of mission workers in this area for service in the rural communities.

(v) Since individual and family health status has serious economic implications, the need for effective family planning should be emphasized by the churches.

(vi) Pastors of churches should be required to attain a minimum level of education, possibly up to a first degree level, before embarking on practice in order to help their flock to appreciate certain core values beyond the purely spiritual.

(vii) Governments and religious institutions should see themselves as partners in the health sector so that it may be possible for each to supply the defects of the other thereby ensuring a more efficient health care system for the rural population.

(viii) Since religion is a powerful means of communication, religious bodies should develop strategies to address, discuss and educate members on the importance of health to all facets of human life.

References

Berger P. L. and R. J. Neuhaus (1981) *To Empower People: The Role of Mediating Structures in Public Policy* Institute for Policy Research Washington DC.

Dillman, D. A. & Daryl J. H (Eds.). (1982) *Rural Society in the US: Issues for 1980s* Westview: Boulder

Ekong, E. E. (1988) *An Introduction to Rural Sociology* Jumak: Ibadan

Essien, A. M. (1997) "New Religious Movements in Annang Society" Is an unpublished Ph.D Thesis Submitted to the University of Ibadan.

Horton, P. B. & Leslie G. R. (1970) *The Sociology of Social Problems* Appleton – Century: New York

Mbon, F. M. (1984) "New Typology for African's New Religious Movements" *Quarterly Journal on New Religious Movements* 8.(3 – 4), 177

Mckeown, T. (1976) *The Role of Medicine* Nuffield Hospital Trust: London

Nwanunobi, C. O. (1992) *African Social Institutions* University of Nigeria Press: Nsukka

Odey, J. O. (1999) *The Days of the Jackals* Snapp Press: Enugu

Odey, J. O. (1997) *Nigeria: Search for Peace and Social Justice* Snapp Press: Enugu

Bassis, M. S., Gells R. J. & Levine, A (1980) *Sociology: An Introduction 2nd Ed.* Random: New York 460.

Troeltsch, E. (1931) *The Social Teachings of the Christian Churches (Translated by Olive Wyon)* George Allen: London

Udoette, D. (2002) "New Religious Movements in Nigeria, The Search: Fostering Research on Religious" *Cultural and Societal Issues* 1(1), 35 – 48.

Umoh, J. O. (2002) "Social Evangelism and the Solution of Societal Problems, The Search: Fostering Research on Religious" *Cultural and Societal Issues* 1(1) 60 – 71

Umoh, J. O. (1994) "Constraints to Good Health Care in Rural Nigeria" *Ibom Journal of Social Issues* 1(2) 1 – 7

Wilmore, G. S. & Cone J. H. (1979) *Black Theology: A Documentary History* Maryknoll: New York

World Development Indicators, (2002) In *The Nigerian Social Scientist* 6(1), (March 2003).

Wright, J. C. (1975) *The Documents of Vatican II* Pillar Books: New York