

**The Church and Health: An Examination of the Contribution of Local Churches to  
Health and Wellbeing in Ndola, Zambia.**

**By**

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**DECLARATION**

I, Mary Zulu Mwiche, hereby declare that this whole dissertation, unless specifically indicated to the contrary in the text, represents my original work. I also declare that I have not submitted this dissertation in any form for any degree purpose or examination to any university.

Signature:.....

Date:.....

As Supervisor, I agree to the submission of this dissertation

Signature:..... Date:.....

Professor Steve de Gruchy

## ACKNOWLEDGEMENTS

This research would not have been carried out without the valuable contributions and support from a number of people.

Foremost, I give thanks to God Almighty and Jesus Christ my Saviour, whose love and faithfulness never cease to amaze me.

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To my husband Ngosa, and children, Meya, Tamara, Gwen, Thandi and Busuma, thank you for being so patient, supportive and believing in me to do the best.

May the Lord Almighty bless you all.

## DEDICATION

**This thesis is dedicated to the Church in Zambia, and in particular the United Church of Zambia, that it may truly realize the assets in it God has given freely for the betterment of society. Thank you for making me be part of this journey to better society.**

## ABSTRACT

This study examines the contribution local churches in Ndola make to health and wellbeing. It is conducted in the wider research programme of the African Religious Health Assets Programme (ARHAP), which seeks to investigate the interface between religion and health. ARHAP's hypothesis is that religions in Africa have assets that could be leveraged for better health and wellbeing by making them visible to public health policy makers and service providers.

This study seeks to contribute to the ARHAP hypothesis by asking the question of what local churches in Ndola contribute to health and wellbeing. The context of the study is in the social, economic and political background of Zambia, highlighting the current health situation of the country. Zambia is beset in poverty, and it is a major factor to the response the government, civil society and religious entities are making to mitigate the impact of diseases such as HIV and AIDS, tuberculosis and malaria, three key health issues that affect the country adversely.

This study shows that the local churches in Ndola contribute in six ways to health and wellbeing. These are presence in the community, spiritual encouragement, direct health interventions, human development, networks and collaboration, and leadership. This contribution is both tangible and intangible and they have an impact on community health and wellbeing directly and indirectly. This confirms and enriches ARHAP's assertion that religion has health assets which if aligned to public health can impact on the global concern to mitigate the impact of poverty and ill health or lack of wellbeing in communities. The findings also questions the rigid divisions between tangible and intangible assets their impact and upon health and wellbeing in direct and indirect ways

Finally the research notes that the pastors and ministers of the churches do not have a self-conscious understanding of themselves and their churches as contributing to health and wellbeing, and so some theological resources are advanced to strengthen this aspect of their work.

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**ACROYNMS**

ARHAP	African Religious Health Assets Programme
RHA	Religious Health Assets
REs	Religious Entities
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
SAPS	Structural Adjustment Programme
CBoH	Central Board of Health
CHAZ	Church Health Association of Zambia
CCZ	Council of Churches in Zambia
EFZ	Evangelical Fellowship of Zambia
ICAZ	Independent Churches Association of Zambia
ZEC	Zambia Episcopal Conference
PAOG	Pentecostal Assemblies of God
UCZ	United Church of Zambia
RCZ	Reformed Church in Zambia
SDA	Seventh Day Adventist Church
MMD	Movement for Multi Party Democracy
PRSP	Poverty Reduction Strategy Paper
WHO	World Health Organization

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## CHAPTER 1

### INTRODUCTION TO THE STUDY

#### 1.0 Introduction

This chapter is an introduction to the thesis. It describes the academic context of the study, namely, the location of the study in the broader context of the African Religious Health Assets Programme (ARHAP), and the social context of the study, namely, Ndola, Zambia and the churches there. This chapter also introduces ARHAP and highlights its purpose. It introduces the leading research question, research method, and main research findings. It is in this chapter that I also introduce the geographical location of the study, mainly Zambia, highlighting its social economic political and religious background. The chapter concludes with an outline of the thesis, and a summary of each of the chapters.

#### 1.1 Academic Background: The African Religious Health Assets Programme.

This study is part of a wider research project, called the African Religious Health Assets Programme (ARHAP)<sup>1</sup>. ARHAP is a scholarly project, undertaken with the intention of using research to acquire knowledge about the relationship between religion and public health that could be used to engage with key health issues affecting communities in Africa today. It is hoped that this knowledge will generate a baseline of information on religious health assets in Africa, as well as helping practitioners and leaders in the field.<sup>2</sup> The conception of religious health assets (RHAs) is presented in the ARHAP Theory Matrix<sup>3</sup> as both tangible and intangible, to refer to the “range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a local or translocal context, by which people engage in activities that respond to their experienced

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<sup>1</sup> See Chapter 3 for more details

<sup>2</sup> “The Least We Can Do: Why an African religious Health Assets Project? By Gary Gunderson in African Religious Health Assets Programme Report of the Pietermaritzburg Colloquium, August 2003.Pg.21

<sup>3</sup> See Chapter 3 of this thesis

situation.”<sup>4</sup> ARHAP seeks to locate in religion what is worth knowing or having, by which religion contributes to the health and wellbeing of society beyond the recognized health care services that it engages in.

The question of religious health assets is significant today in the context of the multi-faceted manner in which diseases are prevalent. The advent of HIV and Aids in particular has highlighted the need to have a multi-sectoral approach to dealing with health issues. Health and wellbeing are no longer dependent only on the provision of proper health care system as HIV and Aids, Malaria and Tuberculosis show that prevention is primary in health and wellbeing. The importance of prevention is shown in the World Health Organization Six Point Agenda<sup>5</sup>, in which the WHO points to its mission to collaborate with other entities, among them, religion, in order to eliminate factors that hinder health such as poverty, environmental degradation, and population movements. WHO recognizes health as a key factor to socio-economic progress and it identifies poverty as a major factor that negates health. In this environment of seeking a multi-sectoral approach to mitigating the impact of disease, ARHAP begun as a scholarly project to:

Develop a systematic knowledge base of religious health assets in Sub-Saharan Africa to align and enhance the work of religious health leaders and public policy decision-makers in their collaborative effort to meet the challenge of disease, e.g. HIV and Aids, and to participate in the creation of health, especially for those in poverty.<sup>6</sup>

At the same time, medical science now advocates a “psycho-socio-environmental” approach, which focuses more on prevention, management and rehabilitation of disease

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<sup>4</sup> African Religious Health Assets Programme, ARHAP International Colloquium, Case Study Focus, Papers and Proceedings, Willow Park, Gauteng, July 2005, Pg. 12

<sup>5</sup> <http://www.who.int/about/agenda/en/index.html/> Accessed 31<sup>st</sup> July 2007

<sup>6</sup> ARHAP International Colloquium, Case Study Focus, Papers and Proceedings, Willow Park, Gauteng, July 2005, Pg. 11

than on mere treatment of body illness using medicines.<sup>7</sup> It is in this context that ARHAP seeks to understand the relationship between religion and health, “focusing on what these religious health assets are, how they work, and what potential exists for strengthening them without undermining the very things they offer or destroying them through inappropriate interventions or engagements.”<sup>8</sup>

## 1.2. The Origins of ARHAP

ARHAP is a research programme with an international outlook,<sup>9</sup> working on the interface between religion and public health in Africa. The programme was formally launched as a working group in Geneva in December 2002 with the purpose of leveraging religious health assets that are inherent in African religions but of which there is not much knowledge. ARHAP seeks to develop a database of knowledge on religious health assets that will enhance the work of all key actors in the promotion of health and wellbeing.<sup>10</sup> Its mission is to develop criteria and related assessment tools that will engage and promote dialogue between public health and religious health providers.<sup>11</sup> The focus and vision of its work is specifically in Africa, where religion plays a significant role in the health and wellbeing of its people. At the same time, the African continent suffers most from aspects that impact negatively on the health and wellbeing of its people, through such things as diseases, the HIV and Aids pandemic, poverty, political instability, and civil wars. Therefore, ARHAP seeks to develop a database of knowledge on religious health assets that will enhance the work of key actors in health provision services. This is based on the knowledge that 30-70% of health care provision is offered by religious entities in Africa, even though there is yet no concrete evidence of ‘where these assets;

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<sup>7</sup> Leah Gilbert, Terry-Ann Selikow and Liz Walker, *Society, Health and Disease: An Introductory Reader for Health Professionals*. Braamfontein: Ravan Press. 1996. Pg. 5

<sup>8</sup> African Religious Health Assets. *International Colloquiu: Case Study Focus, Papers and Proceedings*. Pretoria, South Africa, 13-16 July 2005. Pg. 11

<sup>9</sup> ARHAP is a partnership of researchers and scholars from Emory University in Atlanta, USA, Universities of Cape Town, KwaZulu Natal, and Wits in South Africa, and has collaborative links with WHO, Vesper Society, Germany Medical Mission among others .

<sup>10</sup> ARHAP Background and Conceptual Framework, 2005

<sup>11</sup> Ibid

are, and how they work'.<sup>12</sup> To locate these assets, ARHAP is guided by the following vision and 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.
- 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.<sup>13</sup>

The key theoretical idea at the basis of ARHAP’s work is the notion of ‘assets’, so we need to gain an understanding of what is meant by this term.

### **1.3. Of Assets, Religion and health in Africa**

The strength of ‘assets’ in development theory has been popularized by Kretzmann and McKnight in their book *Building Communities from the Inside out: A path towards*

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<sup>12</sup> <http://www.arhap.uct.ac.za/about.php> Accessed 9<sup>th</sup> August 2007

<sup>13</sup> ARHAP-WHO Report: *Appreciating Assets* Pg.23

*finding and Mobilizing a Community's assets.*<sup>14</sup> They urge against using a needs driven approach to development, which focuses on the problems of communities and sees people as being deficient or not capable of owning the agenda for their own development. This approach results in the community and its people being seen as clients of the process of development, with decisions being made by the outsider of how they ought to be developed. This has resulted in creating a dependency syndrome, and needy people, who survive on the welfare assistance of donors.

On the other hand, an assets driven approach to development recognizes that people and communities have capacities or strengths within them that could be leveraged for improved livelihoods. It recognizes that “successful community development grows out of policies and activities based on the capacities, skills and assets of poor people and their neighborhoods.”<sup>15</sup> Assets driven development recognizes the importance of outside help only once local people themselves recognize, mobilize and appreciate their own resources and relationships (networks) that can build their community.

It is out of this background that ARHAP recognizes that religion is a great asset to health in Africa and seeks to locate these assets and make them visible to public health. Therefore, ARHAP makes use of the following as key terms in seeking to align these assets in the public health domain.

**Assets** refer to a “range of capabilities, skills, resources, links, associations, organizations and institutions already present in a context by which people endogenously engage in activities that respond to their given situation.”<sup>16</sup>

**A Religious Health Asset**<sup>17</sup> (hereafter RHAs) is defined as “an asset located in or held by a religious entity that can be leveraged for the purpose of development or public

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<sup>14</sup> Chicago: ACTA Publications, 1993

<sup>15</sup> Steve de Gruchy. “Of Agency, Assets and Appreciation: Seeking Some Commonalities Between Theology and Development” in *Journal of Theology for Southern Africa*. 117 (Nov 2003) Pg. 31

<sup>16</sup>PIRHANA: For Seekers and health providers. Practitioner’s Workbook. Version 5:June 2007.(ARHAP 2007), Pg.22



health". This provides the notion that an asset has value and if this is not identified and used, it still remains an asset at rest.<sup>18</sup> RHAs located within religion, can be tangible or intangible, and this refers to those aspects that have value and can be leveraged for accessing or improving health and wellbeing.

**Religion** refers to a "wide variety of comprehensive systems of sacred beliefs and practices. These beliefs are often expressed in constituting formal and informal bodies such as churches in Christianity, mosques in Islam, or informal gatherings as in African system."<sup>19</sup>

In this study, we are dealing with religion as understood in the context of Africa, as it is a continent which is highly religious, even long before Christianity or any other religion was introduced. The belief of spirituality and being connected to a higher being has always been present for majority of Africans. It is because religion is so significant to Africa that ARHAP recognizes that it plays an "important role in the way in which the great majority people deal with daily life and find resources for vitality and healing within them."<sup>20</sup> Religion in Africa is one of the significant coping strategies and hence ARHAP seeking to locate the assets that are in it to make them be aligned to public health interventions and policy making.

By **Health**, ARHAP means Public Health rather than individual health. Public health in Africa is a great challenge. The continent is rated globally as the worst affected by poverty, disease, wars, and political instabilities. As we noted in chapter two when we looked at Zambia, Africa has suffered serious epidemics, including HIV and Aids, and has a general poor health status related to malaria, TB and undernourishment. In Africa, "religious beliefs play a major role in shaping people's personal identities, thought

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<sup>17</sup> The Asset Based Approach to Development was initially popularized by Kretzmann and McKnight, see J. Kretzmann and J. McKnight, *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets* (Chicago: ACTA Publications, 1993).

<sup>18</sup> PIRHANA: Version 5.(ARHAP 2007)Pg 22

<sup>19</sup> "Framing Document" in *Case Study Focus, Papers and Proceedings*, July 2005 ARHAP Colloquium, Pg.12

<sup>20</sup> Jim Cochrane "Deliberations on Religion and Religious Health Assets" in *Case Study Focus, Papers and Proceedings*, July 2005 Pg. 20

patterns and perceptions of disease, and the decisions they make which affect their health.”<sup>21</sup> It is in this context that ARHAP is concerned to locate and assess the religious beliefs or assets that could be aligned to key health service providers and policy makers agreeing with the notion that “religious faith and spirituality have been major resources (in Africa) in promoting health and wellbeing”<sup>22</sup> by undertaking “a comprehensive assessment of religious health assets at a province or district level.”<sup>23</sup>

The definitions given above provide an understanding of what ARHAP means by religious health assets and why they are important for health and wellbeing. What is crucial for ARHAP is the idea that religious assets can contribute not just to personal or individual health, but to a broader understanding of public health, and therefore social development.

#### 1.4 Motivation for Study

This study is not the only one being undertaken by ARHAP. This is a collaborative effort of interdisciplinary studies, and so this study draws on other academic initiatives such as research into the *Masangane* HIV and Aids project in the Eastern Cape in which ARHAP seeks to assess the value religious faith plays as a factor to wellbeing. ARHAP has also undertaken research for the World Health Organization in Zambia and Lesotho,<sup>24</sup> to identify, map and assess religious health assets in order to appreciate their value to promotion of health and well being. Other students too have undertaken various aspects of identifying religious health assets in Zambia. For instance, Audrey Matimelo’s study focused on the ‘Impact of Faith Healing Pentecostal Churches on health seekers in Ndola, Zambia. Maybin Kabwe’s study is on ‘Local Churches and health; An examination of five local churches contribution to direct health outcomes on the Copperbelt. Roy Hamalya’ngombe has researched on ‘Religion as a Health asset: The perception of influential Zambian leaders on the relationship between religion and health.’

<sup>21</sup> Gideon Byamugisha, LucyY. Steinitz, Glen Williams, and Zondi P. *Journeys of Faith: Church-based responses to HIV and Aids in three Southern African countries*. Cluster publications, 2002 Pg.1

<sup>22</sup> Byamugisha et. el. *Journeys of Faith* Pg. 1

<sup>23</sup> ARHAP-WHO: *Appreciating Assets*. Pg. 7

<sup>24</sup> Full report on [http://www.arhap.uct.ac.za/downloads/ARHAPWHO\\_execsumm.pdf](http://www.arhap.uct.ac.za/downloads/ARHAPWHO_execsumm.pdf) Pg.1

The study presented in this thesis seeks to build on and contribute to this wider ARHAP work, by examining the contribution of local Christian churches to health and wellbeing in Ndola, in the Copperbelt of Zambia. The following three factors are what motivates this particular study.

The ARHAP theory points to the need to consider religion as a major factor in health. This area has not been fully explored and I undertook this study to contribute to the theoretical work of ARHAP, as the work on the ground in Zambia will then feed back into the ARHAP theory work.

Second, with the increase of poverty and disease in our region, there has been an increase in faith-based initiatives engaged in the alleviation of suffering. Clearly, this provides an example of health assets that exist in religion. This study contributes to providing documentation on what it is that religion contributes to health. The documentation of such 'assets' found in religion are important for three reasons: (i) It is hoped that the documentation of this study will empower the communities to leverage their own assets to promote their own health and become agents of their own wellbeing; (ii) By making visible the health assets in the Church to policy makers, this can be useful for health planning; (iii) It is hoped that this study can lead to dialogue between religious leaders and public health practitioners with the purpose of aligning religious health assets to contribute to the wellbeing of the community and nation at large.

The third motivation for this study is that the present challenges in health and development requires the church to assess its theologies and not to be narrow in their perceptions of current issues. For instance, despite the interventions of religion to mitigate the impact of HIV and Aids in my country, Zambia, the Christian religious community is still not agreed on the importance of the use of condoms in the fight against HIV and Aids. This study in the context of the overall ARHAP aims can contribute to overcoming this problem by making pastoral leadership aware of religious health assets which they could use for the wellbeing of their community.

The above reasons have motivated me to engage with the ARHAP conceptual framework about religious health assets in Zambia, and I strongly believe that this work will help the local churches to engage in health and development in a sustainable manner.

### **1.5 Research Problem, Questions and Objectives**

In the light of the discussion about RHAs above, this particular research project seeks to assess to what extent local churches in Ndola, Zambia recognize and make use of their assets to promote health and wellbeing in their community.

The **key questions** that this study asks are:

- In what ways does the Church understand itself as contributing to the health and the wellbeing of its community?
- What assets does the church have that contribute to community health and wellbeing?
- Do its ministers recognize and appreciate the assets that are in their churches? If so, how do they enhance them?
- How can these assets further be enhanced so as to contribute to community health and wellbeing in this time of HIV and Aids, TB and malaria?

The **key objectives** of the research are therefore:

- To investigate and assess the understanding of the church's contribution to health and wellbeing.
- To analyze the relationship between these church activities and increased wellbeing.
- To contribute to ARHAP search for an adequate theoretical model to understand religious health assets.

