

**Faith and Health: An Appraisal of the Work of the
African Religious Health Assets Program (ARHAP)
Among Faith Communities in Zambia**

By

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DECLARATION

I hereby declare unambiguously that this dissertation is my original work.
It is submitted in fulfilment of the requirements of Master's Degree in Theology, in the
School of Religion, Philosophy and Classics at the University of KwaZulu-Natal,
Pietermaritzburg, South Africa.

I also declare that I have not submitted this dissertation in any form for any degree purpose or
examination.

This dissertation has been language edited by Dr. Karen Buckenham, an approved language
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DEDICATION

This dissertation is hereby dedicated to my God-given family:

Mailed, Praise, Lukumo, Cherish and **Cherina**

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rugged path to my new identity in society.

ABSTRACT

The study is an appraisal of the work of the African Religious Health Assets Program (ARHAP) among Faith Communities in Zambia which was executed on contract with the World Health Organization (WHO). In response to the research question ‘how did the work of ARHAP contribute to the religious understanding of health assets among Faith Communities in Zambia?’ this study uses secondary literature compiled by ARHAP. This study utilised a theoretical framework emerging from the work of women theologians. The framework emphasises the dignity of human life imbedded within the values of the African community. This framework is community oriented, inclusive in nature and affirms mutuality between women and men. The main discussion of this study is concerned with the importance of raising more awareness on the value of RHAs in Zambia, as this can be a catalyst for action leading to enhancement of health. To show this, the study starts by investigating the authenticity of ARHAP and discussing other countries within Africa where ARHAP has successfully carried out its research work. Ten African countries are included in this present study for the purpose of showing the similarities in health related matters that connect Zambia to the rest of Africa. In the Zambian context, this study observes how poverty subverts the awareness and accessibility to RHAs. It argues that the religiosity of Zambians is the key to their awareness. The discussion shows that making Zambians aware about the availability of RHAs in their possession empowers them to maximise their use. It further shows that even though death is inevitable, maximising RHAs can prolong health seekers’ lives. Consistent with the vision of women theologians, this study notes that mutuality between women and men is the central pillar in building a strong community. Based on the findings of this study, women’s willingness to collaborate with men in their community based vision - which is built on mutuality and not hierarchies - is dependent on men’s willingness to redefine what it means to be a man in the context of gender justice and equality. The study also observes that awareness of RHAs is a continuous and gradual process which needs to be engendered. It is recommended that Zambia maintain its connectedness with other countries that have similar health challenges and that collaborate with the Church to continue the process of awareness. Further, that the government of Zambia formally recognise the role of the clergy so that they can make an impact in the community during the awareness campaign of RHAs.

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ABBREVIATIONS AND ACRONYMS

ACHAP	Africa Christian Health Association Platform
AIDS	Acquired Immunodeficiency Syndrome
ARHAP	African Religious Health Assets Program
ARV	Antiretroviral (medicine)
BAM	Bible Alive Ministries
CCZ	Christian Council of Zambia
CHAG	Churches Health Association of Ghana
CHAN	Churches Health Association of Nigeria
CHAZ	Churches Health Association of Zambia
CHI	Churches Health Institutions
CHN	Christian Health Network
DRC	Democratic Republic of Congo
ECZ	Evangelical Church in Zambia
ECZ	Episcopal Conference of Zambia
EFZ	Evangelical Fellowship of Zambia
FAB	Faith Based Organization
FHPC	Faith Healing Pentecostal Churches
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
IHP	Interfaith Health Program
IRHAP	International Religious Health Assets Program
LDHMT	Lusaka District Health Management Team
MDG	Millennium Development Goals
MOH	Ministry of Health
PACSA	Pietermaritzburg Agency for Christian Social Awareness
PIRHANA	Participatory Inquiry into Religious Health Assets, Networks and Agency
RE	Religious Entities
RHA	Religious Health Assets
SAP	Structural Adjustment Program
TARSC	Training and Research Support Centre
UCT	University of Cape Town

UKZN	University of KwaZulu-Natal
UNDAW	United Nations Division for the Advancement of Women
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UPMB	Uganda Protestant Medical Bureau
USA	United States of America
WHO	World Health Organization
WINN	Women's International Network News
WITS	Witwatersrand
ZNBC	Zambia National Broadcasting Corporation

HOW I USED KEY TERMS IN THIS STUDY

ARHAs and RHAs: These are used interchangeably.

Churches: Local Church assemblies in communities excluding para-Church organizations.

Community: Both faith and secular communities.

Faith Communities: Used in general, implying the Church and all its Christian-oriented organizations.

Health Assets: Of both religious and secular institutions.

The Church: Local Christian believers including para-Church organization.

CHAPTER I

THE GENERAL INTRODUCTION TO THE STUDY

1.1. Introduction

Health assets are an important matter in the lives of many people. They are values, qualities or resources that promote health. Health assets are present within both secular as well as religious institutions. Looking at religious health assets in particular, this study discusses how faith communities in Zambia were made aware of the value of African Religious Health Assets (ARHAs) during research undertaken in Zambia by the African Religious Health Assets Program (ARHAP).

This chapter provides a general overview and background to the study, the formulation of the key research question, sub questions and sub objectives. It introduces Engendered Communal Theology as the theory or framework through which the research is interpreted and outlines the methodology used in this study. Lastly, a summary of the entire work of this dissertation is provided.

1.2. Background and Motivation to the Study

The background to the study and my motivation for undertaking it is twofold: First is the motivation arising from literature obtained during course work, and second is my interest in the topic based on my lived experience.

1.2.1. Scholarly Motivation

My interest in undertaking this study began during my academic studies in the Gender, Religion and Health Program in the School of Religion, Philosophy and Classics at the University of KwaZulu-Natal. I was motivated to do further research on the value of Religious Health Assets (ARHA) available in faith communities in Africa. My main interest was particularly on the report that had been produced by African Religious Health Assets Program (ARHAP) for the World Health Organization (WHO) (2006) entitled 'Understanding Religious Health Assets – Zambia Research'. In ARHAP's report, it was indicated that Zambia contributed considerably to the pilot research project that ARHAP

undertook. ARHAP's research carried out in Zambia raises a question as to whether this research increased awareness among faith communities of the RHAs that they possess. Therefore, against this background, the present study inquires and appraises how awareness of ARHAs has influenced women and men in Zambia.

As the words 'religious health assets' will be used frequently in this study, it is important to define what is meant by the term. 'Religious health assets' are found in religion's structures and are imbedded in individual adherents in any particular religious entity.¹ They can be tangible or intangible assets as long as they serve the purpose of bringing more awareness, and lead to improvement in the health standards of the health seekers. From ARHAP's research, it is stated that tangible assets are "Compassionate care, material support and health provisions". Intangible assets are defined as: "Spiritual encouragement, knowledge giving and moral formation."² Being aware that these assets were exposed to Zambians through ARHAP's participatory workshops, my interest is to show the value of these assets to Zambians with a view to fostering more awareness of the religious health assets people possess for the benefit of individuals and the community. My interest, further, is to explore how awareness of religious health assets can promote a gender aware community where men and women mutually support each other for the sake of the community's health.

1.2.2. Personal Motivation

My interest to undertake this study is based on my personal experience in Church work. This was during my tenure of office as a lay pastor in the Evangelical Church in Zambia (ECZ), Ndola City. I am aware that ministry in the Church depends on the health of the members. During my ministry, I observed that people's health was deteriorating to the extent that they faced death. In one instance, one of the youth members of our Church was neglected when he was diagnosed with HIV. Care was withdrawn because he was alleged to have been paying for his sins. He died in a circumstance I later realized we could have helped to prolong his life using the available RHAs.

¹ARHAP, 2007. "ARHAP International Colloquium," <http://www.arhap.uct.ac.za> [Accessed 7th Aug. 2013].p18.

²Steve de Gruchy, Deborah Jones, James Cochrane, Paul Germond, Gary Gunderson, Sinatra Matimelo, Sepetla Molapo, Deborah McFarland, Jill Olivier, Tandi Reily, and Mary Mwiche. 2006.*Appreciating Assets: The Contribution of Religion to Universal Access in Africa. Mapping, Translating and Engaging Religious Health Assets in Zambia and Lesotho*. Report for the World Health Organization. Cape Town: ARHAP. p77-78.

Even though it can be argued that death is inevitable, there are efforts that people can apply to help an ill person before death occurs. I attributed a person's death, in many instances, to a lack of awareness among members of the Church that they could play a major role in helping each other. However, this can only be possible when they are assisted to become aware of their potential. From a gender perspective, I observe that men seem to be adamant in the stance that care giving is not for them, and are adverse to taking care of their sick wives. Conversely, when a man falls sick, the wife nurses him openly and generously. I further observe that there are RHAs in both men and women which are supposed to be practiced to the full, with reciprocity and mutuality, but are dormant. For instance, the attitude of care is quite dormant in men and quite active in women. This situation requires further research in order to find a way of helping members of the church community to recognize the value of the RHAs which they possess.

1.3. The Significance of the Study

This study is significant in that it appraises the work done by ARHAP in Zambia and how the Zambian people responded to the work. It is also a contribution to the religious understanding of health assets among Zambian faith communities. The present study is an important source of information for religious institutions and can challenge the Zambian ecumenical body to recognize the value of RHAs, possibly motivating them to take appropriate action to promote peoples' awareness of them through sensitization. Therefore, this study will be an attempt to motivate Churches in particular to critically make the most of their awareness of RHAs. Considering Steve de Gruchy et al's statement that research does not only need to fulfil academic requirements,³ this study is an attempt to make more information available to the community for more awareness of RHA's they possess.

1.4. Formulation of the Research Problem

This study is inspired by first, the reality of ill health that sometimes leads to death in spite of the availability of numerous ARHA that are not fully utilized. Considering the laid down foundation done by Steve de Gruchy et al on ARHA in Zambia, this study utilizes women's theological understanding to tackle the existing problem. Women theologians advocate for mutual efforts to raise and sustain strong communities. The envisioned objective of this study

³Steve de Gruchy, James, R. Cochrane, Jill Olivier, and Sinatra Matimelo. 2011. "Participatory Inquiry on the Interface between Religion and Health: What does it Achieve, and What Not?" Pages 43-61 in *When Religion and Health Align: Mobilising Religious Health Assets for Transformation*, edited by J.R Cochrane, B. Schmid, and T. Cutts Pietermaritzburg: Cluster Publications. p58.

is to enhance awareness on the availability of RHA in the communities among women and men. It is hoped that this study will promote the current awareness campaign on the availability of ARHAs. Therefore, the problem at hand leads us to the formulation of the research question.

1.5. Formulation of Research Question Sub-Questions and Objectives

1.5.1. The Key Research Question

This study endeavours to answer the following key research question:

How did the work of ARHAP contribute to the religious understanding of health assets among Faith Communities in Zambia?

1.5.2. Sub-questions

- What is the background research work done by ARHAP in Zambia?
- How valuable are the RHAs that were identified in the activities carried out by ARHAP in Zambia?
- In what ways did the activities carried out by ARHAP create awareness of the intersection between health and religion among women and men in Zambia?

1.5.3. The Key Research Objective

The key research objective of this study is:

To study how the work of ARHAP contributed to the religious understanding of health assets among Faith Communities in Zambia.

1.5.4. Sub-objectives

- To show the background research work done by ARHAP in Zambia.
- To understand the value of RHAs that were identified in the activities carried out by ARHAP in Zambia.
- To assess whether the activities carried out by ARHAP created awareness of the intersection between health and religion among women and men in Zambia.

1.6. The Methodological Approach to the Study

This appraisal is a literature-based study relying on secondary data. According to Nieuwenhuis, such a type of study is characterized by the use of already existing literature.⁴ In the assertions of Frey, Botan, and Kreps, they state that within this methodology it demands that a library based approach utilizes a textual analysis method to describe data

⁴J. Nieuwenhuis. 2012. "Qualitative Research Designs and Data Gathering Techniques" Pages 69-97. In: *First Step in Research* edited by Maree, K. Pretoria: Van Schaik Publishers. p71.

contained in texts. It also requires that a selection of texts be considered and the research question is answered through quantitative content analysis.⁵ This study uses a research report entitled ‘Understanding Religious Health Assets – Zambia Research’ compiled by a research team headed by Steve de Gruchy. This report was utilized as a key document while some of the literature was viewed through Engendered Communal theology theory.

1.7. The Framework through which the Study is Undertaken

This study is a response to the following key research question: How did the work of ARHAP contribute to the religious understanding of health assets among Faith Communities in Zambia? The framework used to explore this question is called an Engendered Communal Theology, rooted in the works of African Women Theologians. The Engendered Communal Theoretical framework originated from women theologians’ biblical studies. The perception of Madipoane Masenya is that both biblical and cultural interpretations have created a negative connotation about an African woman.⁶ In their research, Isabel Apawo Phiri and Sarojini Nadar affirm the interface between Jewish and African cultures.⁷ These observations imply that theologizing the theory of the community is biblically and culturally founded. Musimbi Kanyoro asserts that Engendered Communal Theology is an African approach to issues from two angles - ‘religious and cultural’.⁸ This framework rightly fits the research topic as it addresses these two sides of health assets, both the religious and secular health assets.⁹ Of particular relevance to this study is the community orientation of Engendered Communal Theology. Kanyoro argues that it is a theology that requires ‘solidarity’ in an effort to tackle community issues.¹⁰ Peter Mwakalombe also affirms that the community is the main focus for women’s theology.¹¹ Further, this framework provides a gender lens through which RHAs, which are a critical concern in this study, can be viewed. Because of

⁵ Frey, L., C. Botan, and G. Kreps. 1999. *Investigating communication: An Introduction to Research Methods*. (2nd ed.) Boston: Allyn & Bacon. p1-3.

⁶ Madipoane Masenya. 2005. “Trapped Between Two Canons: South-African Christian Women in the HIV/AIDS Era” Pages 113–127. In: *African Women, HIV/AIDS and Faith Communities*, edited by Phiri, I.A., B. Haddad, and M. Masenya. Pietermaritzburg: Cluster Publications. p114.

⁷ Isabel Apawo Phiri and Sarojini Nadar. 2002. “What’s in a Name?” Pages 5-20. In: *Introductions in Feminist Theology*, edited by Grey, M., Ishaerwood, L. and Wootton, J. London: Sheffield Academic Press. p17

⁸ Musimbi, R.A. Kanyoro. 2001. “Engendered Communal Theology: African Women’s Contribution to Theology in the 21st Century” Pages 158-180. In: *Talitha Cum! Theologies of African Women*, edited by Njoroge, N.J. and Dube, M.W. Pietermaritzburg: Cluster Publications. p169.

⁹ Kanyoro. 2001. “Engendered Communal Theology,” p169.

¹⁰ Kanyoro. 2001. “Engendered Communal Theology,” p169.

¹¹ Peter Mwakalombe. 2014. *African Communication Skills in HIV and AIDS and Male Circumcision: Narratives of Behavioural Science Approach to Community Mitigation Strategies*. Ndola: Litovia. P30.

the inclusive language in this framework, it creates an avenue for both women and men to be more aware and access RHAs in their communities.

African Women Theologians hold the community as a main theme and focus in all their research. One of the most important African sayings from the work of John Mbiti is relevant here. His words “I am because we are and since we are therefore I am”¹² describe the value of a single individual in the community, in which every woman and man finds his/her ontological identity. The need to have a strong sense of belonging to the community is one of the prime issues in Engendered Communal Theology. In Zambian understanding, Joseph Daka likens a woman to a hen. Daka says that it is natural that a hen cannot abandon its chicks but a cock can effortlessly desert them.¹³ This implies that women’s closeness to the community is their prime value. It also means women resiliently suffer with their children which practice is not common with men. Daniel Kasomo and Loreen Maseno also state that women are willing to collaborate with men who have a vision to reconstruct cultural and religious perceptions on gender equality. Sharing the priority of the community, this theoretical framework links directly with ARHAP’s method of conducting participatory workshops within the Zambian Faith Communities. RHAs are needed in the community because they enhance the lives of women and men. Health assets are within the community, and bringing awareness to it is only possible when women and men accept to work hand in hand. Thus the Engendered Communal Theology framework is appropriate for this study as it brings in the core values of community life. One of the advantages of this framework is how it can be applied to questions of sustaining the community. Therefore, applying this theory seeks to achieve the vision of women theologians whose struggle for mutuality is imbedded in the life of the community.

Kasomo and Maseno’s understanding is compatible with Zambian indigenous knowledge which says *umunwe umo tausala inda* [one finger cannot pick a louse].¹⁴ This implies that one person’s efforts cannot achieve the desires of the entire community. The plea here is for every woman and man to combine their efforts with a view to maintain the community. Isabel Phiri and Sarojini Nadar relate Engendered Communal Theology to ‘Theology of Relations’. They argue that since Africans believe in communal life, new reflection on the life of a

¹²Daniel Kasomo and Loreen L. Maseno.2011. “A Critical Appraisal of African Women Theology”. *International Journal of Current Research*, 2/1 (January), 154-162.p159.

¹³Joseph Daka. 2007. *The Hidden Truth on Virginity*. Lusaka: Comfort Publishers. p140-141.