### **1.6 Research methodology.**

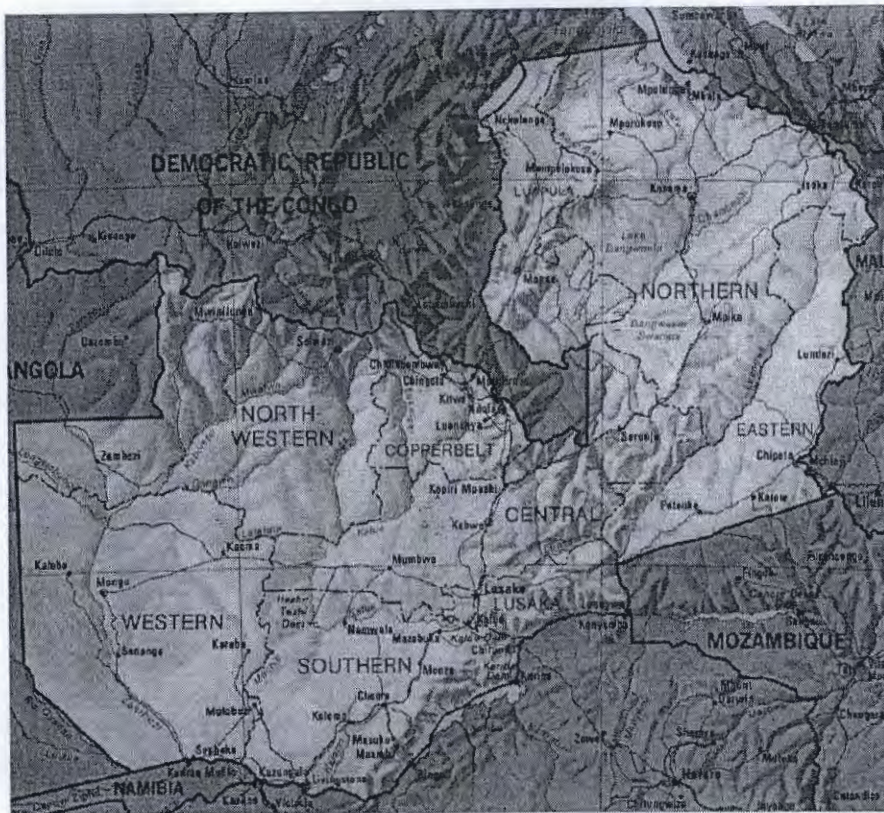


Fig.1 Map of Zambia locating the Copperbelt and in particular Ndola<sup>25</sup>

### 1.8.1. The social-economic and political background of Zambia.

Zambia is a landlocked country located in the Southern region of Africa. It got its independence in 1964 from the British Colonial government. The first era of post independence governance was a one party state of the United Nation Independence Party (UNIP) under the leadership of Dr. Kenneth D. Kaunda. At that point, Zambia inherited a strong economy sustained by copper production. However, the economy slumped in the 1980's, when the copper prices went down. Like many struggling nations, Zambia turned to the World Bank and International Monetary Fund whose assistance led to the adoption of the Structural Adjustment Programme (SAP)<sup>26</sup> in the hope of improving the economy.

<sup>25</sup> <http://www.zambiatourism.com/travel/maps/map.htm>. Accessed 31st July 2007

<sup>26</sup> SAP is an economic policy a country is required to follow when they borrow from the World Bank or IMF. It is characteristic of privatization, liberalization of markets, evaluating of local currency against the dollar and repayment of old debts. Sources on SAP from; [www.whirledbank.org/development/sap.html](http://www.whirledbank.org/development/sap.html), accessed 2<sup>nd</sup> August 2007

This SAP failed as the UNIP government tried to hold on to their socialist policies while the SAP demanded major cut backs in public spending. It has been noted that “SAPs often result in deep cuts in programmes like education, health, social care and the removal of subsidies designed to control the price of basics such as food and milk. So SAPs hurt the poor most.”<sup>27</sup> The negative impact of the SAP on ordinary lives led to food riots in the Copperbelt in 1986 which increased pressure on the ruling government to give up power and subsequently led to a change of governments in 1990.

The new government of the Movement for Multi-party Democracy (MMD) embraced the SAP in a new format of “Poverty Reduction Strategy Papers (PRSP).”<sup>28</sup> The SAPs had become unpopular in most countries, and the international partners introduced this new strategy bearing a new name but anchored on the same principles of SAPs. The new government of MMD, under Dr. Fredrick Chiluba, embarked on the liberalization of the economy which led to a massive privatization of almost all state industries, including the Copper mines. They removed subsidies on education and health, (which led to the emergence of private schooling and clinics), and on agriculture. As the economy ‘seemingly’ improved, the number of the unemployed also increased as privatization led to retrenchments of huge workforces. Industries closed down as new owners designed new strategies of running business. Over the years, the country has tried to reduce inflation and sustain financial stability by controlling inflation and diversifying from mining to agriculture.<sup>29</sup>

UNICEF reports on their website that the current government austerity measures have controlled inflation and discipline in budgeting has improved the overall economic outlook.<sup>30</sup> However, despite these measures, Zambia continues to be a poor country and

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<sup>27</sup> [www.saprin.org/global\\_rpt.htm](http://www.saprin.org/global_rpt.htm) accessed 2nd August 2007

<sup>28</sup> PRSP is a World Bank/IMF approved project for poverty reduction. Zambia adopted this policy in 2002 and ended in 2005 leading to achieving debt relief. See more details in CSPR Zambia, “Observing Poverty Reduction: A Compilation of Participatory Poverty Assessment Summary Reports 2002-2005, September 2006, [www.cspr.org.zm](http://www.cspr.org.zm)

<sup>29</sup> Zambia has since developed the Fifth National Development Plan (FNDP) 2006-2010 for poverty reduction. See CSPR “Observing poverty reduction” Pg.11

<sup>30</sup> [www.unicef.org/infobycountry/zambia\\_1391.html](http://www.unicef.org/infobycountry/zambia_1391.html) Accessed 31 July 2007

is ranked 165 out of the 177 poor countries by the UNDP<sup>31</sup>. The UNDP Human Development Report measures quality of life or wellbeing by the ability of citizens to live a long and healthy lifestyle, higher levels of education and a decent standard of life measured by the ability to earn income or have purchasing power. According to Phiri in *The Path Away from Poverty*, 73 percent of Zambians are living below the poverty datum line.<sup>32</sup>

It is in this context that the 2006 UNAIDS Demographic, social and economic indicators for Zambia records population being at 11,668,000 with a life expectancy for both women and men at 40. Furthermore, 87.4 percent of Zambians live on less than US\$2 a day, while per capita government expenditure on health is at 26 percent. The HIV prevalence in the country stands at 17 percent.<sup>33</sup> Clearly, poverty is a deteriorating factor in Zambia's social-economic progress and it has impacted negatively on the health and wellbeing of its citizens as will be looked at in more detail in chapter two.

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<sup>31</sup> [www.hdr.undp.org/hdr2006/statistics/countries/country\\_fact\\_sheet/cty\\_fs\\_zmb.htm](http://www.hdr.undp.org/hdr2006/statistics/countries/country_fact_sheet/cty_fs_zmb.htm) Accessed 1st August 2007

<sup>32</sup> Besinati Mpepo Phiri, *The Path Away from Poverty: An Easy Look at Zambia's Poverty Reduction Strategy Paper 2002-2004*, Lusaka, Zambia: Civil Society for Poverty Reduction, 2004, Pg. 9

<sup>33</sup> UNAIDS Global Report 2006 Data, [www.unaidsrstes.org/countries/Zambia/zambia.html](http://www.unaidsrstes.org/countries/Zambia/zambia.html) Accessed 2nd August 2007.

### 1.8.2. Background to Ndola

Ndola is located on the Copperbelt Province, in the North Western part of Zambia (see map below). The Copperbelt is named after the presence of copper deposits that were once the lifeline of Zambia's wellbeing. With the privatization of the mines and industries in the early 1990s, Ndola suffered an economic slump, leaving most of its citizens unemployed. According to the Zambia 2000 Census of Population and Housing, the total population of the Copperbelt in this report stands at 1,581,221,<sup>34</sup> and the total population of Ndola stood at 374,757, of which 188,222 were male, and 186,555 were female.

Ndola has forty two health facilities according to the Central Board of Health (CBoH) listing, of which 28 are run by the government and 14 are in private hands.<sup>35</sup> Of the government operated facilities, two are hospitals. One of these, the Arthur Davison Children's hospital, is a referral hospital specifically for children and the only one of its kind in Zambia. The other facilities are health centers or clinics found in most residential areas, which are the first line of treatment, i.e., a patient is required to go to a clinic instead of to the main hospitals. The clinics make referrals to the hospital. The only formal religious health facility in Ndola is Cicetekelo hospice in Lubuto township, a classic example of religious response to the impact of HIV and Aids. It caters for those that are neglected and abandoned by their families as a result of being ill with HIV or Aids.

### 1.8.3. Religion in Zambia

Zambia is a highly religious country, and it can be said that it is a component that is embedded in every aspect of community life. The state religion is officially Christianity which was constitutionalized in 1996. This was after Zambia was declared a Christian Nation by then President Chiluba in December 1991. According to a Church Survey done

<sup>34</sup> Zambia 2000 Census of Population and Housing. CSO: Lusaka, November 2003. Pg 10-15

<sup>35</sup> Health Institutions in Zambia, A Listing of Health Facilities According to Levels and Location for 2002. Central Board of Health, Lusaka Pg. 21-22



by the Evangelical Fellowship of Zambia (EFZ)<sup>36</sup>, 85% of the population are Christians, 12% ascribe to African Traditional religions, 1.5% are Muslims and 2.5% consists of Bahai's and those that have no religious adherence. While Zambia has declared itself to be a Christian Nation,<sup>37</sup> there is however a general tolerance of other religious faiths so long as they are not perceived to be cults of Satanism.<sup>38</sup>

In Ndola, the location of this study, Christianity has a large influence. The town has over 200 registered churches, and there are a number of unregistered churches that operate mostly in peri-urban areas, or 'shanty compounds'. In this study, the churches that are reviewed are those that are affiliated to what are known formally in Zambia as the four 'Mother Bodies', and the Salvation Army which is not affiliated to any mother body. These Mother Bodies are:

- The Evangelical Fellowship in Zambia (EFZ), with a membership of 12% of the Christian population.
- The Council of Christian Churches in Zambia (CCZ), which includes mainline protestant churches such as the United Church of Zambia, the Reformed Churches in Zambia, the Lutherans, and some African Initiated Churches and has about 27% of the Christian membership.
- The Zambia Episcopal Conference of the Roman Catholic Church (ZEC) has 32% of the Christians.
- The Independent Churches Association of Zambia (ICAZ), which caters for the Charismatic and Independent Ministries has 20.2% members.<sup>39</sup>

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<sup>36</sup> Evangelical Fellowship in Zambia, *Church Survey 2003:Challenging the Church on Unreached people and localities Ndola and Kitwe Cities*. EFZ, Lusaka, 2005

<sup>37</sup> Zambia was declared a Christian Nation n 29<sup>th</sup> December 1991 by President F.TJ Chiluba. See more details in *Journal of Religion in Africa*, V.33.4 2003, Pg. 406-407

<sup>38</sup> Constitution Review Report 2005 – 755 persons had submitted to the Constitution Review Commission to maintain the clause of the Christian Declaration. However, the CRC recommended that it be removed as it was exclusive, which led to a hot debate and some protest rallies, walks and prayers conducted by Evangelical Christians. They believe that to remove it from the Constitution opens up the country to Satanic activities.

<sup>39</sup> ARHAP-WHO Report: *Appreciating Assets* 2006,Pg 63

Ndola has a Pastor's fellowship<sup>40</sup>, which is predominantly attended by Pentecostal and Charismatic Ministries pastors. This is an open fellowship of any pastor who wishes to belong to it. They meet weekly on a Wednesday at Ndola Baptist Church situated along Broadway road. The Ministers under the Council of Churches of Zambia also meet monthly under the auspices of CCZ for fellowship. The other congregations that have significant influence in shaping the religious life of Ndola are the Congregations of the Christian Mission in Many Lands (CMML) and the Jehovah's Witness.

### **1.9. Overview of the thesis.**

To engage with the research questions and objectives the thesis proceeds in the following way.

Chapter one has looked at the background of the study, locating it in the African Religious Health Assets Programme, and it gives an outline of the research in terms of its relevance, the research location, the design and a summary of findings.

Chapter two is an overview of the current health situation in Zambia. It describes the context of health in relation to social economic situation and health care provision services.

Chapter three provides an overview of the current state of research in ARHAP, and the theoretical framework that has been developed thus far. This enables us to locate the research at the heart of this thesis.

The research data and findings will be presented in chapters four. Chapter five will present the contribution of local churches in Ndola to health and wellbeing analyzing the data from the perspective of the ARHAP Theory Matrix and other research findings.

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<sup>40</sup> This studyer visited the fellowship during this study to observe what it does.

Chapter six will present a theological analysis of the local churches' contributions and Chapter 7 concludes the thesis with a summary and recommendations.

### **1.10 Conclusion**

This thesis is assessing the contribution of the Church to health and wellbeing in Ndola. It is set in the context of the African Religious Health Assets Programme which is a collaborative study of researchers seeking to correlate the interface between religion and health. This chapter has given the academic background to the study, the social and political background of the context of the study, and the preliminary findings of the research. Chapter 2 will discuss in detail the social, economic and political background of Zambia as it sets the context of our discussion on religion health and wellbeing.

## CHAPTER 2

### BACKGROUND TO HEALTH AND WELLBEING IN ZAMBIA

#### 2.0 Introduction

The previous chapter provided the background to the study, locating the context of study in ARHAP and providing a brief background to the location of the study, i.e., Zambia and Ndola in particular. This chapter examines the health situation in the context of Zambia's social, economic and political life in the recent past. In view of this, I then highlight the endemic health issues in Zambia and particular mention is made of HIV and Aids, Tuberculosis and Malaria as they have seriously impacted on the nation's wellbeing. This chapter ends with a description of the major health providers and the context of religious institution's engagement in health.

#### 2.1 The Socio-economic context of the health situation in Zambia

The economic changes Zambia went through in the 1980's as a result of the increased poverty and the implementation of the Structural Adjustment Programme, resulted in primary health care being negatively compromised. The introduction of the SAP in particular increased poverty levels; led to food riots from December 1986 and paved the way for a change of government.<sup>41</sup> Before the introduction of SAPs, the government provided free medical services. The new government of the MMD adopted the Poverty Reduction Strategy Papers (PRSPs) which supported the introduction of user fees for health services in 1992. Furthermore, healthcare reforms were made which included two key strategies.

First was decentralization, through the creation of District Health Management Boards.<sup>42</sup> Previously, all health facilities and health care were managed from the provincial

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<sup>41</sup> [www.saprin.org/global\\_rpt.htm](http://www.saprin.org/global_rpt.htm)

<sup>42</sup> Zambia Demographic and Health Survey 2001-2002. Central Statistics Office/Central Board of Health, Lusaka, Zambia, ORC Macro, Calverton, Maryland, USA. February 2003 Chapter 1, Pg 3-4

ministry in Lusaka. Decentralization has led to increased efficiency in health care delivery and in networking with other partners at grass root level that are engaged in health. An example of this in Zambia is the creation of the District Aids Task Force (DATF) which consists of community members who work with the DHMB to ensure best practices in health delivery, even if DATF is primarily concerned with HIV and Aids.

Second, the government restructured the Primary Health Care (PHC) programme to work at district level with responsibilities of planning, implementing, monitoring and managing all PHC programmes in the district. The PHC is primarily concerned with the health of communities, “focusing on the needs of undeserved, high risk and vulnerable groups”<sup>43</sup> It was under this programme that the programme of Community Health Workers (CHW) began. The CHW are volunteers, who provide basic health services in their communities, mostly which lack enough trained staff, or are located far from health centers.<sup>44</sup> These work closely with medical staff from the District Health Management Team (DHMT), who are overseers of primary health care work at district level.

Despite the efforts the MMD government has made to improve health delivery services, the quality of health care services continue to be compromised due to escalating poverty. Phiri B.M rightfully describes poverty as having ‘evolutionized’ in the 1990’s and the following table is adapted to show how poverty levels increased in the decade.<sup>45</sup>

Year	Zambia		Rural		Urban	
	Overall Poverty	Extreme Poverty	Overall Poverty	Extreme Poverty	Overall Poverty	Extreme Poverty
1991	69.7	58.2	88.0	80.6	48.6	32.3
1993	73.8	60.6	92.2	83.5	44.9	24.4
1996	69.2	53.2	82.8	68.4	46.0	27.3
1998	72.9	57.9	83.1	70.9	56.0	36.2

*Table 1. Source: CSO: Living Conditions in Zambia 1998: The Evolution of Poverty in Zambia 1990-1996*

<sup>43</sup> Zambia Demographics and Health Survey 2000-2001. Pg. 4

<sup>44</sup> [http://rbm.who.int/docs/zambia\\_act\\_deploying.pdf](http://rbm.who.int/docs/zambia_act_deploying.pdf) Pg. 5 accessed 10/08/07

<sup>45</sup> Phiri. “The Path away from Poverty”, Pg. 23

Today, poverty levels stand at 73%. This in my observation shows that the macro economic policies that the government has put in place are not pro-poor, as can be seen in the output of social services delivery to the grass roots. In the peri-urban and rural areas, people coped with the lack of essential health services by training local community health workers (as they are called in villages), or home care givers as they are known in peri-urban or shanty townships. The evolution of home care started with the increase of Tuberculosis in the 1990's which was related to HIV and Aids. As cases of infections increased, the government health system could not cope with the situation due to the lack of staff. Millen notes that the problem of the brain drain generally affected countries following SAP policies, as government support to quality health provision lessened and staff left for better paid jobs elsewhere.<sup>46</sup>

As a result of poverty, UNAIDS in 2006 reported that life expectancy in Zambia now stands at 40 for both men and women, and 87.4 percent of Zambians live on less than US\$2 a day.<sup>47</sup> Poverty is a key factor to health. The World Health Organization in its six point agenda also notes as one of its major concerns the impact that poverty has on health. "Health is a key driver of socio-economic progress...yet poverty continues to contribute to poor health and poor health anchors large populations in poverty."<sup>48</sup> This is largely true for Zambia (refer to the table above), as evidenced in the recent ARHAP research workshops in Zambia (for the World Health Organisation), in which this studyer participated, and which conducted an appreciative inquiry into religious health assets in the Ndola, Kitwe, Livingstone, Chipata and Lusaka. The following story was told by a Pastor in the Bauleni Workshop in Lusaka which illustrates the interface of poverty and health;

*As a pastor, we had a patient who was sick, a church member, and we prayed for her for two weeks, and each time there was no improvement. Until one time the spirit of God*

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<sup>46</sup> Joyce V. Millen and Timothy H. Holtz, "Dying for Growth, Part 1: Transnational Corporations and the Health of the Poor" in Jim Yong Kim, Joyce V. Millen, Alec Irwin and John Gershman. *Dying for Growth: Global Inequalities and the health of the Poor* (Boston: Common Courage Press, 2000) p 109

<sup>47</sup> UNAIDS Global Report 2006 Data; [www.unaidsrstes.org/countries/Zambia/zambia.html](http://www.unaidsrstes.org/countries/Zambia/zambia.html) Accessed 2nd August 2007

<sup>48</sup> WHO Six Point Agenda, <http://www.who.int/about/agenda/en/index.htm> Accessed 31st July 2007

says, "can you just ask, if she has eaten anything?" So I asked, "Madam, have you eaten anything?" And she said, "how can I get anything?" So the Church decided to do something. In the afternoon, they all went and bought her this and that, such as a bag of maize meal. And the very next morning.....she was healed!<sup>49</sup>

In the same forum, a participant argued that even if one was taking ARV's, without food, their health remained compromised.

*"Because of lack of food, HIV and Aids speeds up, even if you are taking ARV's, if you don't have food, it won't help."*<sup>50</sup>

Clearly, the lack of food security is a concern of health, and a lack of food security is a key pointer to poverty. At this point, it is imperative to understand what we mean by poverty and will use in this study the definition given in a Zambian context. Besinati Mpepo Phiri defines poverty as "a lack of access to income, employment opportunities, normal entitlements such as freely determined consumption of goods and services, shelter and other basic needs of life."<sup>51</sup> The lack of access to income is one of the key indicators used to monitor socio-economic development. In 2004 for example, statistics show that only 38 percent of the population were in gainful employment and received regular wages, while 23 percent received income from trading and 13 received income from own productions, e.g. agriculture.<sup>52</sup>

In the ARHAP Zambia research for the WHO, the transect walks revealed that many people are engaged in trading which showed little profit such as repacking maize meal, sweets, charcoal etc. In the workshops conducted in the Mushili township on the outskirts of Ndola, the market was identified as the key economic activity of the participants. The lack of formal and secure income has led many Zambians to engage in whatever they can sell to earn a livelihood. In fact, there is now a common saying in a local language that

<sup>49</sup> ARHAP-WHO Report, "Appreciating Assets." Pg 8

<sup>50</sup> ARHAP-WHO Report, "Appreciating Assets." Pg 8

<sup>51</sup> Phiri. "The Path away from Poverty" Pg.12

<sup>52</sup> Central Statistics Office, [www.zamstats.gov.zm/lcms/lcm.asp](http://www.zamstats.gov.zm/lcms/lcm.asp) Accessed 10th August 2007

Zambia has become a '*kantemba* country'. A *kantemba* is a makeshift stall, which can be put at any convenient place where one is likely to do business. Thus, for example, in Ndola, it is not uncommon to find some items for sale outside a residential place in almost all residential areas. To this end, street vending is another common feature of trying to combat poverty in households and expresses how there is a lack of secure income due to unemployment.

The '*kantemba*' trading has negatively impacted on the health of citizens. These businesses are situated in the central towns, causing environmental degradation as filth accumulates. Thus for the last twenty years, since the liberalization of the economy, Zambia has always had cholera alerts in the rainy season. Diarrhoea, malnutrition, malaria, diabetes, tuberculosis and HIV and Aids pose serious health endemics in this environment. This scenario justifies the WHO concern that health is no longer about disease; it involves other factors such as environment, food security, impact of urbanization or rural economic etc; and the need to strengthen health systems and collaborate with other partners in order to achieve equity health care for all.

From a constitutional point, which at the time of writing this study was a subject of concern in Zambia, it is the people's wishes that health (along with other essential public services), should be enshrined in the Bill of Rights. At present this is not guaranteed for all citizens,<sup>53</sup> and in fact, government expenditure on health is minimal. According to UNAIDS,<sup>54</sup> Zambia in 2006 spent US\$32,000,000, on domestic health, representing 11.8% of the total budget on health. Of this, 44.7% comes in as donor support, while 48% comes in through non-governmental organizations.

Clearly, poverty is a key factor in combating the general rise in diseases, especially HIV and Aids, Malaria, and Tuberculosis which are significant pandemics in the country.

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<sup>53</sup> [www.jctr.org.zm/downloads/simsonafcast.doc](http://www.jctr.org.zm/downloads/simsonafcast.doc) Accessed 10th August 2007

<sup>54</sup> ARHAP-WHO Report. "*Appreciating Assets*" Pg. 14



## 2.2. Cross cutting health issues in Zambia

In light of the socio-economic factors described above, many Zambians suffer from ill health. Thankfully, the last five years have seen an improvement in public health delivery services, with statistics showing that access to a health facility is at 90.2 percent countrywide, with urban area access at 90.8 and in rural areas at 89.7 percent.<sup>55</sup> While we acknowledge the improvement in health facility services, Zambia continues to suffer the prevalence of diseases that are preventable and curable such as malaria, tuberculosis, diarrhea diseases, and HIV and Aids which currently is un-curable but preventable. The last years have also given rise to increase in diabetes and hypertension. Of much significance is the impact HIV and Aids, Malaria and tuberculosis have had on the nation.

Current statistics show the HIV prevalence is at 15.6 percent among adults aged 15-49. In this, the female infection rate stands at 18 percent and men at 13 percent, a clear indication that women are more susceptible to infections. In the context of poverty, this is not surprising as women, apart from being biologically prone to infections, have resorted to commercial sex to earn a livelihood. For example, the *Post Newspaper* of 8<sup>th</sup> July 2008, tells a story of an old woman aged 63 who is engaged in prostitution. In this article, stories of other women that are involved in prostitution are told, and the reason given for engaging in it is so that they could have food. HIV and Aids has increased the burden of health provision. Currently, the government is committed to care and prevention programmes and has rolled out free Anti retroviral drugs to those infected, of course with the help of donor aid.<sup>56</sup>

Malaria is Zambia's major public health concern, responsible for approximately 50,000 deaths and four million clinical cases annually.<sup>57</sup> Zambia is rated among the countries in Africa with highest related maternal and infant mortality rates caused by malaria.<sup>58</sup> A

<sup>55</sup> [www.zamstats.gov.zm/lcms/lcms.asp](http://www.zamstats.gov.zm/lcms/lcms.asp) Accessed 10th August 2007

<sup>56</sup> The USAID through the PEPFAR fund supports most of the HIV/IDS activities in Zambia. Visit website [www.kosovo.info.usaid-gov/zm/population/phn.htm](http://www.kosovo.info.usaid-gov/zm/population/phn.htm) Accessed 10<sup>th</sup> August 2007

<sup>57</sup> "Artemisinin-based combinations therapy in Zambia: From Policy change to implementation."

[http://rbm.who.int/docs/zambia\\_act\\_deploying.pdf](http://rbm.who.int/docs/zambia_act_deploying.pdf) Pg. 3 Accessed 3rd March 2007

<sup>58</sup> Zambia Demographic and Health Survey 2001-2002. Pg.157

quarter of infant mortality is related to malaria and it accounts for 50 percent of hospitalizations.<sup>59</sup> The government has shown political will in the scaling up and intervention processes of Malaria. In 1999, through the Ministry of Health, government has scaled up programs such as the Roll Back Malaria (RBM) campaign and the use of prophylaxis particularly for pregnant women. The goals of the Roll Back Malaria programme were twofold:

- To have 60% of high risk groups to malaria have access to insecticide treated nets through subsidizing the cost of purchasing the bed nets.
- To make available prophylaxis to 60% of all pregnant women at risk of being sick with malaria

However, despite these interventions, malaria continues to be the leading cause of morbidity in Zambia. The Zambia District Health Services (ZDHS) in their findings note that failure to adhere to interventions has contributed to an increasing death rate as a result of malaria.<sup>60</sup> For instance, the report notes that a lack of education is a factor to ill health. In the use of treated nets, it reports that less than one in five pregnant women slept under a net the night before the survey while 16 percent used an insecticide treated net. 11 percent of women with less secondary education used nets while 44 percent of women with secondary education and more, slept under a net.

Tuberculosis is another disease that affects many Zambians. According to a report on global health, it is estimated that the notification rate of infections for TB in Zambia is at 150 per 100,000 people, twice the African regional average. Recently Zambia has experienced reversal trends in the success it had in combating TB through the DOTs.<sup>61</sup> DOTs is the directly observational treatment involving care givers monitoring patients intake of medication for compliance.<sup>62</sup> Most TB patients are also infected by HIV.

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<sup>59</sup> [www.kosovo.info-usaid-gov/zm/population/phn.htm](http://www.kosovo.info-usaid-gov/zm/population/phn.htm)

<sup>60</sup> ZDHS 2001-2. The Government has launched another survey in 2007 to update statistics.

<sup>61</sup> [www.usaid.gov/our\\_work/global\\_health/id/tuberculosis/countries/africa/zambia\\_profile.html](http://www.usaid.gov/our_work/global_health/id/tuberculosis/countries/africa/zambia_profile.html) accessed 6.11.08

<sup>62</sup> Fredrick Kaona. "An assessment of factors contributing to treatment, adherence and knowledge of TB transmission among patients on TB treatment." Mwenge Social and Health Research Centre, Ndola:2006

HIV and Aids, Malaria and Tuberculosis are not the only serious health crises in Zambia. The other health problems that seem to be on the increase are hypertension and diabetes. The ARHAP-WHO Report further highlights issues of environment such as lack of safe drinking water, unhygienic surroundings, poor road networks and infrastructure as drivers in impacting negatively on health and wellbeing. In this context, we will now consider the key health providers in Zambia.

### **2.3 The Key Health-Care Providers in Zambia**

Having considered the health situation in Zambia, it is significant that we now look at the key providers of health. There are four main providers, namely, government, private, traditional and church.

#### **2.3.1 Health care provision by the government**

The government of the Republic of Zambia is a major provider of health care and facilities through its line ministry, the Ministry of Health. According to statistics from the Central Board of Health, government runs and supports through grants a total of one thousand, one hundred and twenty four health facilities, among them hospitals, health centers and health posts.<sup>63</sup> See table on next page.

The third level facilities refer to the 'big' hospitals which are University Teaching Hospital (UTH) and Chainama in Lusaka, both of which are teaching hospitals, with Chainama specializing in Psychiatry training. The Copperbelt has Ndola Central Hospital and Arthur Davison Children hospital, and Kitwe Central Hospital. All these facilities train nurses and are referral hospitals.

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<sup>63</sup> Health Institutions in Zambia, A Listing of Health Facilities According to Levels and Location for 2002. (Central Board of Health, Lusaka Zambia) Pg.1

Table 2: Summary of Health Institutions by Type, Size and Ownership<sup>64</sup>

Facility Type	No of Units	Total Number of		Number of Facilities Owned by			Total	
		Beds	Cots	Govt	Private	Missions		
3rd Level	5	3,802	452	5			5	
2nd Level	18	5,133	988	12		6	18	
1st Level	74	6,795	1,166	36	17	21	74	
Health Centres	Rural	973	8,077	570	889	23	61	973
	Urban	237	1,632	325	163	74		237
Health Posts	20			19	1		20	
<b>Total</b>		<b>1,327</b>	<b>25,439</b>	<b>3,501</b>	<b>1,124</b>	<b>115</b>	<b>88</b>	<b>1,327</b>

### 2.3.2 The health care provision by private health institutions

Today in urban areas, private clinics are a thriving business and an alternative health care service for citizens in Zambia. The MMD government, in line with its free-market policies, allowed medical staff to open and run their own private practices alongside government health facilities. Private health care provision has become a preferred option for many that can afford it because it guarantees being attended to a doctor, who is regarded as the person with most knowledge in medicine. It also guarantees effective laboratory services and availability of medicines. The private clinics are also known for their quality service as well as efficiency, as people are attended to in the shortest possible time.<sup>65</sup>

In the town centre of Ndola, there are a number of private facilities dealing with clinical health, eye care, dental, gynecology and laboratory services. There are also a number of dispensaries, or private chemists that have opened in the centre of town with adequate

<sup>64</sup> Global Religious Health Assets Mapping (GRHAM) [http://ccih.org/grham/country/zambia/Tables\\_1.htm](http://ccih.org/grham/country/zambia/Tables_1.htm) accessed 10th August 2007

<sup>65</sup> This observation is made by the researcher from the perspective of Ndola where she lives and has had personal experiences of being treated at a government health facility and that of a private clinic.

supplies of medicines and other medical requirements.<sup>66</sup> Out of the 42 facilities listed in Ndola by the CBoH, 14 are owned privately.<sup>67</sup>

### 2.3.3 Health care provision by Traditional healers

Traditional healing has become an increasing phenomena in Zambia today (see picture below). There are two kinds of traditional healing – the herbalist and diviners. Both types of health provision are becoming a prominent feature in Zambia, with the latter having formed an Association. They are now legally recognized by government as partners in health care. This association is called the *Traditional Healers Association of Zambia* (THAPAZ). The herbalists also fall into two categories. There are herbalists that are receiving a formal education in herbal medicines<sup>68</sup> and herbalists that have learnt the skill through traditional ways and these require certification by THAPAZ to practice. THAPAZ is now recognized by the Ministry of Health as a research and health service provider. As other forms of health care become more difficult to access due to poverty, people are turning to traditional approaches of healing. The traditional healers are almost always found in peri-urban areas in which poverty is rife.



*This picture depicts one of the adverts of a traditional healer found in Kabushi, Ndola.*

<sup>66</sup> Researchers observation as she lives in Ndola

<sup>67</sup> Health Institutions in Zambia, Pg 21-22

<sup>68</sup> The Radio Phoenix, a private Radio Station, features herbal healing remedies every Tuesday morning, from 9:00-11:00 hours, which has become a popular phone in programme.

### 2.3.4 Health care provision by Christian Church health institutions

The Christian Church in Zambia has been associated with the provision of health care since the time of its missionary enterprise.<sup>69</sup> As they arrived in some parts of Zambia, the missionaries introduced Christianity alongside providing social services to improve people's livelihood, such as healthcare, improved agriculture methods, schools and welfare societies for women and children. Given this, early missionary evangelism in Zambia is associated with the presence of a health and educational facility. According to Dr. Biemba in his paper "Value-Added and Invisibility of Religious Health Assets", the Church in Zambia provides 30% of overall healthcare and about 60% of rural health services.<sup>70</sup>

In Ndola, the context of study for this study, there is no mission health facility listed in the CBoH Statistics despite the fact that the church is engaged in the mission of health care provision, most of it specialized to meet the needs of the poor in light of HIV and Aids and poverty. For example, the Catholic Diocese of Ndola, through its Health and Healing Ministry, are running about 11 mission hospitals and rural health facilities on the Copperbelt, two of which are in Ndola Rural at Kavuu and Kafuafuta.<sup>71</sup> The Ndola Ecumenical Hospice Association was founded in 1996, and runs home based care programme in ten peri-urban areas in Ndola, and has a hospice located in Lubuto, and a home for the destitute as a result of HIV and Aids in Masala.<sup>72</sup> The pandemic of HIV and Aids and escalating poverty levels<sup>73</sup> in Zambia, together with increased funding support from PEPFAR and the Global Fund, has resulted in an increase in religious entities engaging with communities to improve their health and wellbeing. These activities constitute what ARHAP has identified as religious health assets and this study focuses to locate such assets in the Christian Church in Ndola.

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<sup>69</sup> Missionary enterprise in this context refers to the Christianization of Africa through the coming of missionaries in the late 1800's.

<sup>70</sup> Godfrey Biemba, Value Added and Invisibility of Religious Health assets" in ARHAP International Colloquium 2007: Collection of Concept Papers (Cape Town, 2007) Pg. 21

<sup>71</sup> Catholic Diocese of Ndola, Strategic Plan for 2005 -2007 Health and Healing Ministry, Health Department, Ndola. Interview with Mr. Mufalo Illitongo on 16<sup>th</sup> May 2006

<sup>72</sup> Brochure, Ndola Ecumenical Hospice Association

<sup>73</sup> The Catholic Health and Healing Ministry also notes these factors as significant to their engagement to provision of health care in their Strategic Plan Document (pg iv).

Mission health facilities are found mostly in rural areas. However, the increase in HIV and Aids related illnesses has changed the focus of the Church's understanding of their mission in health from rural areas to urban areas. Table 1.1 above suggests that as per the official records, religious institutions do not have health centres or health posts in urban areas. As we shall see, due to the context of HIV and Aids and poverty prevalence, this is no longer true. This study notes that there are religious health assets that are functioning to mitigate the impact of disease and poverty, which if aligned with the wider public health services, could enhance the wellbeing of communities. In the ARHAP workshops conducted in Zambia, the research revealed that most FBO's had begun in the early 1990's to respond to the need the need for quality health provision especially in vulnerable and poor communities.

## **2.4 Conclusion**

This chapter has given a description of the context of health in Zambia. It highlighted the impact that macro economic policies have had on the quality of health care provision. Poverty has been identified as a key issue that Zambia faces as it strives to provide equity to access health care. Poverty has led to an increase in diseases such as HIV and Aids, malaria and tuberculosis. The chapter has ended with a description of the major health providers and it sets the background of this study which is focusing on the health assets held by the churches, which are not necessarily visible in the health system but have an impact on the health and wellbeing of communities. In order to unpack these assets, the next chapter will examine health, religion and development in the context of the studies undertaken in ARHAP, and will engage with some literature to understand what ARHAP mean by religious health assets.

## CHAPTER 3

### RELIGION, HEALTH AND DEVELOPMENT IN THE CONTEXT OF THE AFRICAN RELIGIOUS HEALTH ASSETS PROGRAMME (ARHAP)

#### 3.0 Introduction

The previous chapter presented the health situation in Zambia. It identified the government, private sector, traditional healers, and the churches as major health care providers. This chapter gives an outline of studies done by ARHAP since its inception and the impact on global health. Through these studies, ARHAP has made visible religious health assets (hereafter RHA's) and calls for enhanced engagement by public health policy makers and service providers with these RHA's. I will also introduce the ARHAP theoretical framework that led to the need for this study, which is set in grounded theory. The Chapter concludes with a summary of the WHO-ARHAP report findings which are particularly related to Zambia as a location of this study.