¹⁴This proverb is both in Ibibemba and Kikaonde dialects in Zambia.

community encourages ‘mutuality’ rather than building ‘hierarchies’.¹⁵ An Engendered Communal Theology Framework informs this study about the significance of the community in which women and men have the potential to build each other.

Theologizing the community concept, Phiri and Nadar insightfully advocate for the deconstruction of patriarchal dominated hierarchies and the reconstruction of a society in terms of reciprocity and mutuality.¹⁶ Asserting that communal theology is instrumental in women’s discourses, Phiri and Nadar convey how women use communal theology to fight for their liberation and the establishment of strong communities. Phiri and Nadar posit that the liberation that women fight for using Engendered Communal Theology is not only for their sake but also for men.¹⁷ Engendered Communal Theology is therefore an appropriate framework for this study because of its inclusive nature. Women’s understanding of a community is deeply rooted in collaboration based on mutual relationships, to build the current and future generations. Hence, men and women are invited to participate together in the struggle for the betterment of the community.

Awareness of the availability of ARHAs, as revealed by ARHAP, is an on-going participatory process. The Engendered Communal Theology framework embraces both women and men in their awareness campaign to access health assets. It is the aspect of inclusiveness in this theoretical framework which creates an avenue for both men and women to collaborate in the awareness and accessibility of health assets. With its emphasis on community and individual well-being, the Engendered Communal Theology framework is also about maintaining the dignity of human life. Therefore, the progression of this study relies upon the Engendered Communal Theology framework through which men and women are spurred to collaborate in order to raise mutuality oriented communities.

1.8. Overview of the Dissertation

This dissertation is comprised of five chapters. Chapter one gives the general overview of the dissertation and states the motivation behind the study. It indicates the significance of this study in making the community aware of RHAs. It also highlights the type of contribution it will make to academia. The methodology which this study engages is included followed by

¹⁵Phiri and Nadar. 2002. “What’s in a Name?” p15.

¹⁶Phiri and Nadar. 2002. “What’s in a Name?” p15.

¹⁷Phiri and Nadar. 2002. “What’s in a Name?” p16.

the formulation of the key research question and the main objective. The chapter also explains the Engendered Communal Theology Framework in which this study is located.

Chapter two appraises ARHAP's research activities in Africa starting with its background. It states the vision and objectives of ARHAP. It also discusses the context of Zambia in which ARHAP carried out its research. In this chapter, poverty is viewed as the main factor which undermines health in Zambia. This chapter also discusses how ARHAP's research activities in other African countries have a connection with Zambia on health related issues.

Chapter three shows the value of twelve RHAs which are most accessed by Zambians, as revealed in ARHAP's report. It describes tangible and intangible RHAs, with particular attention to the Church in which these assets are situated.

Chapter four is about the role of religion with regard to the awareness and distribution of RHAs which it holds. It also focuses on the work of Churches Health Association of Zambia (CHAZ) as the main body which plays an intermediary role between the Church and the government. It highlights the networking between Faith Communities and other structures, and assesses the intersection between faith and health.

The final chapter concludes the dissertation and makes some recommendations for further research.

1.9. Conclusion

This chapter has highlighted the general overview of the dissertation and has discussed the background and the motivation to this study. The scholarly and personal interests that emanated from coursework and ministerial experiences respectively, formed the most significant parts of the motivation for this work. This chapter has also signified the purpose of the study with respect to its contribution to academia. It has highlighted the method employed to approach this study. In addition, it has discussed the Engendered Communal Theology theoretical method in which the concepts of this study are framed. Since this study is using literature compiled by ARHAP, the next chapter will provide the historical development of ARHAP's activities, particularly those on the African continent. It will also show how such works are connected to Zambia.

CHAPTER 2

AN OVERVIEW OF ARHAP'S RESEARCH ACTIVITIES

2.1. Introduction

Having provided a broad overview of the entire study, this chapter seeks to respond to the first sub research question 'What is the background research work done by ARHAP in Zambia?' This chapter provides insights into the purpose of ARHAP, followed by its background. To understand the motivation behind ARHAP, this chapter outlines the main goals and objectives that guide ARHAP's research. This chapter also introduces partners of ARHAP that have contributed to its work becoming visible and appreciated. This will be followed by an account of activities that have been carried out by ARHAP in Zambia, and the context of Zambia in which ARHAP was working. Particular attention will be drawn to the situation of poverty in Zambia and its effects on RHAs. Furthermore, this chapter will discuss the Zambians' understanding of health and the participation of women in the awareness of RHAs. Finally, it will bring to our attention the research activities that were carried out by ARHAP in other African countries with a view to showing Zambia's connectedness with them.

2.2. What is ARHAP?

The acronym 'ARHAP' stands for African Religious Health Assets Program. This programme was essentially created by scholars to undertake research in Africa and the rest of the world with the aim to find the possible ways for religion to collaborate with secular health institutions to create a context in which communities can engage in improving public health. Owing to the growing crises in the health sector, in Africa in particular, ARHAP engages itself in identifying stakeholders that have the potential to contribute to the health and wellbeing of the communities.¹⁸ It is also worth mentioning here that ARHAP does not only focus on Africa.

2.2.1. The Background of ARHAP

ARHAP started in 2002 as an initiative of interested scholars within religion and health. During the deliberations of the Interfaith Health Program (IHP) which was held at the Carter Centre in the United States of America (USA), it was recommended that more research

¹⁸de Gruchy et al. 2006. *Appreciating Assets*. p23.

needed to be carried out in the area of health. In order to assess how best religion could collaborate with the secular health sector, Africa became the main focus of research because of its major health challenges. With this task ahead, ARHAP was officially launched in December 2002 in Geneva, Switzerland. Although ARHAP's special focus was on Africa, it now belongs to the International Religious Health Assets Program (IRHAP), the mother body of the program. ARHAP's work within the first ten years was called phase one, and during this time a substantial amount of work was achieved. Due to these efforts, it was re-launched in 2012 with a broader perspective of research and increased interest of its partners. It was during this launch that ARHAP was re-termed IRHAP to cater for the larger spectrum of research.¹⁹

2.2.2. Collaborative Partners of ARHAP

The endeavours of ARHAP are made possible with its collaborative partners which include the following: University of KwaZulu-Natal (UKZN), the University of Cape Town (UCT), the University of Emory and the University of Witwatersrand (WITS). Apart from universities, ARHAP also works in collaboration with other stakeholders such as Non-Governmental Organizations and the Centres for Disease Control and Prevention. Others which are not specified are professionals in the health fraternity.²⁰

2.2.3. ARHAP's Objectives

ARHAP's vision was to assess the contribution of religion to health and wellbeing. To achieve this, a report by de Gruchy et al states ARHAP's operations within its well-articulated vision. It is aided by the following objectives:

- To assess existing baseline information sources and conduct an inventory ("mapping") of religious health institutions and networks in Africa.
- To articulate conceptual frameworks, analytical tools, and measures that will adequately define and capture religious health assets from African perspectives, across geographic regions and different religions, in order to align and enhance the work of religious health leaders and public policy decision-makers in their collaborative efforts.

¹⁹International Religious Health Assets Program, "An international collaborative network working on the interface of religion and public health" Accessed 13.11.13. <http://www.arhap.uct.ac.za>.

²⁰de Gruchy et al. 2006. *Appreciating Assets*. p23.

- To develop a network that will include nodes of scholars and religious as well as public health leaders in sub-Saharan Africa; plus scholars from outside Africa, religious leaders and representatives of key funding, development and policy-making organizations.
- To train future leaders of both public health and religious institutions in religious health asset assessment skills (capacity building).
- To provide evidence to influence health policy and health resource allocation decisions made by governments, religious leadership, inter-governmental agencies and development agencies.
- To disseminate and communicate results and learnings widely and regularly.²¹

2.3. ARHAP's Activities in Zambia

ARHAP conducted participatory workshops in four provincial centres: Ndola and Kitwe (Copperbelt province), Lusaka (Lusaka province), Livingstone (Southern province) and Chipata (Eastern province). To achieve its vision, ARHAP used Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA) tools to map out RHAs which were available in Zambia.²² In ARHAP's research to understand RHAs in Zambia, it achieved its vision in assessing the contribution of faith communities to health.²³ See Figure 1 for the location of ARHAP's venues where participatory workshops were conducted.

²¹de Gruchy et al. 2006. *Appreciating Assets*. p23.

²²de Gruchy et al. 2006. *Appreciating Assets*. p63 and Gruchy et al. 2011. Participatory Inquiry on the Interface between Religion and Health. p44.

²³de Gruchy et al,2006. *Appreciating Assets*. p62,67.

Map of Zambia²⁴



Figure 1. Showing the venues of ARHAP's participatory workshops in Zambia

2.3.1. The Zambian Religious Context

According to the report issued by Steve de Gruchy et al, it is maintained that about 85% of Zambians profess to be Christians. The remainder profess other religions including Islam, Hinduism, Bahai faith and atheism.²⁵ Paul Gifford posits that Christianity in Zambia was introduced by the missionaries in the late 1800s and was enhanced when the second president of Zambia declared Zambia a Christian Nation in 1991.²⁶ Isabel Apawo Phiri states the

²⁴Blank map of Zambia. http://www.Zambia_blank_outline_map.com [Accessed 4th April 2014].

²⁵de Gruchy, et al. 2006. *Appreciating Assets*. p62.

²⁶Paul Gifford. 2001. *African Christianity: Its Public Role*. London: Hurst and Company Publishers. p198.

perceptions of Zambians on the presidential declaration. She rightly points out that the three mother Church bodies namely; Evangelical Fellowship of Zambia (EFZ), Episcopal Conference of Zambia (ECZ) and Christian Council of Zambia (CCZ) were not in a position to contribute fruitfully to the declaration. She further asserts that Pentecostal Churches accepted it as they believed the reign of God was coming to Zambia through President Frederick Chiluba.²⁷ The result of this declaration was the proliferation of Churches and para-Church organizations.

However, Kabwe Maybin Kabwe rightly argues that even before the presidential declaration was made, there was evidence of the prophetic role of the Church in respect to advocating for the needy. He says the declaration was an additional blessing that paved the way for ministries to emerge.²⁸ In my honours project, I have indicated that the presidential declaration 'brought some dignity to Christian fraternity'.²⁹ It can therefore, be assumed that the presidential declaration graced the emergence of many Churches, adding to the number of already existing RHAs in the community.

2.3.2. The Zambian Political Context

As indicated by Isaac Phiri, Zambia's independence was attained in 1964. Zambia was colonized by the British from the late 1800s up to the time Kenneth Kaunda's government took over.³⁰ Zambia is a democratic nation and Christianity is developing to play a political role in governance.³¹ Being a Christian nation, the Zambian government respects the voice of the Church and this creates opportunities for awareness in terms of understanding and distributing religious health assets.³² The Churches Health Association of Zambia (CHAZ) plays a pivotal role between the Zambian government and Churches. CHAZ is the

²⁷Isabel, A. Phiri. 2008. "President Fredrick Chiluba: Evangelicals and Democracy in a Christian Nation."Pages 95-129. In: *Evangelical Christianity and Democracy in Africa* edited by Ranger, O. T. New York: Oxford University Press. p103-104.

²⁸Kabwe, M. Kabwe. 2008. *Local Churches and Health: An Examination of four Local Churches' Contribution to Direct Health Out-comes on the Copperbelt Province of Zambia*. p28.

²⁹Amos Luwaile. 2012. *A Critical Assessment of the Numerical Growth of the Evangelical Church in Zambia between 1991 and 2011*. Unpublished Honours Project (BTh Hons). University of KwaZulu-Natal, Pietermaritzburg. p26.

'Dignity to Christian Fraternity' here I mean Christianity has gained respect in that even its voice is given attention by the government.

³⁰Isaac Phiri. 2001. *Proclaiming Political Pluralism: Churches and Political Transitions in Africa*. Westport: Praeger Publishers. p13.

³¹Isabel, A. Phiri. 2008. "President Fredrick Chiluba: Evangelicals and Democracy in a Christian Nation. p96.

³²de Gruchy et al. 2006.*Appreciating Assets*.p62 and 68; Phiri. 2001. *Proclaiming Political Pluralism*. P13; Evaristo Mambwe. 2002. *The Challenge of Poverty for the Church in Zambia*. p19.

mouthpiece of member Church organizations which administer health service delivery.³³ This political scenario helps us to understand that political leadership in Zambia has regard for Faith Communities.

2.3.3. The Zambian Cultural Context

In Zambia, people are genial especially in the rural areas. In the urban areas there is more interaction in the townships than in the affluent communities. Using lived experience, the people in the urban communities are multi-cultural and being educated is always aligned with Western culture. In my community, women are well known in the neighbourhood and there is more interaction than men. This is in line with the Engendered Communal Theology theoretical framework in which women pronounce the community to be their main focus. It is important here to articulate the Zambian cultural context for it affects perceptions and experiences in diverse ways.³⁴ ARHAP's research shows that the Zambian culture has 73 ethnic groupings, all with their own dialects.³⁵ Gayatri Murthy observes that there are languages that are used for civic purposes commonly spoken in urban areas including the national television and radio through Zambia National Broadcasting Corporation (ZNBC).³⁶ The purpose of emphasizing languages in the Zambian cultural context is because of their significant role in making the community aware of religious health assets. Languages are a natural media of communication as noted by Lutz Marten and Nancy Kula.³⁷ The rest of the languages which do not have space on national air are not inferior in any way. It is important here to note that in the awareness campaign of health assets, oral and written communication is important as it empowers health seekers to understand their needs in their cultural context.

2.3.4. The Zambian Economic Context and the Situation of Poverty

The fluctuation of the Zambian economy has a long history, dating back to Zambia's independence from colonial authorities. Bized observes that Zambia inherited a strong economy from the colonial rulers. The economy then was heavily dependent on copper. When socialism was introduced under Kaunda's tenure, centralized planning was

³³Churches Health Association of Zambia. 2011. *Annual Report*. Lusaka: CHAZ.

³⁴Loustaunau, M.O. and Sobu, E.J. 1997. *The Cultural Context of Health, Illness and Medicine*. London: Bergin and Garvey. p17.

³⁵de Gruchy et al. 2006. *Appreciating Assets*. p62.

³⁶Gayatri Murthy. 2010. *Zambia's State Run ZNBC Dominates Radio Listening: What Does this Mean. For Information Access?* <http://www.audiencescapes.org/sites/default/file>. [Accessed 4th November, 2013]. p3.

³⁷Lutz Marten. and Nancy Kula. 2007. *Zambia: 'One Zambia, One Nation, Many Languages'* <http://www.repository.essex.ac.uk.1142/1/Zambia.pdf>. [Accessed 6th November, 2013]. p298.

encouraged. Bized articulates the international community's influence on the Zambian economy and how that led to the fall in the copper prices. He further states that the situation could not be contained except to liberalize trade.³⁸ In the research undertaken for the World Health Organization (WHO), de Gruchy et al found that the implementation of a Structural Adjustment Program (SAP) had an adverse impact on the Zambian people.³⁹

The purpose of discussing this situation is because of its influence on efforts to make the community aware of the value of RHAs. De Gruchy et al also argue that the privatization and liberalization of Zambia's economy had an impact on the health systems.⁴⁰ In a situation where the economy is unstable, health assets are equally influenced. Therefore, it requires collaborative efforts to combat the crisis and find a way of making people aware of RHAs in their possession. In the Zambian context, the fluctuation of the economy also raises health consultation and curative fees. This undermines the efforts to make people aware of health assets.

It is important here to provide a broad picture of poverty levels in Zambia. The main idea is to establish whether poverty has an impact on awareness of Zambians regarding the availability of RHAs. De Gruchy et al maintain that poverty levels in Zambia were accelerated as a result of implementing the Structural Adjustment Program in 1991.⁴¹ They further say that the participants in the ARHAP workshops noted poverty as a major cause of a lack of awareness and inaccessibility of health assets in Zambia.⁴² In the same vein Mwakalombe asserts that the situation of poverty in Zambia is in enmity with health.⁴³ This situation demands women and men's concerted efforts. Nonetheless, the poverty situation has been upgraded by the United National Development Programme (UNDP) in their assessment of their Millennium Development Goals (MDGs). The UNDP states that the country of Zambia has slightly moved up from the low-income to the middle-income category. The indication here is that Zambia has been partly weaned off heavy dependence on foreign aid

³⁸Bized Virtual Developing Country. 2001. *The Economic History of Zambia*.
<http://www.bized.co.uk/virtual/dc/back/econ.htm>. [Accessed 6th November 2013]. p3.

³⁹de Gruchy et al. 2006. *Appreciating Assets*. p62.

⁴⁰de Gruchy et al. 2006. *Appreciating Assets*. p72.

⁴¹de Gruchy et al. 2006. *Appreciating Assets*. p62.

⁴²de Gruchy et al. 2006. *Appreciating Assets*. p72.

⁴³Mwakalombe, P. 2014. *African Communication Skills in HIV and AIDS and Male Circumcision*: p47.

for development purposes.⁴⁴ This depiction is clear but communities hardly benefit from the change especially in the rural setting.