#### 3.1 The Global Challenges of health

HIV and Aids has provided a useful window through which the global world now perceives health issues. Bio-medics define health as "a state of complete physical, mental and social well being, and not merely the absence of disease and infirmity."<sup>74</sup> A clinical definition states that health is "the absence of pathological abnormalities or disease."<sup>75</sup> The WHO defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."<sup>76</sup> In the context of development, health is viewed in relation to the capabilities humans beings have available in order to enhance their productivity. "Healthy people are able to work harder and be more productive. As a result of this productivity, they will be in a better position

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<sup>74</sup> Gilbert, Selikow and Walker. *Society, Health and Disease*. 1996. Pg.7

<sup>75</sup> Gilbert, Selikow and Walker. *Society, Health and Disease*. 1996. Pg.7

<sup>76</sup> Godfrey Biemba "Value Added and Invisibility of Religious Health Assets" in Concept Papers. Pg 25



to gain access to education for their children.”<sup>77</sup> The argument is that access to basic health, education and nutrition reduces poverty, a key factor we have identified in chapter two as contributing to ill health and lack of wellbeing and which has led to global concern to achieve health for all.

Two global concerns of interest to this study are the Millennium Development Goals (hereafter MDG’s) and the promotion of Universal Access.

### 3.1.1 The Millennium Development Goals

The Millennium Development Goals<sup>78</sup> (MDG’s) aim to halve world poverty levels by 2015. The three MDG’s which focus on health are:

- improvement of maternal health,
- reduction of child mortality
- Combat HIV and Aids and other diseases.

The MDG’s are important to the context of assessing the impact of religious health assets. It is for this reason among others that ARHAP is assessing the significance of RHAs and how they can be leveraged for practical implementation of global concerns such as the MDG’s. For instance, a report on access to health facilities in Zambia, shows that 90.2% of urban population and 89.7% of rural population has access to health facilities. Clearly, this indicates that for the MDG goals on health to be successful, alternative health models will have to be considered. Thus, ARHAP seeks to make RHAs visible to health policy makers and service providers.

### 3.1.2 Universal Access

The World Health Organization (hereafter WHO) in 2005 recognized the need for an unprecedented humanitarian effort in order to roll out universal access to the prevention,

<sup>77</sup> Kellerman, “*Health and Development*”, 2000. Pg. 184

<sup>78</sup> Eradicate extreme poverty and hunger, 2. Achieve universal primary education, 3. Promote gender equality, and empower women, 4. Improve maternal health, 5. Reduce child mortality, 6. Combat HIV and Aids, malaria and other diseases, 7. Ensure environmental sustainability, 8. Develop a global partnership for development. Source: <http://www.undp.org/mdg/basics.shtml> Accessed 7.11.08

treatment, care and support of HIV and Aids.<sup>79</sup> At the same time G8 countries committed themselves to see an expanded initiative for universal access to HIV and Aids treatment, care and prevention by 2010.<sup>80</sup> The universal access was proposed out of concern that few people, particularly in Africa, were accessing the ARV's. The commitment has five strategic areas of consideration, and it is accompanied by funding unprecedented from 'super powers' to Africa's fight against HIV and Aids, such as the Global Funds and the PEPFAR funds.

The strategic areas identified in Universal Access are: Knowing one's status through counselling, maximizing the use of six preventive strategies (safer sex, reducing transmission through mother to child, injectable drug use, health care setting; improving services to PLWHA and developing new health technologies), continued scaling up of treatment and care, improving strategic information and building capacities in health systems.<sup>81</sup>

It is in the above contexts that ARHAP was commissioned by WHO to conduct a comprehensive assessment of religious health assets, with pilot studies conducted in Zambia and Lesotho.<sup>82</sup> Considering the definitions of health given in a global context, we can deduce that the search for health has the same goal; achieving wellbeing for all people. The language surrounding health is now a major concern in religious circles. It is suggested that the language of health is one that religions, more so the Christian religion with which this thesis is about, need to recapture and re-conceptualize in its every day mission. Gary Gunderson captures this concern when he writes that the "language of health initially seems odd because we have removed the word from its roots in relationships – wholeness-and quite literally privatized it, even monetarized it. Health is one more commodity to be purchased and consumed by individuals. You would think

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<sup>79</sup> ARHAP-WHO Report. *Appreciating Assets* Pg. 6

<sup>80</sup> ARHAP-WHO Report: *Appreciating Assets*. Pg 18-19

<sup>81</sup> TOWARDS UNIVERSAL ACCESS: *Scaling up priority HIV/AIDS interventions in the Health sector*. Progress Report, April 2007, [http://www.who.int/hiv/mediacentre/universal\\_access\\_progress\\_report\\_en.pdf](http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf) Pg. 5. Also ARHAP-WHO Report: *Appreciating Assets* Pg. 19

<sup>82</sup> ARHAP-WHO Report: *Appreciating Assets*. Pg 18

religious groups would know better than that.”<sup>83</sup> ARHAP’s work emerges out of these concerns.

### 3.2 Contribution of ARHAP to Global health

This section will highlight some research work that ARHAP has conducted. The importance of this section is that it highlights what ARHAP has done so far in setting ground for future research in RHAs. It will also be helpful to this study in Chapter 4 when we will analyse the findings of this study.

#### 3.2.1 Conceptualizing of Healthworlds

Among the findings that ARHAP has is in the area of understanding what constitutes people’s healthworlds. This study was done in Lesotho and it was found that in the modern challenges of seeking health and wellbeing, people resort to a plurality of ‘healthworlds’ informed by the religious background.<sup>84</sup> In Sesotho, their healthworld is conceived of as encompassing the whole of life, *bophelo*<sup>85</sup> in which there is no divide between religion and health. Bophelo basically means life in relation to a healthy society. A healthy society is right relationships reflected to self and others, starting with family, then to the village and finally to nation. “The lack of bophelo in any one of these areas means that bophelo of the whole is compromised.”<sup>86</sup>

The Lesotho study contributes to the understanding that in most African religious settings, there is no clear divide between what can be classified as spiritual and separated from the physical or social aspects. The happenings in the latter will often be understood in the context of the former, hence an understanding that most people in Africa have a plurality of healthworlds, i.e. visit a western medical doctor, and at the same time seek

<sup>83</sup> Gunderson. *Deeply Woven Roots*. 1997. Pg. 3

<sup>84</sup> This study was conducted by Paul Germond, Septla Molapo, Thandi Reilay and Eva Vera in 2005, Lesotho

<sup>85</sup> Paul Germond and Septla Molapo, “In search of Bophelo in a time of AIDS: Seeking a coherence of economies of health and economies of salvation” in *Journal of Theology for Southern Africa*. Vol 2, Nov 2006 in Pg 4-5

<sup>86</sup> ARHAP Case Study #2: Lesotho in Case Study Focus, Papers and proceedings, July 2005. Pg 69

the diviner to interpret source of illness, and then also visit a faith healer, and possibly attend a Pentecostal healing service on Sunday.

### 3.2.2 Visibility of RHAs

ARHAP has since its inception carried out a number of research projects that are contributing to enhancing the visibility of religious health assets to the public health domain. Reports of four key research studies done and their findings are given below.

#### 3.2.2.1 Masangane

**Title: “Let us embrace: The role and significance of an Integrated Faith-based Initiative for HIV and AIDS. (2006)**

This study was done in the *Masangane* health project in the Eastern Cape of South Africa, to evaluate the Faith Factor in the treatment of AIDS. *Masangane* (which means ‘let us embrace’) is a faith-based entity which was one of the first such entities to roll out ARV’s. This study further sought to find out the potential role faith-based entities (called Faith Based Organisations/Initiatives, or FBO/Is in the report) have to respond to the provision of ART and if it could be used as a model for a replicable response to HIV and Aids. The findings indicate that FBO/Is could be “stepping stones” into accessing ART as they provide a ‘continuum of care’ responding to different levels of human need, physical, psychological, emotional, relational or spiritual.<sup>87</sup> Trust and credibility are also some of the important health assets of FBO/Is that could be leveraged to reduce stigma in accessing ART in health outcomes.

#### 3.2.2.2 WHO Report

**Title: Appreciating Assets: The contribution of religion to universal access in Africa. (2006)**

We have made reference to this study above which was undertaken for the World Health Organization as a pilot study in Zambia and Lesotho. Its purpose was to assess the

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<sup>87</sup> “Better Words”: pg. 4

potentiality of religious entities as key partners in the universal access to treatment, care and prevention of HIV and AIDS by 2010. The focus of the study was to identify and locate RHAs that can be potential factors in the fight against HIV and AIDS. This report is of particular interest to this thesis and a summary of its key findings are:

1. Religion is ubiquitous in Zambia and Lesotho, yet often hidden from Western view. Given this, an engagement with religiously informed healthworlds is vital for the shaping of public health policy in southern Africa.
2. Religion, health and wellbeing are locally and contextually driven. For those seeking to engage RHAs, religion cannot be viewed as a single, simple cultural “variable” – “no one size fits all”.
3. Religious involvement in health and HIV and AIDS is increasing – particularly since 2000- and religious entities have expressed a strong local commitment and desire to be more effective in the area of HIV and AIDS. Interfaith engagement and dialogue require further explorations.
4. Religious entities are perceived as contributing to health, wellbeing and the struggle against HIV and AIDS through tangible and intangible means. It is this contribution that distinguishes them and gives them strength. Leading tangible factors comprise compassionate care, material support and health provision; leading intangibles are spiritual encouragement, knowledge giving and moral formation.
5. Certain religious entities are acknowledged as ‘Exemplars’ in the community and these demonstrate exceptional programmatic, operational and associative characteristics.
6. An Asset-Based Approach to research and implementation of religion and health initiatives and HIV and AIDS scale up offers the potential for more rapid, sustainable and effective capacity-building and action.<sup>88</sup>

### **3.2.2.3 Gates Foundation**

**Title: The contribution of religious entities to health in sub-Saharan Africa (2008)**

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<sup>88</sup> “Better Words.” Pg. 5-6

This is a case study conducted for the Bill and Melinda Gates Foundation in three countries, Mali, Uganda and Zambia. It sets out to provide a description of the contribution of Religious Entities (REs) and FBO/Is and religious networks to health in especially poor countries of SSA and to identify key areas for investments in health.

A summary of the key findings is that REs/FBO/Is make significant and unique contributions to health services and show great variety in type and extent. Other kinds of contributions noted are in their networking, shifts in ownership of funding from historic mission funding to local agency, severe working constraints, provision of non facility health services to immediate local needs, have multiple healing modalities and are generally underutilized.<sup>89</sup>

#### **3.2.2.4 Tearfund/UNAIDS**

**Title: The potential and perils of partnerships: Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and the DRC. (2008)**

This study was conducted to build mutual trust and create effective and long term sustainable partnerships between faith-based agencies, donors and national institutions in their response to HIV and AIDS. This study was done in Kenya, Malawi and the Democratic Republic of Congo.

A summary of the key findings points to the need to differentiate contexts and stages of various Christian REs in relation to nationally controlled collaborations for networking, effective representation of key stakeholders and a common commitment to monitoring and evaluation. Sectoral groups need to develop collaborative relationships to achieve a multisectoral collaboration and highlights the nature of donor involvement as crucial. Governments need to recognize Christian entities as having vital health assets to

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<sup>89</sup> Details of the key findings in "Better Words", pg. 10

mitigating impact of HIV and AIDS while they also must acknowledge their conservatism as being often a hindrance to effective collaboration and health outcomes.<sup>90</sup>

These four ARHAP research projects are important in the face of the unprecedented humanitarian effort needed to achieve health and wellbeing. These research studies show religion as a dominant factor in Africa of how people understand health and their struggles to achieve it. The results of these studies are of importance not just to religion, but also to public health policy makers and service providers for the need to approach health from an inter-disciplinary and collaborative approach to achieve better outcomes.

At the same time, from ARHAP's research perspective and desire to *understand* what RHAs are and how they work, these research projects have also provided insights into what is happening around religion and health on the ground, and so they provide the basis for the continued need to test the ARHAP theoretical frameworks. To articulate the concepts and frameworks in which these studies were undertaken, ARHAP research is based on what is known as a 'grounded theory' approach, and a matrix was initially conceived to provide a hypothesis to guide the locating of these religious health assets.

### **3.3 ARHAP Theoretical Framework –Grounded Theory**

ARHAP makes use of a 'Grounded Theory' approach to research. This recognizes that the work is set in a 'bounded field of unknowing,' meaning that there are known boundaries to what is being looked at, but within those boundaries there is much that is not known. A Grounded Theory approach means that research is exploratory in nature and operates on "very little established theory" and hypotheses on the ground. In the WHO report, ARHAP speaks of Grounded theory in this way:

Given that we are exploring areas with, as yet, very little established theory, we are intentionally involved in a research spiral moving among certain broad research questions and hypotheses, an emerging body of data "from the ground," and a process of analytical reflection, which in turn shapes emerging theoretical

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<sup>90</sup> See more details in "Better Words", pg.15-16

insights and helps to sharpen the next round of research questions. This gives a fundamental inductive orientation to our work.<sup>91</sup>

On this basis ARHAP has sought to work with the insights and perspectives of ordinary people and key informants in a given situation, making use of research processes such as Appreciative Inquiry, along with other standard qualitative and quantitative means to clarify a hypothesis.<sup>92</sup> The hypothesis of ARHAP is that religion has assets that can enhance health and development. These are referred to as Religious Health Assets, hereafter RHA's. These assets can be both *tangible* and *intangible* and can impact directly or indirectly on health and wellbeing of people. To seek to understand what these religious health assets are and how they can be leveraged for greater use in public health, ARHAP created a matrix as a theoretical framework. This serves as a hypothesis around which theory can emerge from research on the ground.

### 3.4 The ARHAP Theory Matrix

The matrix (see below) was developed by ARHAP scholars as a tool to guide its research into religious health assets and how they impact on health outcomes. It illustrates the possible tangible and intangible religious health assets and their impact directly or indirectly on health.

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<sup>91</sup> ARHAP-WHO Report Pg 7

<sup>92</sup> ARHAP-WHO Report Pg.7



### The Theory Matrix.<sup>93</sup>

Table 3

<b>Intangible religious assets</b>	Possible factors include: <b>1</b> <ul style="list-style-type: none"> <li>• Prayer</li> <li>• Resilience</li> <li>• Health seeking behaviour</li> <li>• Motivation</li> <li>• Responsibility</li> <li>• Commitment/sense of duty</li> <li>• Relationship: care giver and 'patient'</li> <li>• Advocacy/prophetic</li> <li>• Resistance- physical and or structural/political</li> </ul>	Possible factors include: <b>2</b> <ul style="list-style-type: none"> <li>• Individual (sense of meaning)</li> <li>• Belonging-Human/Divine</li> <li>• Access to power and energy</li> <li>• Trust /distrust</li> <li>• Faith-hope-love</li> <li>• Sacred place in a polluting world</li> <li>• Time</li> <li>• Emplotment (story)</li> </ul>
<b>Tangible religious assets</b>	Possible factors include: <b>3</b> <ul style="list-style-type: none"> <li>• Infrastructure</li> <li>• Hospitals-Beds etc</li> <li>• Clinics</li> <li>• Dispensaries</li> <li>• Training and Para- Medical</li> <li>• Hospices</li> <li>• Funding/development agencies</li> <li>• Holistic support</li> <li>• Hospital chaplains</li> <li>• Faith healers</li> <li>• Traditional healers</li> <li>• Care Groups</li> <li>• NGO/FBO- "projects"</li> </ul>	Possible factors include: <b>4</b> <ul style="list-style-type: none"> <li>• Manyano and other fellowships</li> <li>• Choir</li> <li>• Education</li> <li>• Sacraments/rituals</li> <li>• Rites of passage( accompanying)</li> <li>• Funerals</li> <li>• Network/connections</li> <li>• Leadership skills</li> <li>• Presence in the Bundu (on the margins)</li> <li>• Boundaries( Normative)</li> </ul>
	<b>Direct health outcome</b>	<b>Indirect health outcome</b>

It is important to note here that the matrix is not normative, as it is a merely a heuristic tool that guides the research and it is not the description of the reality itself.<sup>94</sup> In terms of a grounded theory approach, it is the initial hypothesis which field work seeks to reject, confirm, or develop in a more sophisticated way.

The matrix suggests that there are four basic kinds of RHAs and these are

- Tangible religious health assets and their direct health outcomes
- Tangible religious health assets and their indirect health outcomes
- Intangible religious health assets and their direct health outcomes

<sup>93</sup> James Cochrane and Barbara Schmid, *ARHAP Tools Workshop Report*. (Cape Town, June 6-8, 2004) Also visit <<http://www.arhap.uct.ac.za>>

<sup>94</sup> James R Cochrane "Deliberations on Religion and Religious Health Assets" In Case study Focus, Papers and Proceedings, July 2005 Pg. 22

- Intangible religious health assets and their Indirect outcomes<sup>95</sup>

This thesis engages with this aspect of ARHAP's work, and seeks to identify these health assets in the local churches in Ndola and to explore their impact upon health. It thus becomes important to this study to define what ARHAP means by tangible and intangible assets and their health outcomes.

### **3.4.1 The Tangible Assets and their Direct/Indirect health outcome**

The tangible assets as noted in quadrant 3 and 4 in the Matrix above are the visible structures and activities such as infrastructure, human resources, hospitals, hospices, clinics, projects or FBOs among others that can be identified as belonging to a religious entity. They are tangible in that they support health outcomes in a visible manner and they support and compliment public health facilities in most countries. These have a direct impact on health outcomes.

On the other hand, religion has tangible assets within itself which may not be obvious RHAs. These are exemplified in quadrant 4 as 'Manyano and other fellowship groups, choir, education, sacraments/rituals, rites of passage, leadership skills among others which have an *indirect* impact on health and wellbeing. This tries to capture the idea that in a wider perspective – whilst not necessarily contributing specifically and intentionally to health – nevertheless religious activities do contribute to health and wellbeing in an indirect way.

### **3.4.2 The Intangible Assets and their Direct/Indirect Health Outcomes**

Intangible assets are not obvious or easily quantified. ARHAP defines intangible assets as the “volitional, motivational and mobility capacities that are rooted in vital affective,

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<sup>95</sup> Steve de Gruchy, “ARHAP Case Study #3: Zambia-Pilot Research Project on the Copperbelt” in Case Study Focus, Gauteng: 2005 Pg 72-73

symbolic and relational dimensions of religious faith, belief, behaviour and ties.”<sup>96</sup> The examples of intangible assets are local knowledge, access, participation, trust, hope, resilience and accompaniment. In the Matrix, intangible assets are exemplified in quadrant 1 and 2 and they too can have a direct or indirect impact on health.

With the concern that religion plays a significant role in health in Africa, ARHAP seeks to document and locate these religious health assets that are both tangible and intangible and document them so that they could be aligned and made visible to public service providers, policy makers and health seekers.

### **3.5 A summary of findings related to Zambia from WHO Report**

We will now briefly consider the findings from Zambia in the research undertaken for the WHO, and which enhanced ARHAP’s thinking about tangible and intangible assets. This is significant to the overall outcome of this particular thesis which is examining the contributions local churches in Ndola, Zambia, contribute to health and wellbeing.

ARHAP conducted workshops for community members and leaders at different levels in four regions; Copperbelt, Livingstone, Chipata and Lusaka. The key question that was asked to both groups is “*What is the contribution of religion and religious entities to health and wellbeing in a time of HIV/AIDS?*”<sup>97</sup> The summary of the overall findings show that religion contributes to health and wellbeing in three categories:

- Within the social, economic, political and cultural context where issues of poverty and HIV and AIDS are highlighted. This category relates how there are variations by regions in their perceptions of health and wellbeing and recognizes the role religious entities currently play to promote health and wellbeing.
- The nature of religious contribution has been categorized as spiritual, moral formation, knowledge giving, advocacy and policy formulation

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<sup>96</sup> ARHAP-WHO Report. *Appreciating Assets*. Pg 40-41

<sup>97</sup> ARHAP-WHO. *Appreciating Assets*. Pg. 67

- The nature of the contribution of religious entities was identified in areas of relationships/networks, and in tangible and intangible ways. The tangible factors are; compassionate care, material support and curative interventions. The intangible factors categorized are spiritual encouragement, knowledge giving and moral formation.<sup>98</sup>

This work has already pushed the hypothesis of the matrix beyond the original ideas, and given a richer understanding of these tangible and intangible and intangible assets. The research in this thesis is seeking to take this further through a more in-depth qualitative survey of some of the churches in Ndola, exploring what they are actually doing about health and wellbeing.

### **3.6 Conclusion**

This chapter has highlighted significant research that ARHAP has since done, concluding with a section of a summary of the finding related to Zambia that will be useful to this thesis in chapter 5. The next chapter will present the data research that this thesis is about; an examination of the contribution of local churches in Ndola to health and wellbeing.

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<sup>98</sup> ARHAP-WHO. *Appreciating Assets*. Pg. 67

## CHAPTER 4

### RESEARCH DATA AND FINDINGS

#### 4.0 Introduction

The previous chapter gives an overview of ARHAP, its inception, objectives and the major works and findings that have been achieved. The primary argument in ARHAP is that religion has assets that contribute to health and wellbeing. These assets may be tangible or intangible, and have direct or indirect outcomes for health and wellbeing. However, they have not been visible to key public health actors, which necessitate the need to identify these religious health assets in Ndola that could be leveraged for enhanced health delivery services. This chapter presents the research data on the extent of the contributions of the local Churches in Ndola to health and wellbeing in Ndola in a descriptive form.

Here we need to just remind ourselves that this particular study seeks to locate the Church in Ndola as an asset to health by identifying some of the activities it engages in which promote health and wellbeing, even when it may not recognize itself as doing so. The hypotheses of this study is that current Christian interventions in health crises can be enhanced with the conscious knowledge of the Christian health assets that impact upon the community's wellbeing.

A further factor to take note of here is that, as noted in chapter 3, this study is located in a research field that has very little established theory.<sup>99</sup> The approach makes use of 'grounded theory' in which data from the ground informs the process of research and shapes the theoretical insights of the research. By exploring what the churches are actually doing about health and wellbeing, this study will enhance the theory of what these assets are and how they 'work'.

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<sup>99</sup> ARHAP-WHO Report. *Appreciating Assets*. Pg. 7

#### 4.1. Methodology: Qualitative Research

This study is qualitative in design. Qualitative research is dependant on data that is gathered orally (words), and is observant of the nature in which such words are said and documented.<sup>100</sup> Adrian Holliday states that qualitative research describes actions in specific settings and it focuses on interviewees as participants more than merely being subjects. It makes use of open ended questions which may lead the researcher to discover areas not prescribed in the research.

This study used semi-structured interviews with open-ended questions given below as a way of sampling the reality concerning the contribution of the church to health. Semi-structured interviews refer to a wide range of instances. Interviews are described as an interaction recorded or inscribed of two or more parties.<sup>101</sup> The interview questions are in general form and were varied in terms of sequence during the interview session. This allowed me to ask further questions for clarification. The interviews were oral, but I made use of standard questions to ensure that the results are standard. The following questions were asked:

1. Give a brief background of your Church
2. What is the mission of your Church?
3. What is your understanding of health?
4. What is your understanding of wellbeing?
5. What are some factors that show lack of health and wellbeing in Ndola?
6. What contributions does the Church make towards enhancing health and wellbeing in communities in Ndola?
7. What do you as Minister/Pastor/Leader contribute to health and wellbeing?
8. Do you preach sermons specifically on health and wellbeing?
9. What is your motivation for doing so?

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<sup>100</sup> J Mouton and H.C. Marais. *Basic Concepts in the Methodology of the Social Sciences*. Pretoria: Human Sciences Research Council. 1990 Pp. 162-170

<sup>101</sup> Daphne Johnson. *Research Methods in Educational Management*. London: Pearson Education Ltd. 1994. Pg. 44

#### **4.2 Sampled Population: The Christian Churches**

The research intended to interview 25 ministers or pastors that serve in congregations that belong to what in Zambia are known as “the Church Mother bodies”; i.e., the ecumenical Council of Churches in Zambia (CCZ), The Zambia Episcopal Conference (ZEC-Catholic), the Evangelical Fellowship of Zambia (EFZ) and the Independent Churches Association of Zambia (ICAZ). These churches were chosen because they are the official institutions that represent the Christian faith in Zambia. Given that there are about 200 registered local churches in Ndola, the research would include more than 10% of the churches and this is considered a significant sample size.

Of the 25 interviews originally scheduled, I only managed to interview 17 persons representing 15 congregations. This is 7.5% of the local churches in Ndola, which is still a significant sample size. All the pastors interviewed were male, and there were two female nuns running particular projects under the Catholic Church. These congregations that were interviewed are the Reformed Church in Zambia (RCZ), the United Church of Zambia (UCZ), Ndola Catholic Diocese, Elim Pentecostal, People’s Church Assemblies of God, the SDA, Salvation Army, Vineyard, Living Waters, Christ Victory Church, and Grace Baptist Church. The Catholic Ndola Diocese have all the projects run under the Bishop’s office. The representation of Churches interviewed is summarized in a table below, and this indicates that there was an even spread across the four mother bodies, as well as two churches that are independent:

Affiliating Body	Congregations	No. of persons Interviewed
ZEC	Ndola Diocese project Managers: Health and Healing dept, IAP, Children's Desk and CBR	4
CCZ	UCZ(2), RCZ(2), SDA	5
EFZ	People's Church, ELIM, Grace Baptist	3
ICAZ	Living Waters, Vineyard, Bethel	3
OTHER	Salvation Army and Eagle's Wings	2
	<b>Total</b>	<b>17</b>

Table 4. Researched Churches representation

#### 4.2.1 Reluctant and uncertain respondents

This study had initially purposed to interview pastors and ministers of local congregations in Ndola. However, we will observe from the presentation of data that the Catholic Church is not represented by the Priests in charge of congregations. The difficult I had in the two Catholic congregations I visited, namely, St Joseph Parish in Chifubu and the Cathedral of Christ the King in the inner city, was that the priests did not understand that they are involved in health or wellbeing. Rather, they referred me to the Diocese offices. Here, I want to acknowledge the helpfulness of Father A. Chanda of the Cathedral of Christ the King, who took and introduced me to the personal assistant to the Bishop of the Diocese in order to get permission to have an interview (letter attached appendix 2). Father Chanda explained that the set up of the Catholic Church is that congregation's deal with pastoral work, while the diocese has set up offices for specific projects the church does that promote health and wellbeing, which fall under the office of the Bishop. With permission granted by the Bishop through the head of human resource, I was then taken round to interview four managers heading different projects related to health and wellbeing. The interviews were conducted within a week on appointment.

At the same time, what was interesting for me to note was that many of the other local pastors and ministers *also* initially did not understand themselves contributing to health



and wellbeing. However, as the interview went on and discussion ensued as to the meaning of health and wellbeing (questions 3 and 4) the pastors began to see the connection and to understand their work in this context. In this way the research took on an 'activist' aspect in which the focus on what the church is doing and what its assets are empowered the pastors to understand their work in a new light. This initial reluctance and inability to see the connection to health and wellbeing is itself a finding that is discussed in Chapter five (see 5.1).

#### **4.2.2 Socio-economic contexts**

A further distinction that was purposefully made in selecting the participants for the study had to do with the location of the Churches. The churches were sampled from both the central part of town (inner city), and the peri-urban townships. This is so because they minister in different socio-economic contexts. Town congregations are known as English speaking congregations, and are perceived to be affluent compared to congregations in townships and shanty compounds which usually minister in a local language. Both townships and shanty compounds are high density areas, and are negatively impacted by poverty levels. The shanty settlements are illegal settlements that have slowly grown and have no utility facility services from the local municipality. The suburbs are the low density areas, with the middle-income and affluent people. As noted in chapter two, in Zambia there is a relationship between the socio-economic context and health and wellbeing, so this is an important element to bear in mind. Thus it may be that local churches share more in common with those from the same socio-economic context than from belonging to the same Mother Body. In the next table we note the socio-economic context of each church to assist our analysis.

Socio-Economic Context	Congregations
Inner city	St.Andrews, Catholic Ndola Dioceses attached to the Cathedral of Christ the King, Living Waters, SDA, Bethel
Townships	Chifubu UCZ, Chifubu RCZ, Kabushi RCZ,
Shanty compounds	Christ Victory, Eagles and Grace Baptist
Suburbs	People's Church, Elim Pentecostal, Vineyard, Salvation Army

Table 5

### 4.3 Respondents' Profile

This study interviewed pastors and leaders of Church projects to determine the Churches involvement in health and wellbeing. The study had targeted to interview 25 pastors of local congregations, however only 17 interviews were achieved. The interviews were conducted between the dates August 2005 and April 2006.

Prior to the interviews, I went to make appointments. In a few cases, I was granted the interview there and then. In most cases, however, I had to go back on appointment to conduct the interview. Of all the interviewees, only one came to my home, as he said it would have been difficult for me to locate where he stays in a shanty compound. I met with the Ministers from the United Church of Zambia and the Reformed Church in Zambia at their Church Offices. At Mitanda Home where the Salvation Army has a Church, the Pastor of the Church was sick, but I was granted the interview by the Pastor in Charge of the Mitanda Home for the Aged, a health facility for old people. I was charged an interview fee at Mitanda, which is part of their administrative fee. With the Seventh Day Adventist, it was difficult to locate the Pastors of the congregations, but eventually I was able to interview the President of the Copperbelt region SDA whose offices are located in the city centre.

As I have mentioned above, it was difficult to get an interview done with Parish Priests in the Catholic Church. Rather, they referred me to interview people that have direct

dealings with programs and activities that enhance health and wellbeing in Ndola. Thus on different days, I was able to interview the Program Manager of the Integrated Aids Program, the Director of Health Services, and the Manager of the CBR Project. The Catholic Church granted the interviews after authority had been granted by the Bishop of Ndola. In all the appointments, I was well received, and most of the interviewees requested feedback once the research is done. All interviewees signed the consent form and no respondent requested anonymity, so real names are used in reporting the findings.

Below is a description of each church interviewed.

#### **4.3.1 Christ Victory Church (ICAZ/Shanty compound).**

Christ Victory Church is located in Twapia Township in Ndola. Twapia is located north west of Ndola along the Ndola-Kitwe dual carriage-way and it is one of the poorest areas of Ndola. The Christ Victory Church was founded in 1991, by Pastor Kabamba and some other Church leaders. It is Pentecostal and an independent ministry, which falls under the Independent Churches Association of Zambia. It has a membership of about 80, though Sunday Services attendance is between 40 – 50 people. Among its members, almost all can be described to be poor. Only about 3 people are in formal employment. The Pastor described his people to be living either by faith or fate, as even those that work or are engaged in small business or hawking cannot be said to be engaged in sustainable employment or business. They Church meets in a rented Council building, and their income is an average of K20, 000 per week, or K80, 000 per month (about US\$20). Christ Victory Church mission is “to win men and women to Christ; empower them to do exploits in all areas of life; to see an educated, healthy society which is able to influence their area of interest.”<sup>102</sup>

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<sup>102</sup> Interview, Pastor J. Kabamba, 25<sup>th</sup> November, 2005

### 4.3.2 St Andrews United Church of Zambia (CCZ /Inner City)

St. Andrews UCZ is found in the central part of Ndola town. It is affiliated to the Council of Churches in Zambia. St. Andrews was built in 1958 and formally opened on February 15, 1959 by the Governor then of Northern Rhodesia, Sir Arthur Benson. It was founded as a Free Church under the Copperbelt Free Churches. It was in this church that the body of Dag Hammarskjold the then General Secretary of the United Nations, who died in the plane crash in 1961 outside Ndola, lay in state waiting to be flown to its country. The United Church of Zambia came into existence in on 16<sup>th</sup> January 1965 as a result of the long standing discussion among the missionaries to amalgamate.<sup>103</sup> Rev. Joel Chisanga identifies the missionary churches that were involved as the Church of Scotland, the London Missionary Society, the United Church of Central Africa and the Paris Evangelical Missionary Society.<sup>104</sup> ST Andrews is mostly an English speaking congregation with most of its members coming from the middle class income group.

### 4.3.3 Kabushi Reformed Church in Zambia (CCZ/Township)

The Reformed Church in Zambia traces its background to the Dutch Reformed Church of South Africa. It is a member of the Council of Churches in Zambia. The Kabushi RCZ congregation was started in 1972, and it is located in the Southern part of Ndola in a township called Kabushi. Kabushi RCZ has a membership of about 700, most of whom are economically disadvantaged. The minister<sup>105</sup> of this congregation highlighted how most of the members are unemployed or if they are employed, work mostly as domestic helpers and get very little pay. Kabushi RCZ extends its ministry to two other preaching points in Twapia and Kang'onga (a settlement area for the blind).

<sup>103</sup> Interview, Rev. J. K Chenge date 30<sup>th</sup> August 2005

<sup>104</sup> Unpublished. Rev. Joel Chisanga. The History of the United Church of Zambia

<sup>105</sup> Interview, Rev. D. Zulu date 30<sup>th</sup> August 2006

#### **4.3.4 Living Waters Global Ministries (ICAZ/Inner City)**

Living Waters Global Ministries was started in Kitwe by Bishop Bernard Nwaka in 1996. It now has more than 26 branches in East Africa, West Africa and two in the USA. In Zambia, it is affiliated to the Evangelical Fellowship of Zambia. Its vision is to extend the Kingdom of God to all nations to the glory of God. In Ndola, Living Waters Global Ministries meets in a rented building in the central part of Ndola.<sup>106</sup>

#### **4.3.5 Bethel City Church International (ICAZ/Inner City)**

Bethel City Church is a member of the Apostolic Faith Ministries in Zambia, an independent Pentecostal ministry. It is found in the central part of town. Their mission is centered on deliverance, and it holds “spiritual clinics”. They strongly believe in the importance of recognizing the three parts of the human being; body, soul and spirit as separate entities that respond differently to situations. The body is seen to be the container which needs to be kept well for the soul and spirit to survive. The mission of Bethel City Church mission is to possess cities, nations and missions and always taking the healing message.<sup>107</sup> The head of the Church at Bethel is an Apostle, and is helped by a number of pastors that deal with the various issues that arise out of their deliverance clinics. It is a member of the Independent Churches Association of Zambia (ICAZ).

#### **4.3.6 Vineyard Church (EFZ/Suburbs)**

Vineyard Church is a fellowship in association with the family of Vineyard churches world wide. It embraces the world wide church mission of church planting and church renewal. The local vision for Vineyard Church in Ndola is to be a community of compassion and power (power in the context of the demonstration of the Spirit’s power – 1 Corinthians 2.4). They have a membership of about 200-250 and they meet at a local

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<sup>106</sup> Interview, Pastor Edward Sibale, date 28<sup>th</sup> December 2005

<sup>107</sup> Interview, Pastor Tayengwa, date 29<sup>th</sup> December 2005

secondary school. The church has three full time Pastors. It is a member of the Evangelical Fellowship of Zambia.<sup>108</sup>

#### **4.3.7 Chifubu Reformed Church in Zambia (CCZ/Township)**

Chifubu RCZ started in 1972 as an extension of Masala congregation. It is a member of the Reformed Church in Zambia as well as the Council of Churches in Zambia. Chifubu RCZ is located in the northern part of Ndola in Chifubu township. The vision of the Reformed Church in Zambia as a whole is “to reflect and embody increasingly as a community to reach society with the life of the triune God and the newness of his Kingdom.” At a national level, the RCZ run Hospitals, Secondary Schools, Primary Schools, and they have a Diaconal Desk specifically for charity and a Business Centre for development issues. Examples of these facilities are Nyanje Hospital in Sinda and Kamoto in Malambo Chipata, Katete Secondary Magwere School of the Disabled, and Hofymere Sec. The Church runs a theological school in Lusaka at Justo Mwale training pastors, teachers in conjunction with University of Zambia.<sup>109</sup>

#### **4.3.8 Chifubu United Church of Zambia (CCZ/Township)**

Chifubu congregation is a member of the United Church of Zambia and the Council of Churches in Zambia. It is situated in Chifubu Township in the northern part of Ndola. The Congregation was founded in the early 1950's under the United Church of Central Africa. In the pre-independence era, it catered for the spirituality of the black migrant workers. Today, the congregation has a membership of 2,400 mostly from the township itself. At the time of the interview, the Minister was quite new having been transferred there six months prior.

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<sup>108</sup> Interview, Pastor Siseho Minyoi, date 25<sup>th</sup> November 2005

<sup>109</sup> Interview, Rev. and Mrs. Maunda, Minister in Charge, date 13<sup>th</sup> March 2006

#### 4.3.9 The Salvation Army – Mitanda (CCZ/Suburbs)

Mitanda Salvation Army Church is one of the five branches in Ndola that belong to the Territorial H.Q which is in Lusaka. It is located along the highway leading outside Ndola going towards the rest of the Copperbelt towns. The Salvation Army nationally has two main focus of ministry which they call the Evangelical and the Social Ministry. Both are headed by trained Pastors, who are referred to by their military rank, e.g. Captain, Major. The Church has its own Bible School in Lusaka and has a policy to train both wife and husband for the ministry.<sup>110</sup> Therefore at the time of the Interview, both Majors Mweembas were present. The Mweembas are at Mitanda as the Administrators of the Social Ministry of the Church, and in particular, they are in charge of the running of the Old People's home called 'Mitanda Old People's Home.'