The UNDP report also shows that even though Zambians are no longer living in abject poverty, the rural population still experiences extreme poverty.⁴⁵ This situation infringes on the community's awareness of and access to RHAs. Despite UNDP's findings, Mwakalombe's observation is in contrast. He observes that health services have not sufficed the rural community.⁴⁶

2.3.5. The Influence of Poverty on Health Assets in Zambia

According to their findings, de Gruchy et al argue that the economic adjustment in Zambia had an adverse effect on the community's awareness of health assets in the sense that hospital/clinic user fees started to escalate.⁴⁷ This means that only those who could afford to pay user fees could access clinical attention. In the Zambian cultural setting, it is anti-cultural to see one's neighbour lacking. It is in this situation where the concept of mutual concern with a view of raising strong communities is promoted by women theologians. Currently, it is rightly maintained by the UNDP that poverty in the rural areas hinders the rural community from accessing health assets - a true reflection of reality that deserves attention by religious health asset providers.⁴⁸ In addition, poverty in Zambia leads to a syndrome of relying heavily on foreign aid for local work. CHAZ is obliged to look for sources of funds to help in the awareness campaign of health assets.⁴⁹ This situation implies that if aid is cut off, appreciating the value of health assets can be affected. However, CHAZ makes great efforts to alleviate poverty by empowering members of the community to engage in income generating ventures, as will be discussed in detail in chapter four.

2.4. Poverty and its Effects on Women and Men's Health in Zambia

The Lusaka District Health Management Team (LDHMT) and Training and Research Support Centre (TARSC) observe that poverty is linked to malnutrition. When women have insufficient dietary consumption, they lack very important vitamins in their bodies, resulting

⁴⁴United Nations Development Programme. 2013. *Millennium Development Goals: Progress Report Zambia. 2013*. Lusaka: UNDP. p13.

⁴⁵United Nations Development Programme. 2013. p16.

⁴⁶Mwakalombe, P.2014. *African Communication Skills in HIV and AIDS and Male Circumcision*. p35.

⁴⁷de Gruchy et al. 2006. *Appreciating Assets*. p68.

⁴⁸United Nations Development Programme. 2013. p16.

⁴⁹Churches Health Association of Zambia. 2011. p20.

in threats to their health. In the case of expectant mothers, LDHMT and TARSC further observe that lack of proper nutrition causes difficulties in their maternal life. They also find the relationship between mothers' health and the resultant pregnancy to be a significant matter worthy of attention. They say that if women are not taken care of with respect to their nutrition, they give birth to unhealthy babies; hence the high death rates in children.⁵⁰ This is a serious issue as it raises concerns about building a strong community. Proper dietary care for women is a source of raising a strong community.

Similar to CHAZ's recognition of women and children to be the most vulnerable in the situation of poverty,⁵¹ de Gruchy et al also observe that poverty is real in Zambia and negatively affects the community in terms of health.⁵² Sarah Bibler and Claire Lauterbach add that poverty forces food prices to escalate making it unaffordable for some households to eat well.⁵³ This pushes up the rate of malnutrition, particularly in children. Malnutrition is one of the problems which hinders the community from accessing health assets because it affects the health of the community.

2.5. Other Aspects that Affect Women's and Men's Health

2.5.1. Human Behaviour

According to de Gruchy et al, some members of the community patronize bars, taverns and night clubs in the evenings and sometimes overnight - a habit that has plunged many people into poverty.⁵⁴ In these places it was observed that immoral activities were being practiced. In the Zambian context, this observation was also true but we have to find out what causes this kind of behaviour. In such places women give in to sexual activities to raise some income for their families. Through this reckless behaviour, some women contract HIV which has serious consequences for their lives. It is therefore noted that human behaviour can be a threat to health standards.

⁵⁰Lusaka District Health Management Team (LDHMT) Zambia and Training and Research Support Centre (TARSC) Zimbabwe. 2013. *Women's Health and Sexual and Reproductive Health in Zambia: A review of Evidence*. p6.

⁵¹Churches Health Association of Zambia. 2011. p28.

⁵²de Gruchy et al. 2006. *Appreciating Assets*. p72.

⁵³Sarah Bibler. And Claire Lauterbach. 2012. *Gender, IFIs and Food Insecurity Case Study: Zambia*. <http://www.genderaction.org/publications/zambiafoodsecurity.pdf>. [Accessed 9th November 2013]. p1.

⁵⁴de Gruchy et al. 2006. *Appreciating Assets*. p69.

2.5.2. Medical Facilities

Poor medical infrastructure undermines the delivery of health services to health seekers. In Women's International Network News (WINN), it was reported that Zambia's maternal mortality rate was too high due to poor medical facilities.⁵⁵ However, it is also noted by Jill Olivier, Clarence Tsimpo and Quentin Wodon that in Sub-Saharan Africa, including Zambia, the largest percentage of medical infrastructure is administered by religious bodies.⁵⁶ Since the majority of Zambians are Christians, it implies that Christianity has a large share in the delivery of health assets to the communities. Lack of proper facilities deprives the community of its right to good health. In some cases, using lived experience in Zambia, health centres and hospitals are distanced from health seekers. In this case women are the most affected because of their obstetric-related cases.

2.5.3. Illiteracy

De Gruchy et al state that access to health assets can also be affected by lack of education.⁵⁷ In a statement released by Hilda Sinywibulula of the United Nations Educational, Scientific and Cultural Organization (UNESCO), Zambia is reported to be one of the countries in the Southern part of Africa that has a high level of illiteracy. The rate of education in Zambia is about 33.8% of the total population and women are outnumbered by men.⁵⁸ This alarming news is an appeal to collaborate with stakeholders to enhance educational standards in Zambia. Since access to education is everyone's right,⁵⁹ women ought not to be denied their opportunities to learn. In my ethnic culture, we say that when you teach a woman you have taught the whole village.

2.5.4. Availability of Food and Nutrition

Food and health assets are inseparable, implying that eating the right food adds to the health of health seekers. A major concern which requires attention in this regard is the availability of food at affordable prices. In the report of de Gruchy et al for the WHO, they observe that lack

⁵⁵Women's International Network News. 2001. *Zambia: Maternal Mortality Rate Takes Heavy Toll*. <http://www.unfoundation.org>, [Accessed 7th November 2013]. p29.

⁵⁶Jill Olivier, Clarence Tsimpo and Quentin Wodon. 2012. "Do Faith-Inspired Health Care Providers in Africa Reach the Poor more than other Providers?" In: *Mapping, Cost, and Reach to the Poor of Faith Inspired Health Care Providers in Sub-Saharan Africa: Strengthening the Evidence for Faith-Inspired Health Engagement in Africa*, 3,7-24, edited by Olivier, J. and Wodon, Q. p52.

⁵⁷de Gruchy et al. 2006. *Appreciating Assets*. p70.

⁵⁸BALITA. "High Illiteracy Levels in Zambia Worries UNESCO" <http://balita.pn/2009/09/10/high-illiteracy-levels-in-zambia-worries-unesco>. [Accessed 8th November 2013].

⁵⁹United Nations Development Programme. 2013. *Millennium Development Goals*. p22.

of food hastens poor health.⁶⁰ In Zambia, there is one particular Zambian cultural practice that needs to be addressed as it threatens women's health. In the Kaonde culture, chicken eggs are likened to semen which is taboo to be taken orally. This mythical understanding has led to forbidding women to eat eggs. This is a serious myth which deprives women of important nutrients they can get from eggs. Bibler and Lauterbach also argue that food security is hampered by exorbitant food prices in the Zambian context.⁶¹ Lack of food and proper nutrition due to both unaffordable prices and cultural myths affect women's health which, in turn, threatens the life of the entire community.

2.5.5. Human Emotions

De Gruchy et al also found that emotional attitudes can be a threat to health, giving examples of 'worries and stigma'.⁶² Among numerous emotional attitudes that people express, we will consider the two that are in the findings of the research team. For Howard Stone, worrying causes depression and it also distorts the realities of life.⁶³ In the research findings of Gideon Byamugisha, Lucy Steinitz, Glen Williams and Phumzile Zondi, they discuss how stigmatized health seekers suffer from rejection.⁶⁴ These emotional feelings have an effect on the health of men and women.

2.6. Zambians' Perception of Health

According to de Gruchy et al, Zambians understand their health problems to be linked to poverty. They also say that Zambians' health issues are directly connected to their weak public health systems.⁶⁵ Arguing from lived experience, Zambians also perceive health to mean the absence of sickness. In Zambian local languages, when one complains of bad health, they imply that they are regularly sick. In their research, de Gruchy et al report that Zambian people have good ways to express health in their languages and that the word 'health' has diverse expressions which are directly or indirectly connected to their religiosity.⁶⁶

⁶⁰de Gruchy et al. 2006. *Appreciating Assets*. p70.

⁶¹Bibler. and Lauterbach. 2012. *Gender, IFIs and Food Insecurity Case Study*.

⁶²de Gruchy et al. 2006. *Appreciating Assets*. p70.

⁶³Howard, W. Stone. 2008. *Defeating Depression: Real Help for You and Those who Love You*. Vereeniging: Christian Art Publishers.p110-111.

⁶⁴Gideon Byamugisha, Lucy Steinitz, Glen Williams, and Phumzile Zondi. 2002. *Journeys of Faith: Church-based Responses to HIV and AIDS in Three Southern African Countries*. Pietermaritzburg: Cluster Publication. p101.

⁶⁵de Gruchy et al. 2006. *Appreciating Assets*. p68.

⁶⁶Steve de Gruchy. 2007. *Re-Learning our Mother Tongue? Theology in Dialogue in Public Health*.

In Audrey Matimelo's empirical research, she illustrates the perceptions of Zambians with regard to health at different levels. In her writing, she discusses how Zambians' understanding of health is holistic. One is said to be in good health when he/she is at peace with God and physically fit. She further says that the implication of personal good health in the Zambian context includes one's sound state of mind.⁶⁷ Robert Badenberg adds that, in the Zambian context, health is frequently viewed as enjoying peace. He further states that health in Zambian understanding culturally refers to "wholeness, strength, purity, or blessing"⁶⁸ It is a common and cultural practice in Zambia for one's health condition to be summarised in a greeting. Zambians' greetings are not brief. They are courteous and intended to convey the right message of one's condition. For instance, in a Zambian cultural greeting, a question like 'how is home?' is an indirect but courteous way of finding out one's condition which compels one to include his/her health situation in his/her response. The strength of such a greeting is that it cements relationships, a core value in Zambian culture.

In the same vein Daniel Johannes Louw asserts that in the African context, health is understood to be a concern for the whole community. And one's illness implies that the community is affected.⁶⁹ Louw hypothesizes that one's healing means healing the whole village and so healing becomes the community's imperative. Within the parameters of Engendered Communal Theology framework, the African understanding of health is situated in the community denoting that one person's illness affects the whole community.⁷⁰ On the contrary, in the urban setting, intercultural behaviour seems to be watering down the typical African values. This situation needs adequate attention and to be properly addressed by cultural and religious leaders in respect of preserving the rich values of Zambians.

2.7. The Participation of Women in the Awareness of ARHAs in Zambia

In their study, de Gruchy et al describe the participants in the research workshops held in Zambian Faith Communities. ARHAP made sure that there was an equal representation by all

www.brill.nl.rt. [Accessed 3rd June 2013],p63

⁶⁷Audrey Matimelo. 2007. *The Impact of Faith-healing Pentecostal Churches on Health and Well-being among Health-seekers in Ndola, Zambia*. p33.

⁶⁸Robert Badenberg. 2002. *The Body, Soul and Spirit Concept of the Bemba in Zambia*. Bonn: VKW Mission Academics 9. p50.

⁶⁹Daniel Johannes Louw. 2011. "Pastoral Care and Counselling" In: *Counselling People of African Ancestry*, edited by Mpofo, E. Cambridge: Cambridge University Press. p161.

⁷⁰Louw. 2011. Pastoral Care and Counselling. p162.

the Faith Communities they invited to the workshops. Although women were more numerous than men in the workshops, they observed that women were not free to participate fully in the presence of men. Further, despite there being a greater number of women attending the workshops than men, there were few women at leadership levels in the workshops.⁷¹

Similarly, PACSA's findings in Malawi, Zambia and South Africa tie with ARHAP's empirical research in which both reports agree that women outnumber men in Churches.⁷² PACSA also argues that women are more active in terms of financial contributions and play healing roles in spite of their being denied opportunities to serve at leadership level.⁷³ It can also be argued that women's leadership not only represents women but men too. This understanding complies with the Engendered Communal Theology framework because of its inclusive nature.

It should be noted that participation in the awareness of health assets begins at informal or formal leadership levels where women's leadership is to be appreciated as well. As the Engendered Communal Framework states, women are very much willing to collaborate with men which requires men to reciprocate.

One of the reasons for women's underrepresentation at leadership levels could be attributed to domination of males. This is a cultural practice which precludes mutuality because men claim to be above women. The other reason, from experience, is that some Zambian men are adamant that they will not attend functions that are led by women. This is a societal ill which ARHAP probably could not have noticed during their period of research in Zambia. In the Engendered Communal Theology framework, men's regressive attitudes inform the message women theologians are advocating about gender equality.

Dorothy Roberts observes that accepting patriarchal domination means subjecting women to inferiority.⁷⁴ Susan Rakoczy has a more insightful approach to patriarchy. In her scholarly argument, she holds that in Latin culture, it is only men who should be heard.⁷⁵ This cultural

⁷¹de Gruchy et al. 2006. *Appreciating Assets*. p66.

⁷²de Gruchy et al. 2006. *Appreciating Assets*. p66.

⁷³Pietermaritzburg Agency for Christian Social Awareness. 2008. *Audit of Gender Related Policies in Southern African Churches*. Pietermaritzburg: PACSA. p7.

⁷⁴Dorothy Roberts. 1997. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Pantheon Books. p5.

⁷⁵Susan Rakoczy. 2004. *In Her Name*. Pietermaritzburg: Cluster Publications. p10.

practice attempts to position women as inferior human beings to men in all facets of their lives. Louw posits that the vulnerability of women in African context is accelerated by patriarchal influence.⁷⁶

The necessity to empower women to make informed decisions is well noted by Anne Clifford who posits that a male dominated society often inhibits women from participating as leaders where they can take part in decision-making and policy-making. Nyirongo argues that the core reason for women's dependence on men for decision-making is because of traditional counselling which holds men in high esteem.⁷⁷ She adds that in a cultural framework, women continue to live under oppression because they are not given autonomy to make independent decisions on issues related to their lives.⁷⁸ In the documents analysed by the United Nations Division for the Advancement of Women (UNDAW), women ought to be given their rightful positions in decision-making.⁷⁹ Even in issues of health, Cain advocates that women be given the freedom to decide.⁸⁰ Liberty to make informed decisions allows women to participate in the activities of the community.

Equality in decision-making opportunities at national and international levels is seen by the United Nations to result in enhanced socio-economic activities. Women's participation in decision making empowers them to redeem their identity and dignity. It also enhances women's potential to build and unify the community which is a fulfilment of their vision.

Considering the above observations, it seems therefore that exclusion of women undermines the value of their contributions to the access of health assets. This social ill requires reconstruction to allow communal participation in the delivery of health assets to the community. It is for this reason that religion ought to address pertinent issues that surround gender inequality so that women can be afforded their rightful position in the community and engage in the awareness of religious health assets.

⁷⁶Louw. 2011. Pastoral Care and Counselling. p163.

⁷⁷Nyirongo, L. 2014. *Creating Gender Synergy in Top Decision Making Roles in Profit and Non – Profit Organizations: Women and Men in Management/Leadership: Yesterday, Today and Tomorrow*. Kitwe: Pioneering Performance Books Ltd. p96.

⁷⁸Anne N. Clifford. 2002. *Introducing Feminist Theology*. Maryknoll: Orbis Books. p164.

⁷⁹United Nations Division for the Advancement of Women. 2005. *Equal Participation of Women and Men in the Decision-Making Processes with Particular Emphasis on Political Participation and Leadership*. p3.

⁸⁰J.M. Cain. 2000. A Global Overview of Ethical Issues in Women's Health. In: *International Journal of Gynaecology and Obstetrics*.70.<http://www.elsevier.com/locate/ijgo>. [Accessed 4th November 2013]. p170.

2.8. Research Activities of ARHAP in Other African Countries

ARHAP did not only carry out its research activities in Zambia but its undertakings were extended to other countries. First of all, it is important to highlight ARHAP's work in these countries with a view to establishing how Zambia is connected to them. This study summarizes the report issued by Beverly Haddad et al regarding their findings in the Democratic Republic of Congo, Mali and Kenya. In addition, it considers the report issued by Barbara Schmid et al for their research carried out in Mali, Uganda, Ghana, Nigeria and Senegal. It also provides a synopsis of the report of Haddad et al for the work of ARHAP carried out in Malawi and shows the findings of de Gruchy et al in Lesotho.

2.8.1. Democratic Republic of Congo (DRC)

The research work in the DRC found that there were collaborative efforts in fighting against health issues. Beverly Haddad, Jill Olivier and Steve de Gruchy found that the collaboration of religious entities with health professionals could be traced as far back as over a century. The first hospitals in the DRC were those that were established by Church missions. Church-based hospitals have continued to work in partnership with the government in the delivery of health services up until now.⁸¹ Like many other countries, Haddad et al write, the DRC has a sound network with other health service providers and donors at international level, most of which were umbrella organizations. They note that the level of participation of Christians in the fight for health is highly commended.⁸² They also report that Christians associated the HIV and AIDS pandemic with other social issues within the country. Notwithstanding doctrinal differences, Churches have pledged their allegiance to partner with ARHAP in their awareness campaign in the fight for health. Churches accepted the blame for not providing pastoral guidance for good health.⁸³

2.8.2. Mali

Schmid et al, Elizabeth Thomas, Jill Olivier and James Cochrane say that the Christian tradition seemed to be making much more effort to provide health care compared to that of the Muslims in Mali, where, initially, Muslims had no intentions to venture into health service delivery. They explain that the Association of Evangelical and Protestant Groupings

⁸¹Beverly Haddad, Jill Olivier, and Steve de Gruchy. 2008. *The Potential and Perils of Partnership: Christian Religious Entities and Collaborative Stakeholders Responding to HIV and AIDS in Kenya, Malawi and the Democratic Republic of Congo: An ARHAP Report*. Cape Town: ARHAP.P98.

⁸²Haddad, Olivier and de Gruchy. 2008. *The Potential and Perils of Partnership*. p107.

⁸³Haddad, Olivier and de Gruchy. 2008. *The Potential and Perils of Partnership*. p108.

in Mali had much control of Church related health facilities. In most of the regions of Mali, Schmid et al write, Malians adapted to all methods of healing such as through the use of prayers, consulting traditional healers and using conventional medicine.⁸⁴ Some religious leaders had shown keen interest in co-ordinating a network of health seekers and health service providers. Schmid et al also discovered that there was still a practice of discriminating against women, in both Christianity and Islam. They also observed that there was a lack of empowering women by way of giving them education.⁸⁵ The practice of giving out resources to the poor is quite comforting especially to health seekers yet it is oppressive in some way because it does not empower women and men to be self-reliant. In terms of teamwork with the government, Schmid et al suggest that there was insignificant partnership with the government and Non-Governmental Organizations seemed to be co-ordinating amongst themselves.⁸⁶

2.8.3. Kenya

With ARHAP's research in Kenya, Haddad et al recorded that Kenyans were religious with the population predominantly professing Christianity. The participation of religious entities in the health and wellbeing of the people dated back to the early 1900s - work which has continued to today. Noting the work of the Church in Kenya, the report says that mainline Churches contributed remarkably to the delivery of health services by providing health centres, especially in the rural areas. Those from the Islamic faith had also been recorded as contributing to the delivery of health services, though not significantly.⁸⁷

Haddad et al found that Kenyan Churches at ecumenical level collaborated to provide health services to health seekers. Further, the level of networking between Churches and Non-Governmental Organizations was noted with appreciation. Unlike in the past, Churches were now able to access funding from donors through the establishment of co-ordinated networking.⁸⁸

⁸⁴Barbara Schmid, Elizabeth Thomas, Jill Olivier, and James Cochrane. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. Unpublished Report: ARHAP. www.arhap.uct.ac.za [Accessed 11th November 2013] p52.

⁸⁵Schmid et al, 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. p53.

⁸⁶Schmid et al, 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. p53.

⁸⁷Haddad, Olivier, and de Gruchy. 2008. *The Potential and Perils of Partnership*. P35.

⁸⁸Haddad, Olivier, and de Gruchy. 2008. *The Potential and Perils of Partnership*. P42.

Haddad et al add that firstly, the Kenyan social context had influenced the spread of the HIV and AIDS pandemic. Secondly, Kenyans sought to make measures to prevent HIV and AIDS. Thirdly, Kenya had a strong collaborative network of religious entities and other stakeholders. Fourthly, there was also willingness to formulate strategies and policies with donors in an effort to strengthen partnerships.⁸⁹

2.8.4. The Kingdom of Lesotho

The research which was carried out in the Kingdom of Lesotho was done concurrently with that which was carried out in Zambia under the sponsorship of the World Health Organization. Priority was given to Zambia and Lesotho due to their similar health circumstances at the time.⁹⁰ Like Zambia, de Gruchy et al write that Lesotho is a landlocked kingdom that was also colonised by the British.⁹¹

De Gruchy et al's research indicated that a large percentage - up to 91% - were Christians, implying that the remaining 9% represented other religions. This is significant data though it does not negate the efforts of other religions in respect of their contributions to the understanding of African religious health assets.⁹² Lesotho contributed remarkably to ARHAP's research by providing a context in which they found it easy to explore the collaboration between religious entities and public health assets within the ambit of Africa.⁹³

De Gruchy et al reported that the people of Lesotho aligned their struggle for health to the political uncertainty.⁹⁴ The study found that the Sothos felt the use of drugs and consumption of alcohol in the urban townships was retrogressive to the campaign for health. The Kingdom of Lesotho was advantaged in one way through the proliferation of Churches in the country, as these contributed a great deal to health.⁹⁵ This added to the number of religious health assets which was the core interest of this work.⁹⁶ Counting the factors which contributed to the undermining of health in the Kingdom of Lesotho, de Gruchy et al found the following: "water and drought, food and hunger, Church, farming, health, education, shelter and

⁸⁹Haddad, Olivier, and de Gruchy. 2008. *The Potential and Perils of Partnership*. p62.

⁹⁰de Gruchy et al. 2006. *Appreciating Assets*. p7.

⁹¹de Gruchy et al. 2006. *Appreciating Assets*. p93.

⁹²de Gruchy et al. 2006. *Appreciating Assets*. p94.

⁹³de Gruchy et al. 2006. *Appreciating Assets*. p94.

⁹⁴de Gruchy et al. 2006. *Appreciating Assets*. p103.

⁹⁵de Gruchy et al. 2006. *Appreciating Assets*. p105.

⁹⁶de Gruchy et al. 2006. *Appreciating Assets*. p108.

unemployment.⁹⁷ Not only were they a threat to health in Lesotho but also in Zambia. Nevertheless, de Gruchy et al write that there is great appreciation of the pivotal role that the Church was playing to enhance health and its advocacy in the Kingdom of Lesotho.⁹⁸

2.8.5. Malawi

According to Haddad et al's report, Malawi's percentage of Christianity was higher than any other country in the region. It was also noted that the Church played a significant role in national matters, of which one of them was health.⁹⁹ Haddad et al also noted that the collaboration of Faith Communities and government institutions was evident at different levels.¹⁰⁰ Other findings within the religious movements affirmed the way religious movements collaborated.¹⁰¹ As regards the promotion of universal access, Haddad et al reported that Malawi was committed to teaching the youth about prevention of HIV and AIDS and played a pivotal role in the distribution of ARVs.¹⁰² Some of the strengths of the religious movements as observed by Haddad et al included the religious movements' access to the grassroots people and the availability of resources at their disposal.¹⁰³

2.8.6. Uganda

Through ARHAP's research, Schmid et al found that Uganda was among the countries in Sub-Saharan Africa with poor health facilities. Owing to this crisis, access to health assets by women and men was very limited even though Uganda's demand for health services was very high. Nonetheless, Schmid et al further observed that there were efforts by religious leaders to avert the situation and that the majority of health seekers use alternative ways to find health assistance. Religious leaders were networking to disseminate information about other health assets and to improve the existing ones other than traditional medicine because of their religious beliefs.¹⁰⁴ Schmid et al acknowledged the work of principle Faith Based Organizations (FBO) in delivering religious health assets as follows: First, the Uganda Protestant Medical Bureau (UPMB) was a link between Church-administered hospitals and the Ugandan Government through the Ministry of Health. It also played the role of

⁹⁷de Gruchy et al. 2006. *Appreciating Assets*. p109.

⁹⁸de Gruchy et al. 2006. *Appreciating Assets*. p114.

⁹⁹Haddad et al. 2008.*The Potential and Perils of Partnership*. p66.

¹⁰⁰Haddad et al. 2008.*The Potential and Perils of Partnership*. p75.

¹⁰¹Haddad et al. 2008.*The Potential and Perils of Partnership*. p81.

¹⁰²Haddad et al. 2008.*The Potential and Perils of Partnership*. p83.

¹⁰³Haddad et al. 2008.*The Potential and Perils of Partnership*. p86.

¹⁰⁴Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. p70-71.

channelling grants from the Government to member Church-administered hospitals and participated in policy making. Second, the Uganda Catholic Medical Bureau (UCMB) was overseeing the procurement of medicines and medical equipment as well as their equal distribution. It was also keen in recruitment of medical staff while maintaining its faithfulness to the bureau's vision. Third, Islam was also running its own organizations in an effort to meet the required distribution of religious health assets to health seekers.¹⁰⁵ In terms of general collaboration, Schmid et al understand that there was a strong networking system making headways to deliver health services to health seekers.¹⁰⁶

2.8.7. Ghana

In Ghana, the findings of Schmid et al show that the biggest Christian organization which was engaged in distributing religious health assets was the Christian Health Association of Ghana (CHAG). CHAG was a mediating organization between Church-administered hospitals and the Ghanaian government. Its service delivery extended to the communities and was involved in the procurement and distribution of medicines in the country.¹⁰⁷ Schmid et al further reported that one of the outstanding roles of CHAG was its involvement with the rural community and its religious health assets. It is also worth noting that CHAG's involvement with the rural communities extended to having keen interest in women's health. CHAG was interested in delivering obstetric services to women.¹⁰⁸ Schmid et al found that the services offered in poverty stricken rural areas helped health seekers avoid travelling long distances in order for them to access health assets. In their findings, Schmid et al add that in terms of collaboration between the government and Faith Based Organizations, Ghana's integration was exemplary and worth emulating. In the midst of freedom of worship, Ghana welcomed dialogue among stakeholders in order to distribute health assets equitably to health seekers. By doing so it created a platform for traditional healers, Church leaders and health professionals to converse on issues of common interest.¹⁰⁹

2.8.8. Nigeria

In the same vein, ARHAP's research was extended to Nigeria, a country that is well known for its large population in Africa. Schmid et al reported that Nigeria's mortality rate was

¹⁰⁵ Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. P70-71.

¹⁰⁶ Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. P70.

¹⁰⁷ Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. P54.

¹⁰⁸ Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. P55.

¹⁰⁹ Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. P55.

highest in the rural areas where more than half of its population live. Churches Health Association of Nigeria (CHAN) was engaged in the distribution of religious health assets to the needy. CHAN faced the challenge of delivering religious health assets to rural areas by increasing the labour force through training. CHAN trains traditional midwives and was also teaching the community about nutrition as a source of health lifestyles. Further, CHAN played a pivotal role of advocating for its affiliates. In the midst of conflicts between Christianity and Islam, CHAN persevered to play its role of advocacy with a vision to distribute religious health assets to women and men. CHAN was facing a challenge from mainline Churches with regard to interacting with proliferating Churches and ecumenical co-operation. Schmid et al observed that related to enhancing religious health asset understanding, Nigeria remained with the challenge of studying interfaith dynamics with a view to strengthening ecumenical collaboration especially around health.¹¹⁰

2.8.9. Senegal

ARHAP's research in Senegal, reported by Schmid et al, showed the distribution of religious health assets. In this country where Christians are outnumbered by Muslims, there were many more challenges than elsewhere. Since delivery of health services was not the primary vision of the Muslims, Christians in their minority strove to do their best. The Catholic Church appeared to be in the forefront of delivering health assets to the health seekers.

In their further research, Schmid et al observed that even though the participation of Muslims was insignificant in Senegal, there was some positive response from them in respect of HIV and AIDS.¹¹¹

2.8.10. The Significance of Articulating Zambia's Connectivity to Other African Countries

The purpose of articulating the works of ARHAP in other countries is to show the validity and dependability of the program. The countries that this study has included have health issues similar to those of Zambia and so their inclusion shows the networks that Zambia is part of. Zambia is affiliated to the Africa Christian Health Association Platform (ACHAP) where it shares knowledge on how best RHAs can be distributed to health seekers equitably. Through its involvement with ACHAP, it also participates in the Christian Health Network

¹¹⁰Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. P56-57.

¹¹¹Schmid et al. 2008. *The Contribution of Religious Entities to Health in sub-Saharan Africa*. P58-59.

(CHN).¹¹² According to Elias Bongmba, ACHAP's role is to strengthen collaborations between its affiliates and their respective governments.¹¹³ Zambia benefits from ACHAP whenever there is a shortage of personnel to distribute health assets.¹¹⁴

One similarity that Zambia shares with the countries discussed in this chapter is the collaboration of religious and secular institutions' health assets. It should also be argued that Zambia does not work in isolation in its endeavors to distribute health assets that are in its possession. Using the theory of Engendered Communal Theology, while making reference to Zambia's indigenous knowledge, Zambia needs the cooperation of other countries with similar health challenges to maintain its communities. This notion is also strengthened by Louis Currat who argues that health issues cannot be solved single-handedly but in collaboration.¹¹⁵

Because of the commonality of health related issues, efforts are to be combined to strengthen awareness and health service delivery systems in Zambia. The inclusion of countries that ARHAP has worked in demonstrates their connection with Zambia as they face similar issues.

2.9. Conclusion

This chapter has responded to the research question, 'What is the background research work done by ARHAP in Zambia?' It has shown the development of ARHAP and its activities at continental level. It has provided an explanation about what ARHAP is, ARHAP's background, the vision and the main objectives, as well as its partners and their contributions. A synopsis of ARHAP's research activities was presented using nine of the African countries in which research was undertaken. It has shown similar situations that connect Zambia to other African countries. The chapter has demonstrated the context in Zambia and has articulated Zambians' understanding of health.

¹¹²The Health Voice. 2013. *Government Commend CHAZ for Raising Awareness on Non-Communicable Diseases as CHAZ host the ACHAP 6th Biennial Conference*. Lusaka: CHAZ.p7.

¹¹³Elias, K. Bongmba. 2012. "Rethinking Old Alliances: Religion and Public Health in Africa. p247-263. In: *Living on the Edge: Essays in Honor of Steve de Gruchy Activist and Theologian*, edited by Cochrane, J.R., Bongmba, E., Phiri, I. and Water, D. Dorpspruit: Cluster Publications. p250.

¹¹⁴Bongmba. 2012. "Rethinking Old Alliances. p250.

¹¹⁵Louis J. Currat. 2006. "The Global Health Situation in the 21st Century: Aspects from the Global Forum on the Health Research and the World Health Organization in Geneva," *International Review of Mission*, 95/376-377 (January/April), 7-20. p16.

With regard to ARHAP's findings in Zambia, this chapter has discussed the religious and political situations. It has also looked at the cultural and economic contexts in Zambia. In further argument, this chapter has argued that within the context of Zambia, poverty is the cause of major setbacks in the awareness of RHAs. In addition, the chapter discussed the participation of women in the awareness of RHAs. In this section it was argued that women were very willing to participate in this noble task because of their vision to maintain the community. The chapter ended with highlighting ARHAP's research activities carried out in other African countries with similar challenges. The purpose was to show that Zambia shares health similarities with, and is thus connected to, other countries. The next chapter will discuss in depth the value of RHAs to Zambians, as identified by ARHAP.

CHAPTER 3

UNDERSTANDING THE VALUE OF AFRICAN RELIGIOUS HEALTH ASSETS TO THE ZAMBIANS

3.1. Introduction

The preceding chapter presented the background of ARHAP, its activities in Zambia and other African countries which have similar health challenges. This chapter answers the question, ‘How valuable are the RHAs that were identified in the activities carried out by ARHAP in Zambia?’ It discusses in detail religious health assets and how they influence the community. Since ARHAP’s focus is on African Religious Health Assets (ARHA), this chapter will discuss what ARHAP defines as tangible and intangible assets, then focuses on ten religious health assets included in tangible and intangible assets as identified by ARHAP. In this chapter, the RHAs are as they were identified by ARHAP though I have organised them in my own format. The purpose of discussing these assets is, first, to show what other scholars say about RHAs in order to add more value to them. Second, this chapter shows the value of RHAs so that Zambian communities can appreciate them.

3.2. What are Religious Health Assets (RHAs)?

In the arguments of de Gruchy et al, Religious Health Assets are values imbedded in individuals and physical facilities which are there and always available to be used. They are situated within the adherents of any religious movement and are held by religious entities for the purpose of enhancing the health and wellbeing of human beings.¹¹⁶ Religious health assets are valuable and so understanding and utilizing them adds more value to human life. In order to assess and appreciate RHAs in Zambia, ARHAP framed its research within Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA) tools. This toolset is used to inquire into and frame the available RHAs in communities. To de Gruchy et al, the initial intention of using the PIRHANA toolset was to produce information that could empower the community.¹¹⁷ This value of empowering the community fits into the parameters of the Engendered Communal Theology Framework.

¹¹⁶de Gruchy et al. 2006. *Appreciating Assets*. p39.

¹¹⁷de Gruchy et al. 2011. “Participatory Inquiry on the Interface between Religion and Health. p58.