Mitanda Home for the Aged as it is popularly known, was started in 1948 as a response to the needs of stranded people. These people were those that came to work on the Copperbelt Mines from other countries and failed to get back to their home countries for various reasons. They were not destitute as we know them today, rather they were just stranded. For this reason, the old people that were at the institution made a contribution towards their own upkeep. This work continued after Zambia got its independence in 1964, however in 1978, it was nationalized by the government then under President Kenneth Kaunda. Zambia embraced the Democratic wind of change in the 1990's and elected in a new government headed by President Fredrick Chiluba. The new government introduced a Capitalist economy, which led to the privatization of most companies, mines, and the selling of land, houses and other properties into private hands. Thus in 1995, the Salvation Army was given to manage the Mitanda Home for the Aged, and in 1997, the President sold and released it back to them at the cost of K1000 (about 2 Rand). This was in consideration that the initial investment and building structures were put up by the Church. The Salvation Army mission is found in their motto 'heart to God hand to

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<sup>110</sup> Interview, Majors Richard Mweemba date 7<sup>th</sup> March 2006

man' – translated as the mission to preach the gospel of Jesus Christ and meet human needs in his name without any discrimination.<sup>111</sup>

#### **4.3.10 Elim Pentecostal Church (EFZ/Suburbs)**

Elim Church in Ndola is situated in an affluent class suburb area called Itawa, along the road leading to Ndola International Airport. It has a membership of about 300 and it is cosmopolitan in character. It has three (3) full time Pastors, employs seven auxiliary staff. It is an international church with its Headquarters in the UK. The Ndola Church is the national headquarters for Zambia, with 13 branches spread across the country.<sup>112</sup> Elim Pentecostal in its name affirms its mission to be a Church where people find rest and refreshment as it was for the Israelites in Exodus 17:27. “The oasis in the desert is a fitting symbol for a church that preaches a message of rest, refreshment, salvation, and healing for the body, soul and spirit in the dry parched wilderness of this world.”<sup>113</sup> Elim is a member of the Evangelical fellowship of Zambia.

#### **4.3.11 People’s Church (EFZ/Suburbs)**

The People’s Church is a branch of the Pentecostal Assemblies of God in Zambia (PAOG). The PAOG is affiliated to the Evangelical Fellowship in Zambia. The People’s Church began in Ndola in 1979, and it is found in Itawa. The People’s Church has three full time Pastors, and the Senior Pastor is the Bishop. To meet the needs of the congregation, they have departments for singles, couples, children and youths. Each of these departments is headed by an elder who is part of the pastoral team of the church. Though a branch of the PAOG, it is independent in the running of the ministry of the Church.<sup>114</sup> Interestingly, they have applied for land adjacent (as at time of interview) to their church on which they have plans to build a hospital as part of the ministry of the

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<sup>111</sup> Salvation Army Information brochure

<sup>112</sup> Interview, Reverend Shadrack Chibanda, Senior Pastor, date 12<sup>th</sup> May 2006

<sup>113</sup> ELIM Pentecostal Church of Zambia Brochure

<sup>114</sup> Interview, Rev. Evaristo Chisompola, Senior Pastor, 12<sup>th</sup> May 2006



church. This has been necessitated by the increase in ill health, and the need to supplement government efforts which are evidently not sufficient.

#### **4.3.12 Catholic Church – Diocese of Ndola (ZEC/Inner city/Shanty compounds/Townships)**

The Interviews at the Catholic Dioceses were conducted with three people in charge of different departments of the Church that are dealing with the health of the community. The Catholic Church set up is that most of the projects are directly under the Bishop's Office, also known as the Catholic Diocese. In seeking permission to conduct interviews with some priests, it was pointed out that though Priests are in a pastoral charge of the congregations, the Church has employed people specialized in particular fields of work, who could be a Priest, Nun or a lay person. Hence, it was difficult to interview individual priests. However, written consent was given by the Bishop through Father Benedict Ngandwe who is the Head of programming and Human Resources.<sup>115</sup> In all, I interviewed four people running different projects that promote health and wellbeing. All health projects fall under the Department of Health, and projects heads interviewed were the Children's Desk Manager, The Integrated HIV/Aids Program (IAP) Manager, the head of the Health and Healing Department, and the Manager of the Community Based Rehabilitation Programme for the Mentally Retarded (CBR). The Catholic Diocese of Ndola health mission is "in obedience to the healing ministry of Christ strives to render accessible, appropriate and affordable holistic quality health care with an open heart for the poor and vulnerable."<sup>116</sup>

##### **4.3.12.1 The Children's Desk**

The Children's Desk was initiated by the late Bishop of Ndola Diocese Dennis De Jong for the purpose of taking care of orphans whose parents died mostly of HIV and Aids. They are concerned with the plight of orphaned and vulnerable children

<sup>115</sup> Letter of consent attached as Appendix

<sup>116</sup> Catholic Diocese of Ndola. Strategic Plan for 2005 -2007. Health and Healing Ministry. Pg. 5

(OVC) as well as children at risk. It works closely with the Integrated Aids Program (IAP). The Desk was started on May 1<sup>st</sup> 2001 and offers psychosocial support in the form of education, medical facilities, recreation, Counselling and other needs as they arise.

#### **4.3.12.2 Integrated Aids Program (IAP)**

This project under the Catholic Diocese was also initiated by the Late Bishop Dennis Jong in response to challenges of a collapsed health system in 1990. At that time, the Church observed through their congregations in shanty compounds of Luangwa in Kitwe and Nkwazi in Ndola that there was an increase of the 'strange' disease.<sup>117</sup> There were two Nuns that were visiting these congregations who begun to organize money and women to visit the terminally ill and help take care of their needs. As more people got ill, they reported to the Bishop's office this strange illness, and out of concern that this disease could be highly contagious since they did not know at that time how it was transmitted, Bishop De Jong contacted a partner in the Netherlands (CORDAID – Catholic Organization for Relief and Development) to send them a medical doctor who could analyze what this disease was and teach the congregations affected how they could prevent infections. In 1993, the Home Based Care Programme was officially launched under the Integrated Aids Programme. The primary objective of this programme is to "address the Aids epidemic in its widest context for the most vulnerable people in society through the provision of holistic care to people with symptomatic HIV infection and their families; prevention of the further spread of HIV; community development; and advocacy."<sup>118</sup> IAP operates in Ndola, and its services extend to the rest of the Copperbelt towns. They have been instrumental in initiating the Home Based Care programme in the rest of the country.

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<sup>117</sup> Interview, Mr. Chanda Fikansa, Program Manager IAP, date 16<sup>th</sup> May 2006

<sup>118</sup> Catholic Diocese of Ndola, Zambia. Integrated Aids Programme. Interim Report January – June 2005, Pg. 4

#### 4.3.12.3 Health and Healing Ministry

This is the department that coordinates the health and healing ministries of the Church. Its main objective is to “provide Zambians with equity of access to cost – effective, quality health care as close to the family as possible.”<sup>119</sup> Its governing idea and working core values is based on “Bringing the Good News to the Poor”.<sup>120</sup> Mr. Mufalo Ilitongo<sup>121</sup>, the Head of Department for this Ministry, said that the Health Department embodies the vision of health and healing for the Catholic Diocese in Ndola, which is the Office of the Bishop. It thus works to build capacity in the health programs for the Church for enhanced health care provision in the communities where there is the presence of the Church. The role of this department is to build capacity to enhancing quality health care in the community projects; provides leadership and management skills to health initiatives of the church; build networks and partnerships for the health projects and monitor and evaluate of all health projects.

#### 4.3.12.4 Community Based Rehabilitation Programme for the Mentally Retarded (CBR)

This project works to ensure that children and young adults with mental retardation are empowered with life skills for independent living in a holistic way. They operate in all six districts of the Copperbelt. Ndola is the provincial head quarters. Their two main models of rehabilitation is the Centre Based and Outreach. In Centre Based, the program runs at congregations where they built a centre at which all the rehabilitation activities take place. In outreach, they go to the home/community of the child, and this approach is focused on rural communities though it is also used in urban areas. In Ndola, the centers are found attached to congregations in Chifubu, Twapia, Chipulukusu (Nkwazi), Mushili, Kaniki and Tugargan.

<sup>119</sup> Catholic Diocese of Ndola. Strategic Plan for 2005 -2007. Health and Healing Ministry Pg. 1

<sup>120</sup> Catholic Diocese of Ndola. Strategic Plan for 2005 -2007. Health and Healing Ministry. Pg. 2

<sup>121</sup> Interview, Mr. M. Illitongo, date 16<sup>th</sup> May 2006

#### **4.3.13 The Seventh Day Adventist Church (Other /Inner city)**

The Seventh Day Adventist (SDA) is an old institution. Like the Catholic Church, it was difficult to interview individual pastors as they have a centralized management. Thus this interview was conducted with the President of the SDA on the Copperbelt, whose headquarters offices are found in the central town of Ndola. The SDA is a health oriented church in that their mission and vision of Christian spirituality is anchored on the wellbeing of its members, by following Moses dietary laws in Leviticus 11 and the prayer in 3 John 1 for people to 'prosper in all things and be in health, just as your soul prospers'. Their primary witness of the gospel is through health and this involves: Health Literature – this is the most prominent work of the church. They employ a Health Evangelist who sells literature on health to the public. It is also a form of the Church's evangelism; Education and Health - they run boarding schools at Mupapa, 45 km from the town centre. Mupapa has also a clinic, which has two wards for male and female; a maternity wing, a laboratory and out patient wing. At Musofu, the Church has a secondary school and a clinic; The Sabbath – their meeting day on a Saturday is for practical health reasons. Every Sabbath, there is the health corner at which a health topic is discussed. The Church has a Health Director based at the headquarters but at each congregation, there is a volunteer health director. They believe that they witness through health activities. The SDA is not affiliated to any Church mother body.<sup>122</sup>

#### **4.3.14 Grace Baptist Church (EFZ/Shanty compound)**

The Grace Baptist Congregation is the only Church quite established in an area called Monkey Fountain where the surrounding communities are very poor. It caters for the poor communities of Kanyara, Bunga, and Twapia overspill. By being the only church, the researchers observation is that there are no other Christian congregations in this place despite that there are a number of Christian western influenced missionary enterprises in paradox, such as The Teen Missions Vocational School, The Mobile

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<sup>122</sup> Interview, Pastor Webster Chabe, date 15<sup>th</sup> May 2006

Mission Vocational Training school, African Mechanics Mission School and a number of small farm holdings.

Most of Grace Baptist members come from the poorer communities, and as such, they cannot afford to engage a full time pastor. The Church is run by Elders, with Mr. Lackson Matolokoshi, with whom the interview was conducted, being one of the leading elders. It has a membership of about 80 people. The Church building hosts a community school which caters for about hundred and thirty children. In the evenings, it is used for literacy classes for adults.<sup>123</sup>

#### **4.3.15 Grace and Truth Baptist Church: Eagles Wings (Other/Shanty compound)**

The Eagles Wings Ministry is an Orphanage and they do run a community school which caters for the poorest of the communities in Monkey Fountain area. These communities are Kanyara, Bunga and the Overspill. Its vision was birthed in the Grace Baptist Church, but the Church could not take it on due to lack of capacity. This made the vision carrier, Mr. Matolokoshi, who is an elder and lay preacher in the congregation, to begin to look after Orphans and Street Children in his own home while he was working as a house servant to missionaries stationed at Mobile Mission Maintenance (MMM). When he retired from service, he bought a two hectare plot within the community of Monkey Fountain and built his house there. Now that he and his family were living outside the Mobile Mission Station (hereafter MMM), more people with needs called on him, and the OVC begun to increase. This led him to share his passion for the children with missionaries he had contact with while at MMM, who since 2003 begun to support him. Today, this work is registered as Eagles Wings, and is run by a Board of directors. It had 30 children in its care at the time of interview, 14 girls and 16 boys. The oldest Child was 20 and the youngest was 8. With the help of outside funding, they have built a three blocked community school, of good quality, and it is well stocked with educational materials. Each classroom caters for about 30

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<sup>123</sup> Interview, Mr. Lackson Matolokoshi (as leading Elder of congregation), date 13<sup>th</sup> May 2006

children. They have three full time staff, a missionary couple helping with administration, and one volunteer. The structure of the school is very modern, and its curriculum is a combination of the Zambian primary school syllabus with the ideas from Australia as is included by the volunteer missionary teachers. They are also engaged in agriculture to enhance food security for the project.<sup>124</sup>

#### **4.4 Research Findings**

The interviews conducted in this study focused on getting the perception of what the pastors/leaders of Churches in Ndola understood to be religious health assets in their congregations that contribute to health and wellbeing. The questions asked and the answers are summarized below in a descriptive form. Respondents will be referred to by their names.

##### **4.4.1 Understanding of Health and Wellbeing**

The respondents in the Churches above were asked to give their own understanding of health and wellbeing. The following are their answers given in categories.

###### **4.4.1.1 Understanding of health**

The respondents understanding of health can be summarized as a condition in which a person's physical, social, and spiritual factors are in sound condition. Pastor Jacques Kabamba of Christ Victory Church said that health is a condition in which a community has no ills that affect their participation in community or national development. Such ills can be listed as poverty, unemployment, disease (particularly TB and HIV), and illiteracy. Reverend Chenge of St Andrews UCZ understood health not simply to be well, or to eat well. It has to do more with the environment a person lives in; the peace of mind; to be sure of what will happen tomorrow, though Christians are encouraged not to worry about tomorrow's needs. This was a similar view held by Reverend David Zulu of

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<sup>124</sup> Interview, Mr. Lackson Matolokoshi (as founder and director of Eagles Wings), date 13<sup>th</sup> may 2006

Kabushi RCZ when he said that it is about the body being well, and a state of mind not being oppressed with life's occurrences, e.g. worries about food, clothing, children etc.

Health was defined in the context of exercising the body physically and spiritually. Pastor Edward Sibale of the Living Waters said it is the condition of the body or mind. It is also the state of being well and free from illness, which is achievable with exercises. The Bethel City Church which practices healing services had a broad understanding of health. Pastor Tayengwa made a distinction of terms of disease and illness that show a lack of health physically. He made reference in particular to HIV and Aids as being in either category. This can be a disease or a sickness. In his words, he said an illness can be *'passed on through blood or contracted through someone.'* Illness is something that which tampers with your emotions, e.g. madness, insomnia, anger, rejection, sexual abuse, hatred.

The above responses show that the Church's perception of health is located in people living a life that promotes their physical, mental, social and economic growth. We can also observe that health is understood in the context of development, with issues of poverty, disease and environment key to having a peaceful mind to achieve health and wellbeing of people.

#### **4.4.1.2 Understanding of wellbeing**

The respondents gave a variety of understandings to the term wellbeing. I have summarized these in four categories; Wellbeing as a livelihood, lifestyle, the whole of life and as health.

##### **4.4.1.2.1 Wellbeing as a Livelihood**

A livelihood in this study refers to income or sources of revenue. Most respondents referred to the need to meet daily needs as that which would make one to live an average lifestyle by Zambian standards. Peoples livelihood should

not be characterized by struggles to obtain food or money. This was said in the context of a general understanding that most Zambians are poor and lack secure means of income due to high levels of unemployment. In the interview with the Minister at Kabushi RCZ, he bemoaned the fact that he serves in a poor congregation and most of his members work as housemaids or in gardens and their monthly income is equivalent to US\$30. This income is what they use to look after their families, often including extended members. For this reason, he emphatically said that “serving in a poor congregation, it is important to put your wellbeing in place before managing others.”

By this he spoke in the context of the stipends that Ministers in traditional mainline Churches receive, which are about US\$50 per month. Therefore, ministers in mainline churches need to have a ‘tent making’ skills like Paul in the Bible, not just to help self, but to cater for the wellbeing of the members who now look to the minister for material help as well.

#### **4.4.1.2.2 Wellbeing as a Lifestyle**

Lifestyle in this category is understood to refer to a standard of living. Most respondent said that wellbeing is being advanced in lifestyle, which is evidenced by achieving prosperity, happiness, no sickness and being financially secure. It also includes having access to food, decent accommodation, and a conducive environment for human habitation, i.e., with access to clean water, passable road networks, sanitation, and communication. The issue of lifestyle is critical to wellbeing, as most residents, particularly those in townships and shanty compounds, live in inhabitable conditions. Even those that live in suburb areas suffer from accessing clean drinking water, (e.g. Itawa), or have erratic water supply, (e.g. Northrise). In this kind of environment, it is true to say that religion has become an attraction, as it gives hope for a better lifestyle. This can also be confirmed in Chapter 4 which shows that the thriving Pentecostal Churches are mostly located in the suburbs.



#### 4.4.1.2.3 Wellbeing as the whole of Life

The wholeness of life can be understood from the Biblical concept of Shalom, life as it ought to be.<sup>125</sup> According to one of the respondents, Major Mweemba, wellbeing is “what makes a person to be a human being”. He identified factors that make a person to be less of a human being as pollution, hunger, violence, lack and degeneration for the environment. Human beings ought to relate to the whole created universe in a manner that is sustainable to both.

#### 4.4.1.2.4 Wellbeing as Health

The respondent from Bethel City Church stated that wellbeing is less important to health, saying that “*without health, one cannot enjoy wellbeing.*” Another respondent stated how mental health is important to wellbeing. Mr Finkansa of IAP understood wellbeing to refer to a state of mind being content with the position one is in. He cited an example that a person may have a lot of money but be emotionally unstable as they are not sure about the position they are in.

### 4.4.2 Understanding of Health and Wellbeing in Ndola

The respondents were asked what they considered to be factors that show a lack of health and wellbeing in Ndola. The question was asked in following up what they understood of health and wellbeing. I must mention here that this question was asked in view of the perception I got that the pastors up to that point had never thought of the church as contributing to health. The answers have been presented in synthesized categories below.

The first category is *socio-economic* factors, and here respondents pointed to factors such as poverty, lack of education, unemployment, poor nutrition, and lack of food. These

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<sup>125</sup> See Perry Yoder. *Shalom* London: Hodder & Stoughton.

factors emerged from almost all the respondents as they have experience working in both social-economic contexts described above.

The second category that emerged is *social behavioral* and points to factors such as early (teenage/child) pregnancies, sexual immorality, commercialized sex, crime, beer drinking, drug abuse, adultery and divorces.

The third category that emerged is *cultural*. The understanding given is that issues of the plight of widows and widowers in some cases, orphans and the vulnerable children now evident in the streets, are a result of the social economic category that has resulted in families not being able to care for each other. On the other hand, one respondent mentioned how those families that care for extended family members are under great pressure to cope. Culturally, a long time ago, the social-economic set up allowed for the care of the extended family which is not practical currently.