3.2.1. Description of Tangible and Intangible Religious Health Assets

The terms ‘tangible and intangible’ health assets refer to visible and invisible health assets. These are assets that can be seen and touched and those that cannot be seen and touched. Seen in Mary Mwiche’s work, intangible assets in the frame of ARHAP are Christian norms which when practiced can enhance the health of health seekers. She explains that intangible assets have direct and indirect effects on human health.¹¹⁸ Matimelo gives examples of the tangible and intangible effects on health. She says that tangible assets which have direct results on health are those such as Churches which practice healing sessions and traditional healers. Intangible assets which have indirect results include the art of motivation, prayers and advocating for noble character.¹¹⁹ It is also important to note that Religious Health Assets work together when tangible and intangible assets are intertwined. One example is when individual adherents [tangible] belonging to a particular religion come together to motivate [intangible] and express their love to health seekers.¹²⁰

Kabwe states that tangible religious health assets are seen in structures such as Church buildings, all their Church-related premises including those which are intended for worship. This description includes all the activities that take place at the Church and in all the hospitals and health centers.¹²¹ These assets are deemed to enhance health outcomes either directly or indirectly. Some Churches also run hospices that are run similar to hospitals in which bedridden patients are taken care of.

A significant explanation about intangible religious health assets is also highlighted by Kabwe. Intangible religious health assets are the invisible ones serving the same purpose of enhancing the health of health seekers. Although they are difficult to talk about in terms of quantity, their significance is not to be underrated. According to Kabwe, these assets include Church activities which create a positive outlook or have positive effects on health seekers. Further, intangible religious health assets are those which contribute to health seekers’ ability to endure their conditions. This endurance leads them to live positively.¹²²

¹¹⁸Mary, Z. Mwiche. 2008. *The Church and Health: An Examination of the Contribution of Local Churches to Health and Wellbeing in Ndola, Zambia*, Unpublished dissertation (MTh). University of KwaZulu Natal, Pietermaritzburg. School of Religion and Theology. p40-41.

¹¹⁹Matimelo. 2007. *The Impact of Faith-healing Pentecostal Churches*. p44-45.

¹²⁰ARHAP, 2007. “ARHAP International Colloquium” p45.

¹²¹Kabwe.2008. *Local Churches and Health*. p49.

¹²²Kabwe.2008. *Local Churches and Health*. p50.

The act of praying for health seekers is one practical instance of an intangible religious health asset. De Gruchy et al rightly refer to intangible religious health assets as deeds of caring and compassion. They further hold that these assets also support health seekers materially.¹²³ Even though these assets are the same have the same meaning as those offered by secular organizations, we cannot leave out what religious bodies are able to offer. More detail on tangible and intangible religious health assets will be given in the following sections.

3.3. Tangible and Intangible Religious Health Assets

According to de Gruchy et al, RHAs are defined as shown below.¹²⁴ This study has added 'Traditional Healing' and 'The Church' (Faith Community).

¹²³de Gruchy et al. 2006. *Appreciating Assets*. p39.

¹²⁴de Gruchy et al. 2006. *Appreciating Assets*.p77-78.

Figure 2

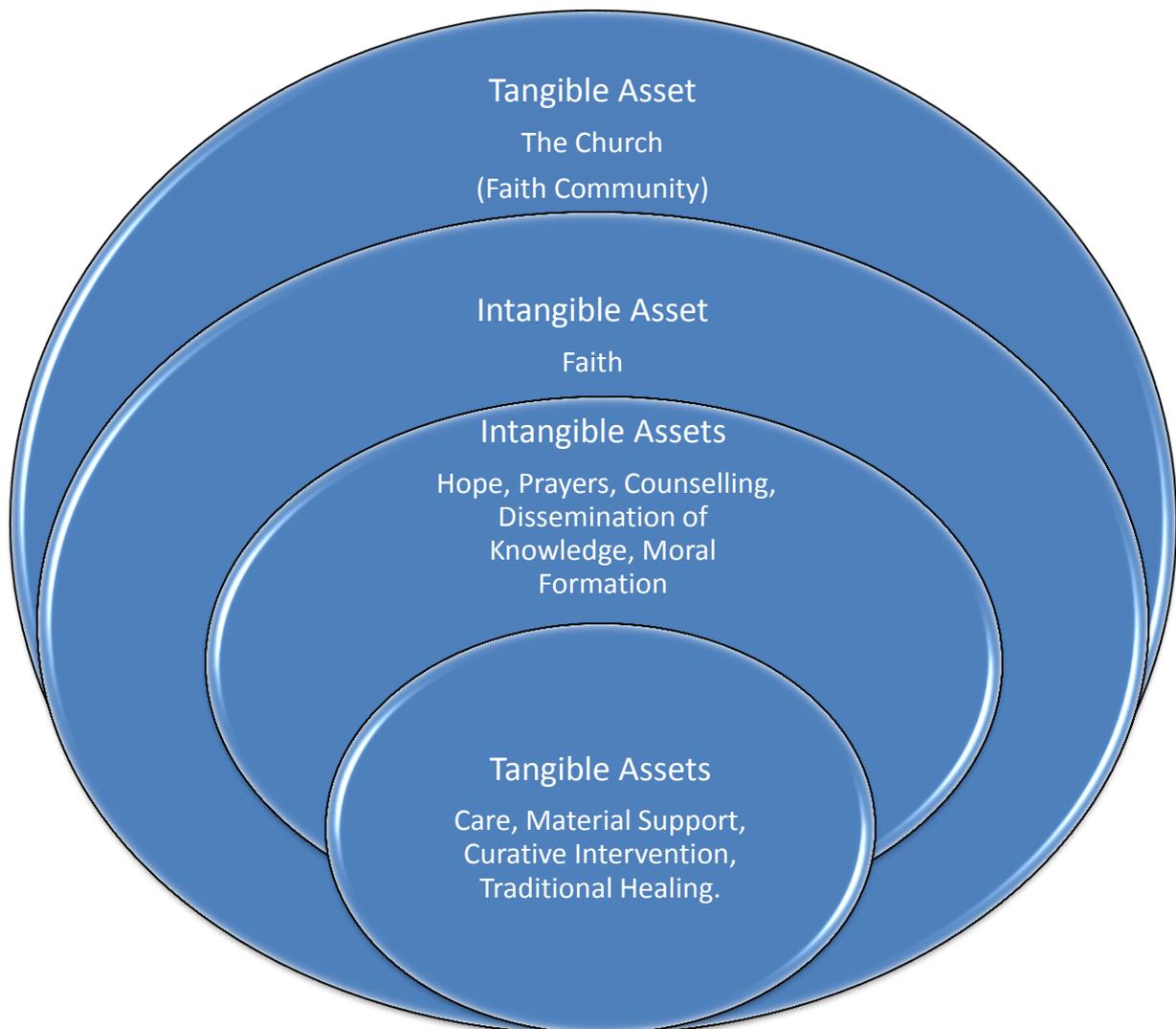


Figure: 2. The outer circle shows the significance of the Church as the key RHA that embraces the rest of the RHAs. The second outer circle shows the importance of Faith in the administration of the rest of the RHAs. The two inner circles illustrate that the rest of the RHAs are dependent on a faith community (the Church) in which faith is expressed in tangible ways. This implies that the Church is a visible asset in which the rest of the RHAs are situated.

3.3.1. *The Church as a Religious Health Asset*

In the findings of ARHAP, de Gruchy et al observe that the Church is the second most integral asset to government run health institutions in respect of contributing to humanity's health.¹²⁵ It is therefore, unavoidable to discuss the issue of health without the Church. It is the responsibility of the Church to ensure its members are in good health. Jean-Marc Ela articulates this eloquently from the African perspective. Ela says that adherents, as first hand religious health assets, ought not to be deprived of their intelligence in dealing with health matters.¹²⁶ He argues that the Church is capable of coaching its adherents and equipping them to take care of each other. Ela further argues that human beings exist to help each other responsibly.¹²⁷ This implies that the Church together with its adherents form the most integral RHA in which the rest of the RHAs find their origin.

3.3.1.1. *The Description of the Church*

The word Church can be traced to Greek origins according to Douglas and Merrill Tenney. They posit that the word Church is a translation of the Greek word 'kuriakos' which means 'belonging to the Lord'. They also add that the word Church comes from another Greek word 'ekklesia', equivalent to the word *congregation*.¹²⁸ The word 'Church' in this study implies local Christian believers' assemblies at denominational and non-denominational levels. It is also applied to Christian based organizations and individual voices that are biblically oriented. In the description of the Church, the word 'belonging' directly interprets the African concept of the community which also emphasizes the sense of belonging. This point is well articulated in chapter one and is appropriate within the Engendered Communal Theology Theoretical framework.

Local people in Zambia understand the Church to be a venue they go to on Sundays to worship God. This understanding paves the way for the Church to extend its services to enhance health and wellbeing of the community. The Church is proactive, implying that it is meant to impact the lives of the health seekers lest it loses its purpose and mission to humanity. The Church is both a tangible and intangible asset in its association with the awareness and distribution of religious health assets. First, as a tangible asset it has Church

¹²⁵de Gruchy et al. 2006. *Appreciating Assets*. p74.

¹²⁶Jean-Marc Ela. 1988. *My Faith as an African*. Maryknoll: Orbis Books. p83.

¹²⁷Ela. 1988. *My Faith as an African*. p83.

¹²⁸J. D. Douglas and Merrill, C. Tenney.(eds.) 1987.*New International Bible Dictionary*. Grand Rapids: Zondervan. p218-219

facilities, such as buildings and the activities it embraces. Second, it is an ecumenical body of those who profess the Christian faith.

3.3.1.2. The Purpose and Mission of the Church in Relation to Health Asset Awareness

The mission of the Church is well articulated in the works of David Bosch. In his scholarly work, Bosch observes that God's intention for humanity is to receive salvation through the mission of the Church.¹²⁹ In the same line, Clifford Madondo argues that practicing faith in the ecumenical Church makes the Church visible to the community. Its obedience to the mission of God makes it accessible by health seekers.¹³⁰ Drawing from the mission of Jesus, the Church takes upon itself the mandate to emulate its master by delivering health services.¹³¹ Emmaus Haankomone adds that healing is a principal ministry of Jesus, thus the contemporary Church also makes it its principal ministry.¹³² Since the Church is part of the community, it is observed here that members of the community ought to utilize it because its availability is a channel of understanding and distributing RHAs by health seekers and health care providers alike. Therefore, affiliating one to the community and Church community creates a strong sense of belonging which suites in the Engendered Communal theology framework.

3.3.2. Faith as a Religious Health Asset

In the context of Christianity, faith is best explained in the light of Christian theology within the confines of the Church and its related ministries. This implies that some biblical terminologies may be used to explain what it means. Faith is a term synonymously used to mean trust.

3.3.2.1. The Description of Faith

In a lay-person's language, the absence of faith simply implies failure to believe. Faith is also explained as absence of doubt. Yet, the Bible uses some terminology to help us comprehend what it means. The key words and phrases, paraphrased, are assurance of what is hoped for

¹²⁹David J. Bosch. 1991. *Transforming Mission: Paradigm Shifts in Theology of Mission*. Maryknoll: Orbis Books. p8-10.

¹³⁰Clifford, C. Madondo. 2009. *An Emerging form of the Church? Community-Based Volunteers in HIV and AIDS Work as Religious Health Asset*. Unpublished dissertation (MTh).University of KwaZulu-Natal, Pietermaritzburg. p71.

¹³¹Luke 4:18 Part of the mission of Jesus was to recover the sight of the blind.

¹³²Emmaus Haankomone. 2013. The Healing Ministry of the Church; Why is the Church in Health Service Delivery? In: *The Health Voice*. 2013. *Government Commend CHAZ for Raising Awareness on Non-Communicable Diseases as CHAZ host the ACHAP 6th Biennial Conference*. Lusaka: CHAZ. p5.

and to be certain of what is unseen.¹³³ In addition, Christians teach that faith is applied to unseen things.¹³⁴ The fullness of hope and the assurance of what is hoped for is an act of faith. Kristofer Hagen has written extensively about faith and its connection to health matters. Hagen notes that “Faith in God is so important to good health”. He goes on to say that faith results in an intimacy with God.¹³⁵

Faith is seen as a key word in the process of healing. In the ministry of Jesus, words like “Your faith has saved you...”¹³⁶ are repeatedly used, implying that faith is used as a catalyst to invoke spiritual powers. Katherine Marshall’s understanding of faith is that it is an inner conviction or belief expressed in a particular religious setting.¹³⁷ In the work of Hornby, it is stated that faith is “a strong religious belief”.¹³⁸ Not negating the other articulations about faith, this sounds more appropriate with reference to the topic at hand.

In religious circles, faith cuts across all religions with diverse dogmatic expressions. In the case of health seekers, faith is one of the ingredients which can help them to be resilient in their different conditions. In more specific terms, according to Christian teachings, faith is a resource that the despondent can fall back on.¹³⁹ In the research findings of ARHAP, it is said that Zambians’ faith is expressed in their religiosity because religion is ‘central’.¹⁴⁰ In light of this finding, Africans’ faith becomes one of the most vital elements to their health. Faith is expressed in both tangible and intangible religious practices. Christianity teaches that faith is made manifest and meaningful when complemented by deed.¹⁴¹ So, health seekers’ health is enhanced by the way care givers express their faith when attending to them.¹⁴²

¹³³Hebrews 11:1 Faith is the assurance and certainty of what we hopefully look forward to.

¹³⁴2 Corinthians 4:18 Faith means focusing on what is not visible because what is invisible is everlasting and what is visible is temporary.

¹³⁵Kristofer Hagen.1961. *Faith and Health*. Philadelphia: Muhleberg Press. p12-13.

¹³⁶Luke 7:50 “Your faith has saved you, go in peace”

¹³⁷Katherine Marshall. 2011. “Frontiers of Public Health and Social Transformation: Faith at the Table” Pages 212-234. In: *When Religion and Health Align: Mobilising Religious Health Assets for Transformation* edited by Cochrane, J.R., Schmid, B., and Cutts, T. Pietermaritzburg: Cluster Publications. p214.

¹³⁸A. S. Hornby. 2006. *Oxford Advanced Learner’s Dictionary of Current English (7th Edition)* Oxford: Oxford University Press. p527.

¹³⁹Philip Yancey. 2001. *Where is God when it hurts? A Comforting, Healing Guide for Coping with Hard times*. Grand Rapids: Zondervan. p221.

¹⁴⁰de Gruchy et al. 2006. *Appreciating Assets*. p21.

¹⁴¹James 2:17 “...faith by itself if it is not accompanied by action, is dead”

¹⁴²Madondo. 2009. *An Emerging form of the Church*. p67.

3.3.2.2. *The Contribution of Faith to Health*

Hagen holds that faith in God leads to health seekers to accept medicine as within the will of God.¹⁴³ His opinion is that the use of physical medicine is not possible without the application of faith. Faith becomes the foundation of treatment, using either prayers or medicine.

Gideon Byamugisha, Lucy Steinitz, Glen Williams, and Phumzile Zondi have a broader understanding of how faith works in the treatment of disease. Byamugisha et al stress that whatever desires we wish to fulfil in our life depend on our faith. The achievements one wants to make in life rely upon the amount of faith one applies. They say that putting faith in action is an act of faith which plays a pivotal role in one's life. Byamugisha et al also argue that faith is a stimulant.¹⁴⁴ Those who apply it make progress in life personally or collectively [in the community]. They further assert that faith plays an important role in shaping the lives of those who genuinely apply it.¹⁴⁵ Regarding faith in respect to HIV and AIDS, Byamugisha et al witness to how faith works in Churches to fight against the pandemic. In some Churches people form groups which meet on certain days for prayers.¹⁴⁶ One can conclusively say that the application of faith is indeed a contribution to one's health.

One of the notable contributions of faith to health is well explained by Harold Koenig, a specialist in medicine and theology. Harold Koenig cautiously notes that before one receives treatment, faith visualizes one's wellbeing.¹⁴⁷ In another statement, Koenig adds that when one has an ailment, faith lessens it.¹⁴⁸ Faith has an enormous contribution to the understanding and distribution of RHAs. Those who apply it find it meeting their needs, hence prolonging their lives.

¹⁴³Hagen. 1961. *Faith and Health*. p63.

¹⁴⁴Byamugisha et al. 2002. *Journeys of Faith*. p1.

¹⁴⁵Byamugisha et al. 2002. *Journeys of Faith*. p1.

¹⁴⁶Byamugisha et al. 2002. *Journeys of Faith*. p2.

¹⁴⁷Harold, G. Koenig. 1997. *Is Religion Good for your Health? The Effects of Religion on Physical and Mental Health*. New York: The Haworth Pastoral Press. p103.

¹⁴⁸Koenig. 1997. *Is Religion Good for your Health?* p103.