The fourth category of factors is *environmental* and these have to do with such issues as poor sanitation, housing, dilapidated road infrastructure, and unsafe drinking water.

The sixth category is *spiritual* and factors that contribute to lack of health and wellbeing are demons, witchcraft, curses, and poor presentation of the gospel.

The above representation of factors that cause lack of health and wellbeing show that the Pastors in Ndola seem to have a good grasp of the wider context of health, and therefore of the importance of how these factors have an indirect impact on health. Secondly, the pastors experiences of these factors are mostly located in socio-economic contexts that seem to have a direct impact of the choices and responses people make to their health and wellbeing. Here it is important to bear in mind that the factors are the perceptions of the church leaders, and the research process could not claim these to be objectively true. Nevertheless, from the researcher's experience of living in Ndola, and in the findings of the WHO research, this confirms that the struggle for health and wellbeing as perceived by the church leaders is beset in poverty.

#### **4.4.3 Contribution of the Churches to health and wellbeing**

In this section, I will identify each church and which Mother Body they belong to, and the socio-economic context in which they work. Here we remind the reader of the socioeconomic context of the churches by locating which type of location they are found; i.e.

More wealthy: Inner city, Suburbs

More poor: Townships, Shanty compounds

Further, this section will describe what activities each church is doing that contributes to health and wellbeing.

##### **4.4.3.1 Christ Victory Church (ICAZ/Shanty compound).**

The activities identified by their pastor are listed below.

- Primarily preaching of the Gospel as part of proclaiming the will of God for people not to be ill or poor.
- They help the needy as the Lord provides. At time of interview, the Church is taking care of thirteen orphans, two of whom have been put in school. They all are aged between 8-13 years old.
- They are actively involved in visiting the sick and terminally ill. They pray and encourage as well as give material help when they can.
- They have partnered with Jubilee Centre to rally the church to fight against HIV/AIDS.
- They preach complete abstinence
- They provide entertainment such as games, computer literacy.

#### 4.4.3.2 St Andrews United Church of Zambia (CCZ /Inner City)

Some initiatives have been taken to achieve the health vision in 2005, whereby eight (8) wheel chairs were given to church members in need, donated by the Rotary club. The Rotary club has regularly donated wheel chairs to the church. The Senior citizens wellbeing is taken care of on Sundays by providing transport to pick them for church from their homes. The other activities the church is involved in are:

- St.Andrews is a founder member of Cicetekelo Home, a palliative care for patients that are terminally ill.
- It has a Medical Profession Committee of Doctors and Nurses who occasionally give health talks to the Church.
- It has an HIV/AIDS committee which has plans to get involved in home based care.
- It started a school 20 years ago to promote the well being of children who could not access further education as a result of the cut off point system.<sup>126</sup> It now runs as a private church school catering for children from pre-school to high school.
- The Women's Christian Fellowship has adopted the Post Natal ward at Ndola Central Hospital. They help the poor to buy medicines, prayer, comforting and accompanying through regular visits.
- The Men's Christian Fellowship has on its programs a regular visit to the local prisons to help the prisoners spiritually and materially, e.g. providing detergents and helping those that are sick in prison by doing their laundry.

#### 4.4.3.3 Kabushi Reformed Church in Zambia (CCZ/Township)

The church is engaged in the following activities:

- Encourages food production which leads to health living. As an example to his congregation, the pastor has a garden about a hectare where vegetables are grown, some of which is sold.

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<sup>126</sup> United Church of Zambia. St Andrews Congregation Mission statement Pg.1

- Sporting and offering worship to young people that attracts them to church and keeps them off the streets. An example, the church held a youth Sunday open day at which the public including government civic leaders were invited to witness the display of the youths in the various activities they are involved in as a church. This was held on 18<sup>th</sup> September 2005.
- Encouraging small businesses
- Engaging in farming, even if it is at small scale
- Brick molding to put up a church hall and other buildings that can raise income. They are using local materials to make the bricks. They also plan to build a 3x5 classroom block. The vision of the school is to promote well being of the community through raising literacy levels to the minimum basic level.
- Offer courses in tailoring and designing, computer skills to youths, mushroom growing. They have 12 sewing machines and a knitting machine have engaged a tailor who teaches tailoring. They are managing to supply a local school with uniforms.
- Celebrates harvest annually which encourages people to give. Harvest promotes well being of the poorer and vulnerable groups in the church as part of the collection goes to meeting their needs.

#### **4.4.3.4 Living Waters Global Ministries (ICAZ/Inner City)**

Living Waters Global Ministries desires to raise a health church, family and individuals and promote their well being through church sporting activities, and encouraging them to go to the gym. The other activities Living Waters is engaged in are:

- Playing games and encouraging exercises. Use of Bible quizzes, asking questions that demand a lot of thinking to answer.
- Support their members that are HIV+ by paying their medical bills, and other obligation such as rent, food when they are unable to. Its budgeted for in the church budget. The most affected are members from high density areas such as Mushili and Pamodzi and they consist of 60% of their membership.

- They have a Department of Mercy Ministries run by church members. They have plans to build an orphanage.
- They encourage and support people in financial difficulties at home or work. Constitutionally, they believe in the doctrine of paying tithes and giving of offerings and the laws of prosperity, blessings and curses. They believe tithes and offerings has an impact on the well being of people.
- Prayer – as an intangible asset. They hold spiritual clinics to deal with persons past problems, or deliverance. They have strong belief in the reality of demons.

#### 4.4.3.5 Bethel City Church International (ICAZ/Inner City)

Bethel City Church contributes to health and well being through deliverance clinics. Almost all their sermons are focused on healing, and they have spiritual clinics during the week which operates like a an ordinary health clinic. The pastors and trained helpers are the ‘spiritual medical persons’. They have trained on average 120 people quarterly to help with the clinic. They have set aside 13 rooms that deal with different types of infirmities and 3 consultation rooms. Patients register, are seen by first level personnel who assess the nature of their problem, and then refers them to a pastor specialized in dealing with that kind of problem identified. As a result of this system, Bethel City Church records that a total of 76,000 patients had gone through the clinic for spiritual healing January to December 2005. The breakdown is as follows;

Jan-May	26,000 patients
June-Sept.	22,000 patients
Sept-Dec	22,000 patients.

Pastor Tayengwa revealed that they experience 80% healing, restoration and deliverance in their clinics. However, they recognize the impact of HIV on the community as well as other diseases that may need medical attention. In this regard, 10% of their healing is through medical intervention while they also experience failure which total to 10%. Failure is when the disease is beyond their power and leaves it to the will of God. On the medical cases, they work closely with the two government hospitals of which the Senior

Pastor of the church, Apostle Robert Bwalya is a Board member of one of them. The Church also makes use of the Medical doctors and nurses who are their members, of which one of the Doctors who is also a pathologist testifies of the power of faith healing through prayer.

Bethel City Church mission is to possess cities, nations and missions and always taking the healing message. To do this, they have:

- Deliverance clinics, also called Spiritual clinics managed similar to how general health clinics/ hospitals. The pastors and trained helpers are the 'spiritual medical persons'. They have trained on average 120 people quarterly to help with the clinic. They have set aside 13 rooms that deal with different types of infirmities and 3 consultation rooms. All infirmities are classified to be under 29 demonic spirits.
- Counselling skill training including specifically HIV/Aids counseling. It is a one year course.
- Public relations to do with honoring the clients
- Marriage counselling policy includes VCT – the church will not marry people who do not know their status.
- In house training of pastors and medical people in communication skills in relation to enhancing health. Believe that 57% of body language determines the kind of person you talking to.

#### **4.4.3.6 Vineyard Church (EFZ/Suburbs)**

Its activities include:

- Spiritually, always preaching the gospel as the first point of liberation
- The mercy basket ministry aimed at meeting needs in the church and the community, the idea of mercy goes back to the Vineyard understanding of the Kingdom of God – compared to Jesus ministry of compassion and mercy. From daily offering, takes out 10% every Sunday goes to the mercy ministry. The

almsgiving enhances health – physically while the preaching targets spiritual. This is done once a month.

- They have a particular focus to empower men in their talents through the men's ministry. Men meet every Saturday morning and invite speakers to teach on entrepreneurship. The fellowship of men has equipped the men to take over leadership roles in the church which were mostly dominated by women previously, e.g. have a topic manhood that helps and challenges them to take up their roles and responsibilities, in the personhood of the man. They believe that it is not health for a man not to take up his roles and responsibilities distinct from that of women. They now have two men in the church Board which is a new feature. They encourage men who have no jobs to engage in productive avenues. Productivity is not conceived in the fact that men could engage in other ways such as agriculture to sustain their lives.
- They run a feeding program which they call 'Charlie's lunch' at the Church house. They have targeted women from Kawama whom they also teach health skills.

#### **4.4.3.7 Chifubu Reformed Church in Zambia (CCZ/Township)**

Chifubu RCZ is concerned with the well being of the family. They believe that spiritual issues do not justify the church as being spiritual; a living church is engaged in making the human live in totality. Therefore

- They have a program on health education in the Women's dept, often invite qualified persons in the church to teach
- Run a community school (free education) and a have a feeding programme for the vulnerable in the community.
- Run Home Based Care using members of the church, specifically trained within the church, they renders the services to the community
- They work hand in hand with the local health clinic – helps to sensitize people on certain health issues as they are often called upon,



- They conduct Psycho social Counselling, the Minister, his wife and two other members trained in that.

They take a person as 100 person human, who has spiritual, physical and social needs that are combined to make church.

#### **4.4.3.8 Chifubu United Church of Zambia (CCZ/Township)**

The church is engaged in the following activities:

- Spiritual level- Congregation Bible studies on Wednesdays, section fellowships once a week, where there is a study of God's word and encouraging one another, Sunday services contribute to well being and the health of people through the liturgy and preaching that is meant to uplift people's health and well being.
- Physically – gave an example of the Boys Brigade and the Girls Brigade whose programme is tailored to shape young people physically among other aspects. They engage in sports, mental games to develop mental and locomotors skills.
- Mentally - the church runs a pre school, a community school for the vulnerable free of charge from grades 1 to 3 and expands yearly. They have acquired a plot in the community to build a primary school for the poor.

#### **4.4.3.9 The Salvation Army – Mitanda (CCZ/Suburbs)**

The Salvation Army mission is found in their motto 'heart to God hand to man' – translated as the mission to preach the gospel of Jesus Christ and meet human needs in his name without any discrimination.<sup>127</sup> The activities the engage in to promote health and wellbeing are as follows;

- Nationally, they run hospitals and clinics. The Salvation Army were the first to respond to HIV/Aids through training programs, sensitization and they initiated the Home Based Care Programme in Zambia. This was through their famous Chikakanta Mission Hospital in Southern province.

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<sup>127</sup> Salvation Army Information brochure

- They emphasize the importance of nutrition, hence they are engaged in agriculture to grow such foods as pumpkin leaves, ground nut Soya, maize. Mitanda Home project has its own farm in Luanshya where it grows its own food, and they rear cattle for meat and milk. They are now venturing into poultry. For instance, they project budget this year is twenty six million kwacha and of this they receive four million kwacha from the government and their territorial head quarters. They have to raise the balance. Since they look after old people, at time of interview they were 24, and they need good nutrition for their health, they have had to engage in other fundraising activities such as putting up some of the property on site for rent and guest house facilities.
- They have feeding programs, and carry out under-five clinics to monitor the health of children that are on their feeding programme. They supply milk and have qualified nutritionist and nurses who carry out this programme in partnership with the government who supply the nursing staff.
- They have a clinic at the Centre with two full time nurses to over see the health of the old people in their care. One of them (photo in Appendix) is in charge and she is also a Pastor, together with her husband who is in charge of the congregation at the same place.
- They also run a training programme at the Home for nurse assistants and care givers. Apart from raising money, they project assists to provide trained care givers to the community and benefits the Home by availability of trainees who assist with caring for the old people.
- They run a community School in Kawama, a shanty compound, catering for orphans and other vulnerable children. As a congregation, they see themselves as an integral part of the universal church and aim to preach the gospel of Christ that serves the human being holistically.
- They undertake training in entrepreneurship in agriculture, carpentry and poultry keeping.
- They have bought a farm along Ndola-Kabwe Road which helps in provision of food and improves the welfare of the surrounding community by job creation.

#### 4.4.3.10 Elim Pentecostal Church (EFZ/Suburbs)

It does the following to promote health and wellbeing;

- They are involved in education and training. At the Church site, they run a pre-school and a Bible school
- They have a carpentry workshop, which in partnership with the government social department; they train street children in life skills.
- As a congregation, they consider the healing ministry as part of the worship of the church, and so when guided by the Holy Spirit, they minister spontaneous healing.
- From time to time, they sponsor some of their members for skill training such as tailoring, brick laying and computer training. The Carpentry workshop and the Bookshop at the Church are now staffed with some of the members that have received some training.

#### 4.4.3.11 People's Church (EFZ/Suburbs)

People Church contributes to health and wellbeing in the following ways;

- Counselling
- Prayers for healing
- Deliverance ministry but they do refer to other specialized wings such as the Psychiatric wing at Ndola Central Hospital when they see a case needs medical attention
- There is a primary school at the Church
- The Caring Department of the Church looks into the needs of orphans, widow/ers and the needy.
- They have an HIV department run by a Senior nurse from Ndola Central Hospital who is their member
- To meet needs of the congregation, they have departments for singles, couples, children and youths. Each of these departments is headed by an elder who is part of the pastoral team of the church.

- They have applied for land adjacent to their church as they have plans to build a hospital as part of the ministry of the church. This has been necessitated by the increase in ill health, and the need to supplement government efforts which are evidently not sufficient.

#### **4.4.3.12 Catholic Church – Diocese of Ndola (ZEC/Inner city/Shanty compounds/Townships)**

The Catholic church is engaged in various health and wellbeing activities, and below is a description of some of them done under different projects.

##### **4.4.3.12.1 The Children’s Desk**

Its services extend beyond Ndola and include: Giving material support through education bursaries, health care and nutrition to the OVC’s; offering psychosocial support through counseling, recreation, and spiritual support; training guardians, care givers and youths in life skills; paralegal services; awareness of OVC’s program through the Community radio Station of the Church.<sup>128</sup>

##### **4.4.3.12.2 Integrated Aids Program (IAP)**

Its main activities include the following;

- They run the Home Based care programs which cares for patients in their homes. As most illnesses are HIV related, they are involved in counseling, spiritually and psycho social; providing food supplements; they are engaged in prevention activities and provide technical support to other institutions needing capacity building in HBC.
- They support orphans
- They are supervising three Home Based Care programs that are covering six shanty compounds in Ndola. They are also the central office for all HBC activities on the Copperbelt.

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<sup>128</sup> Interview with Sr. Kateule Rosaria Chewe, date 17<sup>th</sup> May 2006

#### **4.4.3.12.3 Health and Healing Ministry**

The role of this department is to

- build capacity to enhancing quality health care in the community projects;
- provides leadership and management skills to health initiatives of the church;
- build networks and partnerships for the health projects
- monitors and evaluates all health projects.

#### **4.4.3.12.4 Community Based Rehabilitation Programme for the Mentally Retarded (CBR)**

The CBR currently runs the following programs:

- Prevocational training
- Day care facilities for 52 children in Ndola
- Special education – 159 are enrolled in this facility
- Physiotherapy – 87 are being attended to in this program which is mainly available for children with retardation and those with physical disabilities such as cerebral palsy
- Home Training program –done in Ndola and it has 115 clients enrolled. These are individual designed education programs depending on the needs of a child. It works with the support of the parents or caregivers.
- Epileptology – they provide drugs to about 962 that are enrolled on this program
- Child abuse follow-ups – they work in collaboration with the Zambia Police Victim Support to curb child labour, sexual abuse and other forms of abuse.
- Counselling – targeted to parents who most times find it difficult to come to terms with the disability of their child.
- Social services dealing with mentally children that are orphaned
- Income generating activities such as running a farm, rearing chickens, husbandry and agriculture.

#### **4.4.3.13 The Seventh Day Adventist Church (Other/Inner City)**

The main activities to promote health and wellbeing are;

- Health Literature – this is the most prominent work of the church. They employ on commission pay a Health Evangelist, who sells literature on health to the public. It is also a form of the Church's evangelism.
- Education and Health- they run boarding schools at Mupapa, 45 km from the town centre. Mupapa has also a clinic, which has two wards for male and female; a maternity wing, a laboratory and out patient wing. At Musofu, the Church has a secondary school and a clinic.
- The Sabbath – their meeting day on a Saturday or Sabbath is for practical health reasons. Every Sabbath, there is the health corner at which a health topic is discussed. The Church has a health Director based at the headquarters but at each congregation, there is a volunteer health director. They believe that they witness through health activities.

#### **4.4.3.14 Grace Baptist Church (EFZ/Shanty compound)**

Its main activity that contributes to health and wellbeing is a community school which caters for about hundred and thirty children. In the evenings, it is used for literacy classes for adults.

#### **4.4.3.15 Grace and Truth Baptist Church: Eagles Wings (Other/Shanty compound)**

It is engaged in the following activities;

- OVC care and orphanage
- Provides schooling from grades 1 to 7 (See photo Appendix)
- Skill training
- Farming and poultry for sustainability

#### **4.4.4. Summary of church contribution to health and wellbeing**

From the above data, we can summarize the contributions the local churches in Ndola contribute to health and wellbeing in six ways;

1. Presence in the community
2. Spiritual encouragement
3. Direct health interventions
4. Human development
5. Networks and collaboration
6. Leadership

These contributions will be analyzed further in Chapter 5.

#### **4.4.5 Minister's/Pastor/leader contribute to health and wellbeing**

The Minister's/pastors/leaders/ were asked what they understood to be their contribution to health and wellbeing in their congregations. Their responses are summarized below in four synthesized categories.

##### **4.4.5.1. As Facilitator**

In this role, the pastors see themselves as leading and guiding members to fulfill their potential. The pastors at Bethel City Church see their role as that of leading, encouraging and motivating people. Because its mission is centered on healing, they require that all their pastors and lay leaders undergo training in communication in order to lead and guide people into a healthy lifestyle.

##### **4.4.5.2. As Counselor**

Most ministers are trained to undertake counseling with their members. However, with the advent of HIV and Aids, some ministers have recognized the need to be trained in psycho-social counseling to counteract the impact of the disease. The respondent at

Kabushi RCZ, said that he was encouraged to do this in order to enhance his role as that of *giving alternatives to life's challenges*. At Mitanda Home for the aged, the respondent said counseling is cardinal to their ministry as most of the old people in their residence are not happy to be at there and desire to be with their families. They constantly have to counsel and reassure their residents of their love and care.