3.3.2.3. Faith and Healthy Lifestyles

It is well noted by de Gruchy et al that moral behaviour can be influenced by religion through practicing faith.¹⁴⁹ Faith is not merely exercised as a way of life but it has some benefits which trickle down to the body and thus keep one healthy. The health of one person is the health of the entire community. Kristofer Hagen enumerates the benefits of exercising faith without hesitation. In the first place, he articulates that faith in God is a pathway to healthy living. Hagen asserts that when one exercises faith, one experiences forgiveness of sins. This experience leads to a life with a clear conscience. According to Hagen, when one's conscience is clear, one is likely to experience a sound sleep. S/he may also experience peace of mind and smooth digestion of food.¹⁵⁰ He adds that there is no physical medicine that when taken can result in having a good conscience. Hagen argues that faith helps one to have good morals. These morals help one to live in harmony with the others in the community.¹⁵¹ Hagen further asserts that when one does not live a life of faith, s/he is likely to have no joy, and lack of it breeds medical problems. He cites the following as examples of the outcome of lack of faith: "ulcers, hypertension, colitis, insomnia, nervousness, weakness, injuries, accidents, etc."¹⁵² It is also insightfully noted by ARHAP that faith produces a peculiar lifestyle and that by consistently exercising it also enhances one's health. Furthermore, ARHAP observes that following a good diet is part of improving one's health.¹⁵³ Bible Alive Ministries (BAM) observes that every diet is sanctified by God implying that unhealthy food can cause sicknesses in the body.¹⁵⁴

Thomas Plante and Allen Sherman have raised several points which are also noted by Koenig. Koenig observes that the consumption of alcohol, unlawful sexual relationships and smoking have adverse effects on one's health. He adds that as a result of refraining from these unhealthy practices, people of faith have fewer complaints about "distress, depression, anxiety and other emotional disorders".¹⁵⁵ Plante and Sherman also argue that people of faith rely upon their beliefs with regard to premarital sexual relationships.¹⁵⁶ Sexual relations

¹⁴⁹de Gruchy et al. 2006. *Appreciating Assets*. p74.

¹⁵⁰Hagen. 1961. *Faith and Health*. p9.

¹⁵¹Hagen. 1961. *Faith and Health*. p10.

¹⁵²Hagen. 1961. *Faith and Health*. p11.

¹⁵³ARHAP. 2007. *ARHAP International Colloquium*. p35.

¹⁵⁴Bible Alive Ministries. n.d. *The Pathway to Health: God's Will is for our Health*. Ndola: Bible Alive Ministries. p3.

¹⁵⁵Koenig. 1997. *Is Religion Good for your Health?* p80.

¹⁵⁶Thomas, G. Plante and Allen, C. Sherman (eds.) 2001. *Faith and Health: Psychological Perspectives*. New York: The Guilford Publications. p3.

mentioned by these authors include extra marital sexual affairs. In the perception of the Evangelical Church in Zambia (ECZ), sex outside marriage, including premarital sex, is viewed as a social ill.¹⁵⁷

Edward Shafranske asserts that as there is no time for clinicians to raise issues of faith when attending to patients; the Faith Communities ought to instil faith in their members prior to receiving any medical attention.¹⁵⁸ In his research Shafranske found that psychologists and physicians reported their acceptance of the fact that certain clients needed the influence of faith for them to be rehabilitated.¹⁵⁹ This is a clear indication that faith plays an important role in reshaping the mind-set of health seekers.

A healthy lifestyle does not rule out death. Jeff Levin observes that even though people of faith are also vulnerable to sickness and death just like the non-religious, they are associated with lower rates of bodily disorders. They are more on the side of well-being.¹⁶⁰ In his research, Levin says that faith is a “protective factor”. Levin specifies that faith directly benefits health by manifesting itself in “hope, optimism, and positive expectation”.¹⁶¹

In other research, George Ellis’s opinions about faith are significant in this discourse. Ellis quotes Frankl, saying that faith produces hope when a person is unable to substantiate himself or herself. In his opinion, faith benefits one in looking forward to a bright future.¹⁶² Hope is also highlighted by Doug Oman and Carl Thoresen. In their commendation of faith, Oman and Thoresen, among other products of faith, mention hope. They say that lack of faith has negative effects on one’s health. Oman and Thoresen observe that lack of faith results in “fear, sadness, and anger”.¹⁶³

¹⁵⁷The Evangelical Church in Zambia. 2008. *Constitution*. Kitwe: Christian Education Department ECZ. p14-15.

¹⁵⁸Edward P. Shafranske. 2001. The Religious Dimension of Patient Care within Rehabilitation Medicine: The Role of Religious Attitudes, Beliefs and Professional Practices” Pages 311-338. In: *Faith and Health: Psychological Perspectives*, edited by Plante, T.G. and Sherman, A.C. New York: The Guilford Publications. p316.

¹⁵⁹Shafranske. 2001. The Religious Dimension of Patient Care within Rehabilitation Medicine. p324.

¹⁶⁰Jeff Levin.2001. *God, Faith and Health: Exploring the Spirituality-healing Connection*. New York: John Wiley and Sons. p8.

¹⁶¹Levin. 2001. *God, Faith and Health: Exploring the Spirituality-healing Connection*. p13.

¹⁶²George Ellis.2006. “On Rationality and Emotion, Faith and Hope: Being Human in a Scientific Age”. In: *The Quest for Humanity in Science and Religion: The South African Experience*, edited by Shutte, A. Pietermaritzburg: Cluster Publications. p23.

¹⁶³Doug Oman and Carl, C. Thoresen. 2002. “Does Religion Cause Health?: Differing Interpretations and Diverse Meanings” *Journal of Health Psychology*, 365-380. p368.

Generally, long life expectancy is everyone's dream. Koenig notes in his research that faith is a factor that prolongs one's life. He attributes this to the fact that many people of faith disagree with social practices which increase the risk of cancerous and heart-related diseases. The awareness and avoidance of such ill behaviours results in lower mortality rates.¹⁶⁴ In the same line, Philomena Njeri Mwaura stresses that faith produces a smooth healing process. She says faith increases hope resulting in optimism.¹⁶⁵ It is difficult to ascertain whether the process of medical treatment has been successful through the use of medicine or faith. In other words, it is not easy to conclude that it is faith or medical treatment which has completed the process of healing. It is noted here that healthy lifestyle benefits the community because it reduces the rate of sickness that leads to death, thus increasing life expectancy.

3.3.3. Hope as a Religious Health Asset

Hope is an intangible asset which is applied to both normal and ill health. According to de Gruchy et al, it is part of Spiritual Encouragement.¹⁶⁶ It prolongs life in the process of waiting to be restored to good health. Hope is applied in both secular medical service delivery and by Faith Communities. Regarding the administration of pharmaceuticals, Yancey asserts that pharmacists are equally not certain about the drugs they dispense. He argues that the greatest element in the case of dispensing drugs to health seekers is human hope.¹⁶⁷ Yancey quotes Harold G. Wolf saying "Hope, faith and purpose in life is medicinal..."¹⁶⁸ He observes that hope is part of the body mechanism that feeds one's will to live. In addition, he says that it is an ingredient in the inner person which is applied to cope with hardship.¹⁶⁹ It also helps a health seeker to remain focused as he/she looks forward to good health. Yancey quotes Paul as saying that hope is realistic when one engages in looking forward to what he/she does not yet have.¹⁷⁰ True hope is based on what is unseen yet it helps the health seeker to see

¹⁶⁴Koenig. 1997. *Is Religion Good for your Health?* p92.

¹⁶⁵Philemona, Njeri Mwaura. 2006. "The Anthropological Dimension of a Patient's Treatment: A Response to Prof. Bernard Ugeux," *International Review of Mission: The Global Health Situation and the Mission of the Church in the 21st Century*. 95/376-377, 36-142. p140.

¹⁶⁶de Gruchy et al. 2006. *Appreciating Assets*. p78.

¹⁶⁷Yancey. 2001. *Where is God when it hurts?* p207.

¹⁶⁸Yancey. 2001. *Where is God when it hurts?* p208.

¹⁶⁹Yancey. 2001. *Where is God when it hurts?* p209.

¹⁷⁰Yancey. 2001. *Where is God when it hurts?* p210. Romans 8:24-25 "But hope that is seen is no hope at all...But if we hope in what we do not yet have, we wait for it patiently."

reality.¹⁷¹ Therefore, hope is an integral element in the healing process of any health seeker because it enables a health seeker to visualise his/her healthy life before healing takes place.

3.3.4. Prayer as a Religious Health Asset

Prayer is an intangible religious health asset which falls within the category of Spiritual Encouragement.¹⁷² Since one of the ways in which faith is expressed is through praying, this act of praying becomes a step forward in practicing one's faith. Christians teach that prayer is a way of communicating with God. When health seekers or those who intercede for them pray, they are expressing their dependence upon God for divine intervention in their ill health. Although prayers are expressed in various ways, Michael Breslin and Christopher Alan Lewis quote James arguing that prayer provides a wide and all-inclusive vocabulary. They further suggest that prayer is in every way possible a kind of an inward spiritual union or dialogue with divine power.¹⁷³ They add that challenging circumstances are averted with consistent prayer in that God responds and participates in one's life upon hearing prayers.¹⁷⁴ This conversation with God in prayer is indeed a channel of distributing this religious health asset. Siang Yang-Tan and Natalie Dong posit that praying with faith also increases trust in present-day medicine which is one of God's ways of healing.¹⁷⁵ Zambian health seekers value prayers hence the increase of Faith-healing Pentecostal Churches in Zambia (FHPC).¹⁷⁶ Therefore, prayer is an intangible RHA which is expressed in tangible methods.

3.3.5. Counselling as a Religious Health Asset

De Gruchy et al put Counselling in the category of RHAs that fall under Spiritual Encouragement.¹⁷⁷ Counselling demands the presence of the counsellor - which brings a great deal of comfort to the ailing person. It is a skill which is therapeutic. Building on Anthony Yeo's argument, dialogue with a health seeker forms an important part in the ministry of delivering health services. A counsellor's role of listening to the story of a health seeker turns

¹⁷¹Yancey. 2001. *Where is God when it hurts?* p211.

¹⁷²de Gruchy et al. 2006. *Appreciating Assets.* p77.

¹⁷³Michael Breslin and Christopher Alan Lewis. 2008. *Theoretical Models of the Nature of Prayer and Health.* Accessed 24.4.13. <http://dx.doi.org/10.1080/13674670701491449>. p 10

¹⁷⁴Breslin and Lewis. 2008. *Theoretical Models of the Nature of Prayer and Health.* P16

¹⁷⁵Siang Yang- Tan and Natalie Dong. 2001. "Spiritual Interventions in Healing and Wholeness" Pages 291-310. In: *Faith and Health: Psychological Perspectives*, edited by Plante, T.G. and Sherman, A.C. New York: The Guilford Publications. p299.

¹⁷⁶Matimelo. 2007. *The Impact of Faith-healing Pentecostal Churches on Health and Well-being among Health-seekers in Ndola, Zambia.* p95.

¹⁷⁷de Gruchy et al. 2006. *Appreciating Assets.* p77.

into a healing process.¹⁷⁸ This understanding is also strengthened by Paul Lekholokoe Leshota who argues that western medication is not enough to provide total health. He adds that counselling is another method of healing.¹⁷⁹ In the Zambian context, counselling is perceived to be a process of helping someone to understand himself/herself. Through insightful conversation, a person understands his/her inner abilities to solve his/her own problems.¹⁸⁰ Matimelo also affirms in her research that counselling is an asset which is accessed by Zambians.¹⁸¹ With this in mind, both women and men need counselling in order to raise their hopes and prolong their lives.

3.3.6. Dissemination of Knowledge as a Religious Health Asset

De Gruchy et al show that the Church plays a pivotal role in providing health knowledge. It makes a great deal of effort to supplement the mandate of the government. Quoting Wolfensohn, de Gruchy et al write that the Church in Sub-Saharan Africa actively participates in understanding and delivering health services.¹⁸² Churches can be reminded that both men and women are to benefit from their knowledge sharing. Women need to have equal access to learning as it is an essential way to acquire knowledge. The Church offers this kind of education in terms of sensitizing the community. According to Kabwe, dissemination of knowledge is an intangible asset.¹⁸³ Therefore, disseminating knowledge cannot be detached from the distribution of health assets because it is a channel for empowering health seekers.

3.3.7. Moral Formation as a Religious Health Asset

Religious teachings transform the character of women and men. Moral behaviour is a religious teaching that influences one's way of living Kabwe writes, and shapes a person's life.¹⁸⁴ It is observed here that moral formation produces self-control which also leads to behavioural change. Details about self-control are shown in the next section. Kabwe adds that

¹⁷⁸Anthony Yeo. 2002. "Pastoral Care and Counselling". Pages 175-189. In: *International Perspectives on Pastoral Counselling*, edited by Farris, J.R. New York, London, Oxford: The Haworth Press.p181-182.

¹⁷⁹Paul Lekholokoe Leshota. 2013. "Healing, Counseling, and Anti-Retroviral Therapy" pages 189-211. In: *In the Name of Jesus! Healing in the Age of HIV*, edited by Chitando, E. and Klagba, C. Geneva: World Council of Churches. p197.

¹⁸⁰Tamilenthi and Charles Tobias Mbewa 2012. "The Perception of Guidance and Counselling to the Grade- IX and Grade-XII Pupils: An Investigation of Petauke District Schools of Eastern Province of Zambia," *International Multidisciplinary Research Journal*2/7, 13-18.

¹⁸¹Matimelo. 2007. *The Impact of Faith-healing Pentecostal Churches on Health and Well-being among Health-seekers in Ndola, Zambia*. p101.

¹⁸²de Gruchy et al. 2006. *Appreciating Assets*. p21

¹⁸³Kabwe.2008. *Local Churches and Health*. p53.

¹⁸⁴Kabwe.2008. *Local Churches and Health*. p53.

this falls into the category of intangible assets. The Church can be utilized as a centre for moral education with a focused view to enhance the health of health seekers.¹⁸⁵ Plante and Sherman write that people of faith have “health behaviours”. The behavioural changes in their lives prevent them from high risk of “morbidity and mortality”. Plante and Sherman itemize some of the direct benefits of faith according to their research. First, they say that people of faith refrain from smoking because it is contrary to their beliefs. Second, they also shun drinking alcohol because they believe it alters their behavioural patterns.¹⁸⁶ In his opinion, Edgar Jackson suggests that when faith is genuinely applied, it leads to behavioural change. Jackson further notes that one of the advantages of changing one’s behaviour is that it removes stress.¹⁸⁷ This is another religious health asset which is intangible and putting it into practice produces direct benefits for men and women. Not only does it benefit individuals, but the entire community.

3.3.7.1. Self-Control

This study understands self-control to be one virtue which can be practised within the process of changing one’s behaviour. Self-control is restraining oneself from one’s detestable habits which are inconsistent with particular norms of a community. In Christianity, it is taught that self-control is a virtue that is expected of every Christian.¹⁸⁸ It is also known as self-discipline over one’s desires. The issue of being faithful to each other, particularly in a marriage setting, has been problematized by Jill Olivier, James Cochrane, and Barbara Schmid. They argue that faithfulness “does not guarantee the fidelity of a partner”.¹⁸⁹ Both a woman and a man have to be faithful to each other. Failure to practice self-control threatens health in that one fails to remain faithful to one’s partner. As a result, a person risks contracting sexually transmitted infections (STIs) and HIV. A community in which adults and youth do not have the strength to control themselves against ill behaviour does not contribute effectively to the upbringing of the current and future generations.

¹⁸⁵Kabwe. 2008. *Local Churches and Health*. p53.

¹⁸⁶Plante and Sherman (eds.) 2001. *Faith and Health: Psychological Perspectives*. p3.

¹⁸⁷Edgar Jackson.1986. *Your Health and You: How Awareness, Attitudes, and Faith Contribute to a Healthy Life*. Minneapolis: Augsburg Publishing House. p68.

¹⁸⁸Galatians 5:22-23 “But the fruit of the Spirit is love, joy, peace, patience, kindness, goodness, faithfulness, humility and self-control...”

¹⁸⁹Jill Olivier, James Cochrane, and Barbara Schmid. 2006. *ARHAP Literature Review: Working in a Bounded Field of Unknowing*. Cape Town: ARHAP. p52.

3.3.8. Care as a Religious Health Asset

In this study two types of care are discussed: Spiritual Care and Compassionate Care.

3.3.8.1. Spiritual Care

Spiritual Care falls under the category of Spiritual Encouragement and is an intangible RHA.¹⁹⁰ As women are well noted for their caring attitude, Christina Landman in Phiri, Haddad and Masenya argues that resulting from women's offering Spiritual Care, health seekers are relieved of their emotional distress. She also speaks of empowerment coming from Spiritual Care which further leads to health seekers becoming responsible for their own health. Landman observes that Spiritual Care revives one's health as one learns to make amends with God and it helps the health seeker to stop blaming himself/herself. Further, she suggests that Spiritual Care relieves the health seeker of his/her fears of death.¹⁹¹ This religious health asset contributes a great deal toward raising the hope of the health seeker, thereby prolonging his/her life. Under the ministry of the Church, this religious health asset is well administered because it is practiced by those who have received basic training. Landman rightly acknowledges that offering Spiritual Care is very much needed because it recognises the dignity of human beings and is based on the assumption that all people are spiritual beings.¹⁹²

3.3.8.2. Compassionate Care

In a context where health seekers are in a difficult situation, Faith Communities are obliged to rise to the occasion to help the needy. Faith Communities respond to health seekers by way of showing them compassion. This religious health asset recognises that when one is passing through despondency they need compassion. According to Kabwe, this is called a tangible asset. And within compassionate care, Kabwe adds, there is "home based care, support, compassion and love".¹⁹³ Compassionate care is evident in situations where health seekers are visited in their homes or other places of care. In Zambian communities, home visitation is very common and is mostly practiced by Faith Communities. It also shows how important each member of the community is to others.

¹⁹⁰de Gruchy et al. 2006. *Appreciating Assets*. p77.

¹⁹¹Christina Landman, 2005. "Spiritual Care-giving to Women Affected by HIV/AIDS" Pages 189-208. In: *African Women, HIV/AIDS and Faith Communities*, edited by Phiri, I.A Haddad, B., and Masenya, M. Pietermaritzburg: Cluster Publications. p189.

¹⁹²Landman. 2005. *Spiritual Care-giving to Women Affected by HIV/AIDS*. p194.

¹⁹³Kabwe.2008. *Local Churches and Health*. p53.

The Church administers care as part of its mission. The attitude of looking after someone when they are unwell and are seeking after health is expressed through offering care, especially empathic care. Considering this issue from a gender perspective, Isabel Phiri holds that care is a traditional value of women. Their provision of care is evident in families and larger communities. But, their admirable desire to care for health seekers is inhibited by financial constraints since few African women are in formal employment.¹⁹⁴ Lilian Siwila problematizes the issue of care with assertions that to some extent care can be a threat to women's health. In her argument, she says that women's care giving makes them vulnerable to contracting diseases in the way they care for the sick. Because of the vulnerability of women, Siwila also advocates for a balanced share of responsibilities among women and men.¹⁹⁵ Although this is viewed in the context of HIV and AIDS, the practice applies to other situations. Phiri observes that there is an imbalance in care giving in the sense that women provide the major share of quality care in comparison with men.¹⁹⁶ To balance social responsibilities, men ought to fully participate in providing health care. Offering care improves the condition of health seekers.

Landman in Phiri et al posits that providing health care prolongs the lives of health seekers. Through receiving care, the health seekers' beliefs are strengthened, resulting in improvement in the quality of their health.¹⁹⁷ Landman adds that care acknowledges and sustains the dignity of humanity.¹⁹⁸ Her understanding points to the fact that human life deserves more attention in the event of sickness. Her assertion seems to be pointing to the fact that we are to maintain human dignity. Furthermore, Landman observes that health seekers can feel isolated in their illness, and care breaks the barrier which creates such feelings.¹⁹⁹ Therefore, care fosters the sense of belonging to a particular community despite one's health condition. Compassionate care is a practice that fits with the Engendered Communal Theology framework because it is a means of sustaining the values of the community.

¹⁹⁴Isabel Apawo Phiri.2005. "African Women of Faith Speak out in an HIV/AIDS Era" Pages 3-20. In: *African Women, HIV/AIDS and Faith Communities*, edited by Phiri, I.A., Haddad, B., and Masenya, M . Pietermaritzburg: Cluster Publications. p15.

¹⁹⁵Lilian Siwila. 2007. Care-giving in times of HIV and AIDS, When Hospitality is a threat to African Women's lives: a Gendered Theological Examination of the Theology of Hospitality. In: *Journal of Constructive Theology*. p72.

¹⁹⁶Phiri. 2005. African Women of Faith Speak out in an HIV/AIDS Era. p15.

¹⁹⁷Landman. 2005. Spiritual Care-giving to Women Affected by HIV/AIDS. p189.

¹⁹⁸Landman. 2005. Spiritual Care-giving to Women Affected by HIV/AIDS. p194.

¹⁹⁹Landman. 2005. Spiritual Care-giving to Women Affected by HIV/AIDS. p191.

3.3.9. Material Support as a Religious Health Asset

Supporting health seekers with tangible items offers great consolation. It is also evidence of love. Christians teach that love cannot be detached from giving.²⁰⁰ The Church as a health asset is therefore obliged not only to preach but to put love into practice by supporting health seekers. By doing so, the Church is actively participating in the delivery of health services. Offering material supporting by giving items that can be of use in the time of facing health challenges such as “food, commodities, clothes etc” is important.²⁰¹ From experience, people who are vulnerable need these items more than anyone else, especially those living with HIV and children who are orphaned. In the Zambian culture, material support is viewed as evidence of love. One example of material support can be observed during hospital visitation time. During this time, friends and relatives of patients bring food stuff to the patients. This practise is common and has become part of Zambian culture. Therefore, this RHA plays an important role in supplementing the tangible needs of health seekers. The beneficiaries find strength in this RHA because it also revitalizes their sense of belonging to a particular community. Material support also cements relationships between men and women.

3.3.10. Curative Intervention as a Religious Health Asset

Curative Intervention is an example of a tangible asset. In accordance with ARHAP’s report, de Gruchy et al define Curative Intervention as interventions in the health of one who seeks healing, whether it be through medication or divine method.²⁰² Yang Tan and Jong indicate that praying with faith increases trust in “modern medicine as an avenue of God’s healing”.²⁰³ Their understanding is that it is God who heals through modern medicine. Robert Bwalya asserts that the God who heals through physical medication is the same God who heals through prayers. He adds that the intellect of medical personnel is a manifestation of God’s wisdom and so both prayer and medical attention are to be administered as modes of health service delivery.²⁰⁴ As an apostle whose healing sessions through prayer are recognized by a government hospital, his argument is that both modes of healing are God-given. In the same line, anyone providing health care, either through prayer or physical medication, is obliged to respect the opinion of the health seeker. Yang Tan and Jong write:²⁰⁵

²⁰⁰John 3:16 “For God so loved the world that he gave his one and only Son...” NIV.

²⁰¹Kabwe.2008. *Local Churches and Health*. p53.

²⁰²de Gruchy et al. 2006. *Appreciating Assets*. p78.

²⁰³Yang Tan and Jong. 2001. *Spiritual Interventions in Healing and Wholeness*. p299.

²⁰⁴Robert Bwalya. 2009. *The Worst Pains*. South Africa: Bethel City Church International – Lesotho. p5.

²⁰⁵Yang Tan and Jong. 2001. “*Spiritual Interventions in Healing and Wholeness*. p296.

The health care provider must use discernment in assessing whether the client is ready to use spiritual resources, especially if the client is not religious or is struggling with his or her faith. When the health care provider differs from the patient on some topic of faith or religious belief, she or he should be careful to maintain a respectful attitude and refrain from imposing his or her opinion on the client.

Therefore Curative Intervention, through physical medicine or prayer, facilitates healing for both men and women.

It is clear here that both methods of healing are God-given and members of the community ought to accept them as these can enhance their lives. From Christianity's point of view, the above mentioned religious health assets are situated in the Church, including para-Church organizations. Therefore, the Church as a religious health asset is an umbrella that embraces the other assets.

3.3.11. Understanding Traditional Healing As a Health Asset

Although traditional healing is a contested matter in Christianity, Zambians are aware that it is a health asset which is easily accessible. Louw's survey shows that African traditional healers are very popular in communities because they offer attractive health assets.²⁰⁶ During ARHAP's workshops in Zambia, de Gruchy et al heard mixed feelings from participants about traditional healing.²⁰⁷ Besides it being a health asset, traditional healing is viewed negatively among many Christian circles. In their discussions, participants distinguished between diviners, witchdoctors and herbalists. Herbalism, for example, is simply the use of natural herbs for healing purposes.²⁰⁸

In their perceptions of traditional healing, evangelical Christianity does not differentiate between these terms.²⁰⁹ Wilbur O'Donovan believes that witchery and divination can either inflict pain or heal someone because of demonic influence behind them.²¹⁰ Nonetheless, in whichever way traditional healing is practiced, it has proved to have helped some health seekers, including people who openly condemn this practice but make consultations with

²⁰⁶Louw. 2011. "Pastoral Care and Counselling" p156.

²⁰⁷de Gruchy et al. 2006. *Appreciating Assets*. p83.

²⁰⁸de Gruchy et al. 2006. *Appreciating Assets*. p39.

²⁰⁹de Gruchy et al. 2006. *Appreciating Assets*. p84.

²¹⁰Wilbur O'Donovan. 2006. *Biblical Christianity in African Perspective*. Katunayake: New Life Literature. p332-334.

diviners and witches at night. In de Gruchy et al's findings, both women and men with sexual and barrenness issues secretly consult traditional healers. It is also debated that God is the source of healing through both conventional and traditional methods.²¹¹ This gives us a picture that traditional medicine is also one of the modes of delivering health assets. Believing in traditional healing or not does not alter its usefulness. The underlying fact is that it is a health asset.

3.4. Conclusion

In response to the question, 'How valuable are the RHAs that were identified in the activities carried out by ARHAP in Zambia?' this chapter has illustrated the implications of both tangible and intangible RHAs. Alongside a discussion of the Church and its health related mission, the chapter has shown that within the Church can be found all the RHAs, and that these are enhanced through health seekers' faith. Following the sequence of RHAs as shown in Figure 2, under the heading of intangible RHAs, this chapter highlighted that accompanying the administration of medicines, human hope is essential. Hope prolongs the life of the health seeker. Prayer is also recognised as one of the healing processes of health seekers. God intervenes in the life of the health seeker upon listening to a health seeker's prayer. The importance of the presence of a counsellor was discussed, as was the therapeutic value of the counselling process as it enables a health seeker to share their story.

The chapter discussed how dissemination of knowledge through sensitization empowers health seekers. In addition, teaching the community Moral Formation can lead to behavioural change as it increases the level of self-control. Under tangible RHAs, the important practice of Care by Faith Communities – both Compassionate Care and Spiritual Care - was highlighted, noting that women as well as men ought to participate in care-giving with a view to maintaining the community. In the process of delivering health assets, it was discussed that material support was crucial because it shows evidence of love. Curative Interventions that include conventional medicine and faith practices are to be accepted as both have the same source of power to help health seekers. Although Traditional Healing was understood to be controversial, it is one of the RHAs. Using the Engendered Communal Theology theory, this chapter has demonstrated the value of RHAs to the Zambian community. The next chapter discusses the intersection between health and faith communities.

²¹¹de Gruchy et al. 2006. *Appreciating Assets*. p84.

CHAPTER 4

THE INTERSECTION BETWEEN HEALTH AND FAITH COMMUNITIES IN ZAMBIA

4.1. Introduction

The preceding chapter gave us detailed information of RHAs and articulated how valuable they are to the Zambian community. It illustrated the Church as an umbrella institution which embraces all the RHAs while applying faith as an important aspect in the administration of RHAs. In light of the Engendered Communal Theology Framework in which this study is situated, this chapter seeks to answer the question, ‘In what ways did the activities carried out by ARHAP create awareness of the intersection between health and religion among women and men in Zambia?’ It seeks to identify the intersection that exists between health and Faith Communities with clues from ARHAP’s research activities. It seeks to demonstrate the work of Churches Health Association of Zambia (CHAZ) as a link between health and Faith Communities and assess the awareness this has brought about in Zambia. Zambia’s Faith Communities have an organised health service delivery system through the structure of CHAZ as will be shown in the next section.

4.2. The Work of Churches Health Association of Zambia (CHAZ) in the Awareness and Distribution of RHAs

CHAZ’s vision is: “A Zambian Society where all people are healthy and live productive lives, to the glory of God”.²¹² Although Marshall has generally argued that Church-administered health institutions are insignificantly known,²¹³ the case of CHAZ is different in this respect. Through CHAZ’s efforts to fulfil its vision, it works with Church-administered hospitals in Zambia and creates cooperation through the platform it provides to its one hundred and fifty one affiliates.²¹⁴

²¹²Churches Health Association of Zambia. 2011. *Annual Report*. p14.

²¹³Marshall. 2011. “Frontiers of Public Health and Social Transformation” p225.

²¹⁴The Health Voice. 2013. *Government Commend CHAZ for Raising Awareness on Non-Communicable Diseases as CHAZ host the ACHAP 6th Biennial Conference*. P4.

Figure 3

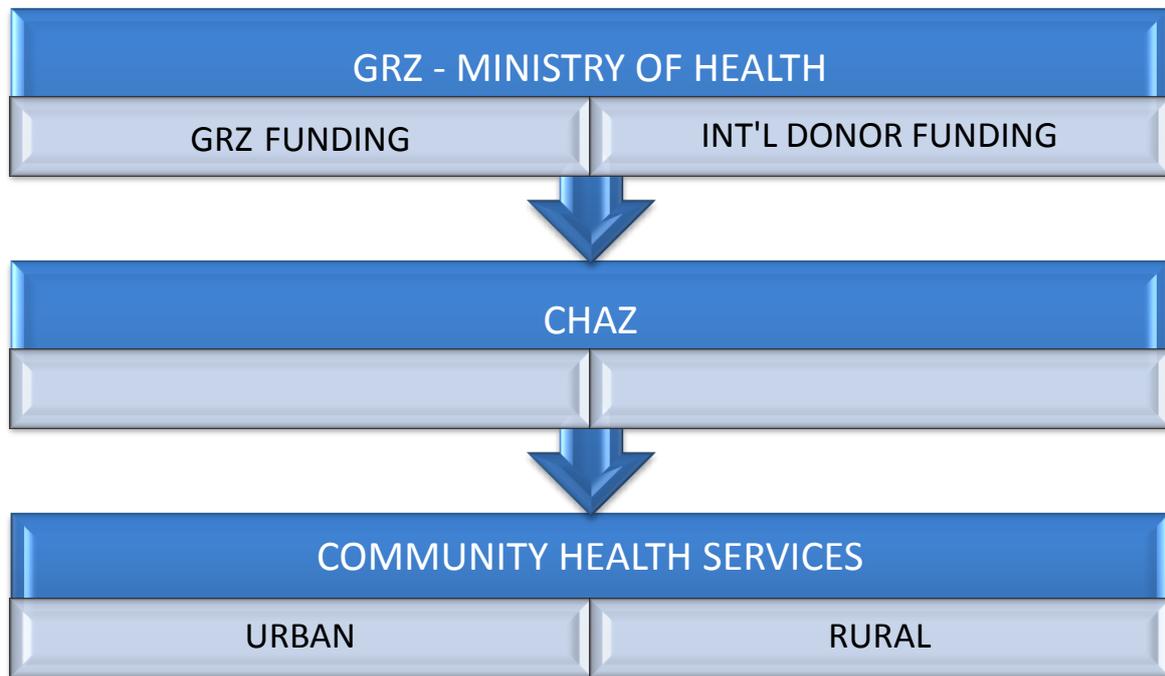


Figure 3. Showing how CHAZ plays a mediating role to channel resources to the community. CHAZ is funded by the government of Zambia through the Ministry of Health (MOH) and some external donors which resources are channelled to both the urban and rural communities.

CHAZ is deeply concerned about the awareness and distribution of health services with Christian virtues, especially to rural areas. Aware of the expensive health services that members of the community can hardly afford, CHAZ seeks to help the community. Part of CHAZ's mission is to make health services affordable to the community through using internal methods of raising funds.²¹⁵

Olivier et al assert that CHAZ delivers about 30% of health care services at national level in Zambia, and 50% of the services in Zambia's rural communities. Erratic care and lack of access to health services in rural areas is a major concern for CHAZ.²¹⁶ For example in the year 2010, among the Churches Health Institutions (CHI) that CHAZ sourced funds for were twenty seven mission hospitals and health centres which are all based in the rural areas.²¹⁷

²¹⁵Churches Health Association of Zambia. 2011. *Annual Report*. p14.

²¹⁶Olivier, Tsimpo and Wodon.2012. "Do Faith-Inspired Health Care Providers in Africa Reach the Poor more than other Providers?" p11.

²¹⁷Churches Health Association of Zambia. 2010. *CHAZ News Bulletin*. Lusaka: CHAZ. p5

CHAZ is also committed to empowering members of the community to participate in decision making regarding the utilization of health facilities within their reach. Within the rural communities, CHAZ promotes the creation of health cooperatives. In these cooperatives, participants are actively involved in providing health services to the community.²¹⁸ This contributes greatly to the understanding of RHAs because men and women are given opportunities to make decisions with regard to knowledge about the accessibility of health assets. It is observed here that when men and women participate in the awareness and distribution of health assets, they own the program. Mwakalombe suggests that harnessing community collaboration requires creation of leadership from within the community in order for women and men to own any community health activity.²¹⁹ Within the Engendered Communal Theology Theoretical Framework in which this study is framed, this collaboration between men and women in understanding and delivering health services is very much encouraged.

In 2012 CHAZ made a tremendous achievement when it critically assessed gender equality in the awareness and accessibility of quality health assets. CHAZ also trains health community workers to complement professional staff, especially in the context of combating malaria.²²⁰ Similar to the role of the Ministry of Health (MOH), CHAZ routinely participates in the distribution of information, medicines and other medical equipment to its affiliates.²²¹ In a rural setting, each hospital/health centre has a shelter which is mainly used by women. In 2012, CHAZ renovated these shelters to homes.²²² It can also be argued that the absence of men's shelters/homes must also be considered. While these shelters are used by women who take care of their beloved ones who are sick and expectant mothers, it is not true to think that there are no men who have a heart to care for the sick. Although it has been argued that care is most practiced by women,²²³ men are also care-givers and there should be homes where they can give care. Even though, as observed by Siwila, women are the primary care-givers in the community,²²⁴ in a community that is collaboration oriented, men are to participate in care giving as well. It is when RHAs can be understood and distributed evenly.

²¹⁸Churches Health Association of Zambia. 2012. *Annual Report*. Lusaka: CHAZ. p18.

²¹⁹Mwakalombe, P. 2014. *African Communication Skills in HIV and AIDS and Male Circumcision*. p97.

²²⁰Churches Health Association of Zambia. 2012. *Annual Report*. p20.

²²¹Churches Health Association of Zambia. 2012. *Annual Report*. p23.

²²²Churches Health Association of Zambia. 2012. *Annual Report*. p21.

²²³Phiri. 2005. African Women of Faith Speak out in an HIV/AIDS Era. p15.

²²⁴Siwila. 2007. "Care-giving in times of HIV and AIDS. p72.

Based on ARHAP's report for the WHO, de Gruchy et al argue that there are other networks which do not ascribe to CHAZ yet they are fulfilling a similar mission. For instance, Charismatics and Pentecostals in Zambia have also contributed to the awareness of religious health assets through prayer sessions.²²⁵ De Gruchy et al further note that Church-administered hospitals/clinics are accessed more than those of the government, because of the virtues of care and love offered by purpose-oriented workers.²²⁶ In addition, Matimelo observes that Pentecostal Churches are actively involved in the same awareness campaign by allowing their Church premises to be used as immunization venues.²²⁷

4.3. The Intersection between Faith Communities and Health in Zambia

De Gruchy et al emphasize the fact that religion's contribution to the understanding and distribution of religious health assets is significant.²²⁸ Religion "...provides the positive energy that generates a life of health and wellbeing".²²⁹ In this understanding, the Church plays a pivotal role in transforming the community through religious education. In my opinion, the Church is a centre for moral education through which it transforms the behaviour of women and men. This role explains why de Gruchy et al assert that "there is a strong connection between religion, morality and health".²³⁰ The three key words in this quotation stand for the role of the Church in conveying transformational education which results in a healthy community. The central role of the Church is also noted by Vhumani Magezi in his observation that most of the health service delivery organizations are spearheaded by the Church. He adds that the role of the Church in awareness and distribution of RHAs is not to be underrated.²³¹

For de Gruchy, the basis of the health of the community lies in visible structures, and these structures include Churches. He understands the Church to be a 'social structure' within which there is commitment to healing and providing the community with knowledge

²²⁵ de Gruchy et al. 2006. *Appreciating Assets*. p73

²²⁶ de Gruchy et al. 2006. *Appreciating Assets*. p75.

²²⁷ Matimelo. 2007. *The Impact of Faith-healing Pentecostal Churches on Health and Well-being among Health-seekers in Ndola, Zambia*. p100.

²²⁸ de Gruchy et al. 2006. *Appreciating Assets*. p76.

²²⁹ de Gruchy et al. 2006. *Appreciating Assets*. p79.

²³⁰ de Gruchy et al. 2006. *Appreciating Assets*. p80.

²³¹ Vhumani Magezi. 2012. *From Periphery to the Centre: Towards Repositioning Churches for Meaningful Contribution to Public Health Care*. Unpublished dissertation (MTh). Potchefstroom: North-West University. p1.

pertaining to their health.²³² The Church achieves this through providing sensitization lessons that change the behaviour of the community. This finding is in line with the understanding of Zambians about the Church. They understand that a Church is where they go on Sundays to worship God. It is therefore important to note areas in which the Church is contributing significantly. Mwakalombe adds that pastors are the most significant workers in the community because they mobilize the community to respond to issues which include public health and hygiene.²³³ This assertion is contrary to the Engendered Theoretical Framework because ‘pastors’ denote male leaders. For Nyirongo, collaboration between women and men is vital to achieving community matters. Nyirongo further says that accepting women’s leadership is a paradigm shift which ought to be accepted by male leaders amicably.²³⁴

According to de Gruchy et al, religion embraces numerous assets that health seekers benefit from. Some assets are visible while others are invisible. Using the PIRHANA tools, ARHAP found that there are clusters of assets that are situated in religion, as we have already observed in chapter three.²³⁵ It is also noted in de Gruchy et al’s findings that: “It is the interweaving of the intangible within the tangible which gives the tangible its specific religious character and it is the expression of the intangible in tangible ways which gives the intangible its legitimacy.”²³⁶ This quote synthesizes the significant role religion plays in producing positive health outcomes. The interconnectedness of tangible and intangible assets makes religion visible to the community. This visibility makes it easy for men and women to take part in the awareness and distribution of these assets. It is also of great importance to note here that it is the expression of intangible assets which gives meaning to the Church. It is from this point that we have to realize that personal health always contributes to the health of the entire community.

The theory of community is the main focus in this work. Mwiche argues that the presence of the Church is very helpful to the community. She understands that wherever there is a community of people, the availability of religious health assets is guaranteed. Further, Mwiche observes that in the Zambian context the Church is found even in parts of the country where roads are impassable. Some of these Churches are even among those that are

²³²de Gruchy. 2007. *Re-Learning our Mother Tongue?* p49.

²³³Mwakalombe, P. 2014. *African Communication Skills in HIV and AIDS and Male Circumcision.* p29-30.

²³⁴Nyirongo, L. 2014. *Creating Gender Synergy in Top Decision Making Roles.* p287.

²³⁵de Gruchy et al. 2006. *Appreciating Assets.* p76.

²³⁶de Gruchy et al. 2006. *Appreciating Assets.* p78.

providing health services.²³⁷ This is a great contribution to health and happens to be one of the strengths of Faith Communities. The widespread presence of the Church is verified in de Gruchy et al's report, where it shows that the number of Churches was second to that of schools in every community where they carried out their research.²³⁸ Therefore, the task of understanding these religious health assets is a communal concern. This implies that both men and women ought to engage themselves in the distribution of health assets and ensure members of the community access them consistently. In this respect, it is also noted that ARHAP's findings did not consider the negative aspects of religion, precisely Christianity, with regard to the distribution of ARHAs.

Nevertheless, it must be pointed out that even though religion offers hope to many health seekers, its Scripture can be used in ways that are detrimental to people's health, particularly when its meaning is distorted. This affects women a great deal because certain interpretations of the Bible disfavour them. Phiri remarks that some Churches acknowledged that they have contributed to the HIV and AIDS pandemic owing to their emphasis on the "theology of sin".²³⁹ Misinterpretation of the Scripture is also examined by Oduyoye when she problematizes the use of the Bible.²⁴⁰ As an example, she refers to how women are subjected to discrimination even when they are menstruating.²⁴¹ To overcome this problem, Oduyoye advocates for a theology of 'inclusiveness' in which men and women reciprocate ideas.²⁴² It is therefore critical to interpret the Bible correctly in order for the Faith Community to be meaningful in dealing with health matters.

4.4. The Networking of Faith Communities in the Awareness of African Religious Health Assets

With regard to the contribution of Faith Communities to the health and wellbeing of health seekers, de Gruchy et al observe the interaction between secular and Faith Communities with their collaborative networking for a common cause. They also say that majority of the health workers belong to Christian Churches²⁴³ – an accurate observation given that, as reported

²³⁷Mwiche. 2008. *The Church and Health*. p82.

²³⁸de Gruchy et al. 2006. *Appreciating Assets*. p70.

²³⁹Phiri. 2005. *African Women of Faith Speak out in an HIV/AIDS Era*. p7.

²⁴⁰Mercy Amba Oduyoye. 1995. *Daughters of Anowa: African Women and Patriarchy*. New York: Orbis Books. P174.

²⁴¹Oduyoye. 1995. *Daughters of Anowa*. P178.

²⁴²Oduyoye. 1995. *Daughters of Anowa*. p181.

²⁴³de Gruchy et al. 2006. *Appreciating Assets*. p81.

earlier, Zambia is a predominantly Christian country.²⁴⁴ These Christian groupings are observed to be networking to a greater degree than other faith groupings, adding to the strength of the presence of the Church.²⁴⁵ As further observed by CHAZ, there is already collaboration between Protestant and Catholic Churches in bringing awareness to the community about RHAs.²⁴⁶ It should also be noted that in spite of this networking, not all the Christian Churches agree to collaborate ecumenically. For example, in the Zambian context, Jehovah's Witnesses estrange themselves from ecumenical work that is meant to benefit the community. This is rather retrogressive because women and men who belong to this Church face the same health challenges that others do. The framework in which this study is located advocates that men and women, irrespective of their Church affiliations, complement each other in the community so that participation in the awareness and distribution of ARHAs is done in partnership.

In de Gruchy et al, their findings with regard to Faith Communities point to the clusters of RHAs. It is cautiously noted that the six clusters are crucial to the awareness and contribution that Faith Communities make to health and wellbeing of the community. Emphasizing the same point, the Church is viewed as central to the awareness and distribution of health assets. Their further observation shows that what makes the Church's contribution meaningful is the way it adds love to all its endeavours. In contrast, in the government-owned health institutions, delivery is done professionally and according to their skills training.²⁴⁷

The collaboration observed by ARHAP's workshop participants between the Church and government-administered health institutions relates to helping people infected with HIV. It is evident therefore that work with HIV positive people - previously a contentious issue - is now receiving maximum attention by both institutions. The maximum attention is now in contrast to the previous negative approach by the Church. The Church was at the forefront of practicing stigmatization.²⁴⁸ Now, both entities are observed to be fighting for a common cause that maintains the dignity of the community.

²⁴⁴de Gruchy et al. 2006. *Appreciating Assets*. p62.

²⁴⁵de Gruchy et al. 2006. *Appreciating Assets*. p82.

²⁴⁶Churches Health Association of Zambia. 2012. *Annual Report*. p33.

²⁴⁷de Gruchy et al. 2006. *Appreciating Assets*. p87.

²⁴⁸de Gruchy et al. 2006. *Appreciating Assets*. p89-90.

4.5. Conclusion

This chapter has responded to the question, ‘In what ways did the activities carried out by ARHAP create awareness of the intersection between health and religion among women and men in Zambia?’ It has shown that Faith Communities are a focal point with regard to awareness of RHAs. It has also identified the functions of CHAZ which plays an intermediary role between the Church and the Zambian government. It has also argued that religion’s view of women has an effect on the collaboration of the community in dealing with RHAs. Using the Engendered Communal Theology theory, this chapter argued that women’s plea to work in partnership with men was crucial to their vision. This chapter has also discussed religion’s contribution to health based on ARHAP’s report. It has ended with highlighting the networking of Faith Communities in the awareness campaign of RHAs in Zambia. The following chapter infers the research activities of ARHAP in Faith Communities in Zambia and makes some suggestions for further research.

CHAPTER 5

CONCLUSION: SUMMARY AND RECOMMENDATIONS OF THE STUDY

5.1. Introduction

This chapter provides the final conclusion of the study based on the research question ‘How did the work of ARHAP contribute to the religious understanding of health assets among Faith Communities in Zambia?’ Viewing this question through a framework which is located within the work of women theologians, the study used an Engendered Communal Theology Theoretical Framework to appraise the work of ARHAP among Faith Communities in Zambia. This study was based on the report that ARHAP compiled during its participatory workshops which were conducted in Zambia under the leadership of Professor Steve de Gruchy. The research was contracted by the World Health Organization (WHO). As this study draws to its conclusion, it is important to synopsise the findings to show its achievements and put forward some proposals.

5.2. How ARHAP has Contributed to the Religious Understanding of RHAs in Zambia

There is evidence from recent findings that Zambians have continued to appreciate their own valuable RHAs. Members of the community, whether recognized or unrecognized have had a tremendous response to ARHAP’s activities.²⁴⁹ Recent data shows that Zambia is actively involved in the utilization of RHAs in diverse religious traditions, making the Church more visible to the community. Many health seekers have options either to consult Traditional Healers or the Church for prayers.²⁵⁰ As healing campaigns are also conducted during week days, it is evident that even those who do not belong to the church go to be prayed for. In some cases prayers are used as an evangelistic tool to bring more people into the Church. Referring to the Engendered Communal Theology Framework, RHAs are for every member of the community regardless of their Church affiliations. This observation points to the fact that human life has to be dignified and sustained in a community setting. By using the Engendered Communal Theology Framework, this dissertation was inevitably engaged with the term ‘community’. This term was emphatically utilised to show that the theory was framed within the context and focus of the Zambian community. ARHAP concentrated on

²⁴⁹Jill Olivier, James Cochrane, and Steve de Gruchy. 2012. “Mapping Religious Community Health Assets and Initiatives: Lessons from Zambia and Lesotho,” p59.

²⁵⁰Olivier, Cochrane and de Gruchy. 2012. “Mapping Religious Community Health Assets and Initiatives,” p60.

involving the community which was appropriate in the focus of women theologians' theory of Engendered Communal Theology.

5.3. Summary of the Dissertation

Chapter one provided a general overview of the entire study, beginning with a discussion of the scholarly and personal motivations underlying this study. It also selected literature by which to appraise ARHAP's work among Faith Communities in Zambia. The literature surrounding this topic was library based. It showed ARHAP's findings as well as the assertions and theology of women theologians through which this study was framed. It was in the works of women theologians that the Engendered Communal Theology Theoretical Framework was situated. The chapter also explained the methodological approach which was applied in this study. The study was guided by the Engendered Communal Theology Framework and methodology, and has ultimately led to the conclusions and recommendations arising from the research.

In chapter two, this study looked into the historical background of ARHAP, as well as its vision and the main objectives. This chapter also illustrated that ARHAP does not operate in isolation but with collaborative partners. ARHAP is shown to be a dependable program that has the vigour to pursue further research studies while making the communities aware about the availability of health assets belonging to religion and secular health sectors. There should be continued vigorous efforts applied to making the Faith Communities aware and able to access these health assets, with a view to maintaining the dignity of human life. Zambia shares many similarities in terms of health-related matters with other countries in Africa. This implies that Zambia cannot operate in isolation but must learn to maintain its connectedness to other countries in order to keep its communities aware of and encouraged to access RHAs.

Chapter three emphasized the value of religious health assets to Zambians. In an effort to appraise the work of ARHAP through the Engendered Communal Theology Framework, this chapter achieved its purpose by showing that the Church embraces all the RHAs. Further, the chapter set out to illustrate that faith is a catalyst in making RHAs real, and presented recent findings which reveal the interaction between faith and the efficacy of conventional medicines. With reference to Figure 2, all the intangible RHAs are enthused by the driving force of faith. Even more importantly, the utilization of these assets is proven to prolong human life. Therefore, identifying these RHAs adds value to the dignity of the Zambian

community. It also adds value and relevance to the existence of the Faith Communities in Zambia. This chapter also established that though evangelical Christians impugn against consulting traditional healers, traditional healing is one of the most accessed RHA in Zambia. This chapter's findings are consistent with the vision of women theologians' Engendered Communal Theology Framework which focuses on the community. Thus, the availability of RHAs cannot be managed single-handedly but with a complementary concern of both women and men.

Within the boundaries of the Engendered Communal Theology Framework, chapter four assessed the activities carried out by ARHAP in Zambia with a view to finding out if such activities created more awareness amongst the Zambian community. These activities were discussed through the lenses of an Engendered Communal Theology Framework. Chapter four further established that within the Church, there are important para-church organizations which work as auxiliary arms of the Church. CHAZ is one renowned organization which is working extensively to promote the intersection between health service delivery and the Church for the benefit of the community. Although there are some Churches which disassociate their services from ecumenical collaboration, this chapter appreciates the networking of the rest of the Faith Communities in Zambia.

5.4. Recommendations for Further Research

- As I recognize the relevance of the participatory workshops conducted by ARHAP in five of the provincial centers in Zambia, it is of great importance to extend the same workshops to other provinces where ARHAP did not reach. These are: Western, North-western, Muchinga, Luapula, Northern and Central provinces.
- Making people aware of the availability of ARHAs is a continuous and gradual process. It is therefore, important to continue researching in this area so as to identify hindrances and make further improvements to the awareness campaign.
- Following the Engendered Communal Theology theory, women are more active than men in care provision. There should be mutuality in the provision of health care services by women and men. Therefore, a deliberate attempt should be made to explore further why there is still an imbalance in health care provision.

5.5. Conclusion

This dissertation has achieved its purpose in its finding that, building on the strength of ARHAP, women and men can partner as co-workers in the distribution of RHAs with a view to sustain the current and future generations. It has also found that communal theology can transform men and women, restore sanity and maintain human dignity by reconstructing communities in terms of the values of mutuality. This study has established that the Faith Community is found to be central in the awareness of RHAs and that it could be of great importance for the government to give full recognition to the assets of the Church and to create solidarity in the awareness campaign. Using the methodology and the Engendered Communal Theoretical Framework, it is very clear that this appraisal is pointing to religion as a custodian of rich health assets that belong to the *Zambian* community.

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