#### **4.4.5.3. As Teacher**

The Minister of Chifubu UCZ said his greatest concern presently is to encourage members to fight and conquer poverty. Poverty is a great enemy to society. He sees his role as imparting skills through preaching and teaching to enhance development. Most of his recent sermons then were on prosperity. He conducts seminars which empowers people with skills to create wealth.

#### **4.4.5.4. As Development Worker**

This was a role that was given by the church leaders in the Catholic diocese involved in various projects. They see themselves as development workers, working to build capacity to enhance quality of health care. They also provide useful links with development partners as they provide structures of accountability which is often lacking in smaller religious entities. In this case, they gave an example of how they are a recipient of CHAZ Global fund for disbursement to other projects on the Copperbelt.

In this question, the researcher observed that most of the pastors interviewed have not been consciously thinking of themselves as agents of health or wellbeing. There seemed to be a dichotomy of understanding between what Church is and what Community is. In some cases, the pastors opted to skip this part of the interview.



#### 4.4.6 Motivation for engaging in Health and wellbeing

Various answers related to the Bible were given. Almost all the Ministers/Pastors reflected upon a portion of scripture as the basis of their motivation as a church to engage in health and wellbeing. For instance, Vineyard Church is motivated by their theological understanding of the Kingdom of God encompassed in Micah 6:8 as an all inclusive term. For them, it means that people should live the kingdom standards of abundant life, health and wealth here on earth. Quoting John 10:10, the Pastor said

Abundant life is spiritual, social, moral, and an ethical life. This world is not heaven but it does not need to be hell either.

Other motivational factors given are that Christians ought to be practical following the example of Jesus. In Luke 4:16-18, Jesus speaks of the totality of man, with concern to release the oppressed and to proclaim the lord's favor. St Andrews is motivated by this passage of scripture to engage with the community holistically. Their faith must be evident in the works of love and service in the community as is exhorted in James 1:27.<sup>129</sup>

We can observe from the activities of the church that contributes to health and wellbeing that the pastors understand that the real motivation comes from following the biblical mandate to fulfill the commission to make disciples and to heal and restore the broken hearted (Mark 16: 6-17). The Churches fulfill this mandate in various ways, evidenced in this study from doing practical activities such as providing schooling, home based care and in spiritual activities such as prayers and deliverance clinics. The Church's mission statements described in their profiles also reflect this motivation.

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<sup>129</sup> NKJV- Pure and undefiled religion before God and the Father is this: to visit orphans and widows in their trouble, and to keep oneself unspotted from the world.

## 4.5 Conclusion

This chapter has presented the research data on the contributions the local churches in Ndola make to health and wellbeing. The data is presented in descriptive form, giving the profiles of the churches, their understanding of health and wellbeing generally and in Ndola and gives in point form the activities that the churches are involved in that contribute to health and wellbeing. The contributions have been summarized in five categories (see 4.4.4.20) which will be discussed in detail in the next Chapter. It has also highlighted in a synthesized category the contribution the pastors/ministers/leaders make to health and wellbeing and concludes with their motivation for doing so. The next chapter will focus on the contributions the local churches in Ndola make to health and wellbeing and will analyze them in relation to the ARHAP Theory Matrix and other research findings done so far.

## CHAPTER 5

### AN ANALYSIS OF THE CONTRIBUTION OF CHURCHES IN NDOLA TO HEALTH AND WELLBEING

#### 5.0 Introduction

The previous chapter presented the research data gathered on the contributions local churches in Ndola make to health and wellbeing. This chapter will focus on analyzing the six contributions that this study has found as to what the church in Ndola contributes to health and wellbeing. These are spiritual encouragement, human development, direct health interventions, belonging, networks and collaboration and leadership. These contributions will be analyzed using the ARHAP Theory matrix context and its wider studies in locating health assets that are found in religion.

#### 5.1. Analysis of the Respondent's perception on health and wellbeing in religion

In conducting the interviews with the pastors and ministers in particular, I observed that most of them had never consciously thought of health as a component in religion nor of religion as having assets that can be aligned to public health. This is mostly true of churches that belong to the mainline mother body, CCZ, EFZ and to a certain extent, ICAZ. The initial reaction to the question 'what does your church contribute to health?' took most of them aback and I had to elaborate on it. Perhaps it is for this reason the two Catholic congregations (ZEC) I visited referred me to the Bishop's office, emphatically saying their congregations did not deal with health.

However, there are exceptions as in the Catholic Church who have developed a structured system at diocesan level that specifically works to promote health, the Health and Healing Department. The Bethel City church (ICAZ) too have so spiritualized health that they have come up with their own classification of what causes diseases and illness, mostly identified as caused by demons, curses or witchcraft. They do recognize though,

that some ill health is caused by biomedical factors hence they have a referral system to general hospitals for such. To achieve health, Bethel trains its own 'spiritual' medical personnel.<sup>130</sup> The Seventh Day Adventists formally understand themselves as having a healthy religion, observing the Sabbath and dietary laws but from the description of how they carry out their vision, it is clear that they have left to operate in the spiritual realm. They have health corners in every congregation each Sabbath but these are not operated with any collaboration with public health institutions.

ARHAP has recommended the need for 'respectful dialogue' in which religious leaders and public health practitioners engage in dialogue that will lead to an appreciating of assets in both settings for the "sake of decency, universal access and development of communities."<sup>131</sup> The little insight of this study confirms the need to engage in respectful dialogue as the Church has assets that can enhance health and wellbeing that need to be aligned to public health interventions. However, the local churches need to be more conscious of the health assets they have and what they can do to enhance health and wellbeing. The findings of these contributions are discussed in the next section.

## **5.2. First Contribution: Presence in the community**

The first factor that can be drawn from this study is that the Church is local, translocal and transnational. It is present in communities in a way that cannot be compared to any other grouping in civil society. For instance, in Zambia, the Church is present in the remotest and most inaccessible parts of rural Zambia,<sup>132</sup> and in some cases churches are the only providers of any social facilities such as a clinic or a school in that area. In this sense, the local church is both a tangible asset, made visible by its structures if it has and the members that belong and take their faith as a vocation to be lived in the community.

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<sup>130</sup> Interview with Pastor Tayengwa, dated

<sup>131</sup> ARHAP-WHO Report. *Appreciating Assets*. Pg. 130

<sup>132</sup> See G. Biemba "Value-Added and Invisibility of Religious Health assets, ARHAP Colloquium 2007, Pg. 21

The visibility of the church in the communities makes its presence tangible. The visibility of the Church is not so much in its tangible buildings than in its being a part of that community. This is said in the context of this study where some congregations interviewed do not have physical structure and rent worship space in schools and other city halls, e.g. Living Waters. An analysis of all the churches interviewed show that it is in the actions of expressing their mission that they have responded to social challenges to improve the health and wellbeing of their communities. The Church has had to move the pulpit into the community. For example, when we examine the Catholic Church's health projects, we observe that they are involved in the community in a way that makes the church present in the community.

What is common in all these projects is that they are found in the poorer communities. The CBR is actually attached to selected congregations in perceived disadvantaged communities, e.g. Mushili and Chifubu Catholic Church, where physiotherapy programmes are offered for children. The HBC programmes are all done in the poor communities. From the researcher's experience living in Ndola, there is no HBC targeted for the suburbs or in the inner city.

### **5.3. Second Contribution: Spiritual encouragement**

Spiritual encouragement is understood as "the way in which religion gives people an inner strength to proceed with resilience, courage and determination in the midst of ill health, poverty and misfortune. It includes things like hope, spiritual care, prayer, faith, trust, encouragement."<sup>133</sup> In this study, the pastors/ministers/leaders located the contribution of the church to health and wellbeing in the socio economic context that is characterized by diseases such as the HIV and Aids, Malaria and TB, poverty leading to increased immoral behaviour and in environmental degradation. In this context, the pastors/ministers/leaders see the greatest contribution that the church makes as being the offering of spiritual encouragement, which includes factors such as prayer, preaching,

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<sup>133</sup> Steve de Gruchy "The Value of Religion in Religious Health Assets" in ARHAP International Colloquium 2007: Collection of Concept papers. Monkey Valley Resort, Cape Town. 2007, Pg. 16

bible studies, and deliverance, giving of tithes and offerings, and in fellowships of women, men, boys and girls in their various groups.

Preaching and prayers are seen as the primary means the Church has to offer health and wellbeing. This is evidenced at Christ Victory Church, where the pastor stated that *“preaching the Gospel is part of proclaiming the will of God for people not to be ill or poor”*. At Bethel City Church, Pastor Tayengwa alluded to the fact that since their mission is to health, almost all their preaching is related to promoting health and wellbeing.

Spiritual encouragement is an intangible asset and it has direct and indirect impact on health. This finding adds to the interpretive framework ARHAP seeks in which to make RHAs visible to the domain of public health. For instance, this study show that Bethel City church has records of people that go through their spiritual clinics, which mostly involve prayer and preaching, and thousands continue to go there because prayer has been attested to heal and restore people’ health and wellbeing. They have evidence of prayer, an intangible factor, having a direct impact on health and wellbeing, recording the numbers of those that have been healed or exorcized or restored through prayers. On the other hand, factors such as women’s, men’s and youth fellowship groups are tangible, visible in their uniforms and can be quantified. However, the bible studies, preaching and praying together have an indirect impact on their health and wellbeing, while their outreach ministries, i.e. visiting prisons, adopting a hospital ward (St Andrews) or caring for the vulnerable through soup kitchens (Vineyard, Living Waters) have direct impact on health and wellbeing.

Therefore, this study shows that the local congregations of Ndola contribute to religious through their spirituality. This is a Religious Health Assets which is “a leading cause of life”<sup>134</sup> and which adds value to community life both in tangible and intangible ways.

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<sup>134</sup> Term used by James R. Cochrane in article: Religion, Public Health and a Church for the 21<sup>st</sup> Century” in International Review Mission.

#### 5.4 Third Contribution: Direct Health Interventions

From a biomedical sense, HIV and Aids has provided a helpful window through which we now examine religion as an asset to health.<sup>135</sup> This is so because religion can respond to human crises in a way that it provides a resilience that society under normal circumstances cannot cope with. A survey in America shows that this statement is either mostly true or completely true.<sup>136</sup> The September 11, 2001 incident in New York City in the USA revealed the Church to have such assets that enabled society to cope with the tragedy in such manner that scientific measures alone could not provide. In a similar way in Zambia, the HIV and Aids pandemic has led to increased religious interventions particularly from the Church. From the Churches interviewed in this thesis, almost all of them have responded to mitigating the impact of HIV and Aids through practical interventions. These tangible religious health assets that the Church in Ndola contributes include:

- Cicetekelo Hospice in Lubuto run as an Ecumenical project, Chishilano project in Nkwazi for PLWHA , supports OVC, and runs the HBC programme for Nkwazi and Chipulukusu, two of the largest shanty compounds in Ndola. The IAP under the Ndola Catholic Diocese coordinates all the registered HBC's.
- The Salvation Army runs dispensaries at Mitanda and Kawama clinics. The clinic at Kawama focuses on under fives as malnutrition is highly prevalent in the community.
- The Seventh Day Adventist church has a clinic at Mpapa about 25 km from Ndola city which has a maternity facility that caters for a wide catchments area.

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<sup>135</sup> J. Cochrane. ARHAP Colloquium 2005

<sup>136</sup> Harold George Koenig. *The Link between Religion and Health: Psycho neuro-immunology and the Faith factor*. Oxford, New York: Oxford University Press. 2002 Pgs. 11-12 on [www.amazon.co.uk](http://www.amazon.co.uk). Accessed 15.03.06

The Bethel City Church International is unique in that its mission and growth is hinged on its mission in healing. I was amazed at the way it has structured its healing ministry which follows the pattern of established government health facilities. The Pastors are trained in how to pray for healing, they have 13 consultation rooms which cater for various ailments and three consultation rooms. This health program runs at the Church site located in the central part of town and it is open to everyone.

### **5.5. Fourth contribution: Human Development**

The ARHAP Theory Matrix in chapter three of this thesis shows possible health assets in quadrant 3 and 4 that sets the agenda for the grounded theory in ARHAP studies and for this study. From the activities that local churches in Ndola do to promote health and wellbeing, this study shows that the Church is contributing to human development in the form of education, skill development and in capacity building.

This is evidenced by a number of educational activities that are taking place in these Churches. The UCZ runs pre, primary and secondary private schooling owned by St Andrews UCZ and all congregations in this interview have an early childhood training operating within their premises; Eagles School for the community and OVC's run by an Elder at Monkey Fountain Baptist Church; Dominican Convent Girls Secondary School, special education for differently-abled persons run by the Catholic Diocese; Community schools and pre schooling at Chifubu UCZ. Elim Church and the People's church also have pre and primary schools on their premises. The Salvation Army at Mitanda offers training in nursing care for home based care givers, while the Catholic IAP and Health and Healing Department build capacity in health provision and HBC programmes.

To collaborate this finding in the wider ARHAP studies, the Zambia research for WHO shows that education ranked higher in factors seen as necessary to health and wellbeing in five regional sites as shown in table below<sup>137</sup>:

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<sup>137</sup> ARHAP-WHO Report. *Appreciating Assets* 2006, Pg. 71-72



Educational Factors	51
Religious factors	47
Medical factors	44
Food security	26
Environmental factors	14
Economic factors	7
Attitude and emotions	3
Local factors	5
Wider social factors	2
Traditional factors	1
<b>TOTAL</b>	<b>210</b>

Another area in which the Church is engaged in human development is in the work of the uniformed groups. In the mainline churches, it is a pattern to have uniformed groups of fellowships such as the Women fellowship (Mother's Union in the Anglican Churches, Women and Men Christian Fellowship in the United Church of Zambia, '*Amai akabungwe*' in the Reformed Church, the Catholic Women's league while the Salvation Army uses the ranking system). In almost all these churches, they have youth groups in which peer education plays a vital role. The fellowship groups take their own initiatives.

Of the Churches in this study for instance, the St. Andrews Men Fellowship (MCF) visits the prison once a month and takes material support for the prisoners, while the Women's Christian Fellowship (WCF) has adopted a ward at the Ndola Central Hospital where they help with provision of drugs, cleaning materials as well as its general upkeep. This shows that the Church is an asset of social and human development that government facilities could engage with towards greater health and wellbeing in the community.

### **5.6 Fifth contribution: Networks and Collaboration**

A contribution that is evident in this study is that Church is relational. It is a network of persons from different backgrounds striving to live in cooperation and understanding. In other words the Church is a society and a society is described as a "cooperation of several

individuals, no matter under what conditions, in what manner and to what end”<sup>138</sup> or simply as a network of relationships built on trust.

The Church in Ndola has built a network of relationships and collaboration to enable it to respond to issues that affect the health and wellbeing of its community. In this study, we can observe that the Church’s capacity to respond to challenges of health and poverty depends on its ability to work with its members that volunteer to work as caregivers or community school teachers. For instance in 2005, Cicetekelo hospice had 35 volunteers, all women, drawn from all the Churches in the community.<sup>139</sup> What motivates the Church to get involved are intangible factors like love, faith and hope. These factors are strengthened when there is trust in relationships. The Church has these factors inherent to what it means to be Church<sup>140</sup> and the members express their faith by volunteering in practical ways to alleviate the suffering of others.

The ability of the Church to accompany its members and the community through various interwoven process of life is the greatest strength of the Church. Gunderson in *Deeply Woven Roots*, notes that the Church has strengths inherent in it that it can use and leverage for enhanced quality of life in its communities such as: the strength to accompany, convene, connect, to tell a story, to bless, to give sanctuary, to pray and to endure. It has been discovered that these factors are closely linked to prevention of disease, pre-mature death and general ill-health in a community.<sup>141</sup> In another study, he notes that “many of the strengths function as mediators of social determinants of health.”<sup>142</sup> In this study, the Catholic Health and Healing department is a good exemplar of how the Church can accompany its communities in the struggle for improved socio-economic livelihoods that are critical to health and wellbeing. It has taken its health and

<sup>138</sup> Paul Germond and Sepetla Molapo, In search of bophelo in a time of AIDS: seeking a coherence of economies of health and economies of salvation Pg. 21

<sup>139</sup> Mary Mwiche, B.Th Honours project, 2005, Pg. 28

<sup>140</sup> NIV, 1 John 3: 17 “If anyone has material possessions and sees his brother (*sic*) in need but has no pity on him, how can the love of God b in him?”

<sup>141</sup> G. Gunderson, *Deeply Woven Roots*, Fortress Press, MN, USA 1997

<sup>142</sup> Mirriam Kiser, Deborah L. Jones, Gary R. Gunderson “Faith and Health: Leadership Aligning Assets to Transform Communities” in *International Review of Mission: The Global Health Situation and the Mission of the Church in the 21<sup>st</sup> Century*. Vol 95. no. 376/377. Jan/April 2006. Pg. 54

healing ministry in the communities, resourced by personnel from any Christian denomination, and sources for funding for these works in communities. Therefore, we observe that at the community level, it is a network of Christian churches while at the funding level, it collaborates with government, CHAZ and other International partners.

However, such networking and collaboration is not as tangible in the other Churches under review as compared to the Catholic Church. Part of the reason for this position is observed by Carmody, and I agree with him, when he suggests that in its engagement in social issues, the Church has been highly spiritualized such that it often lags behind in promoting issues of social –justice. This study also made this observation in Chapter 4 in describing the ‘reluctant respondents.’ The Catholics have taken the church into the community not as Congregational projects, but rather as a collaborative effort of all churches but managed by the Diocese. For them, part of the vocation of the Church is speak with and on behalf of the vulnerable, and to promote social justice in society.

The other Churches’ activities in this study also reveal to a certain extent collaborative networks. The Christ Victory Church acknowledges the Jubilee Centre, a Christian evangelical FBI in Ndola, as one of its useful resources in mitigating the impact of HIV and AIDS on its members. The UCZ, RCZ and the Catholic Church collaborate in the running of Cicetekelo Hospice in Lubuto. CHAZ as a network umbrella body of all Christian health work registered with it collaborates with the Ndola Catholic Diocese to effect its work in Ndola. This proves that the Church has built relationships of mutual trust and cooperation to enhance health and wellbeing in the community.

### **5.7 Sixth Contribution: Leadership**

Leadership is an important factor to aligning the health assets which are found in Churches. The best practice observed in this thesis of how leadership is aligned to building health and wellbeing is shown in the Catholic Diocese ‘Health and Healing Ministry’. This department is unique in that its engagement is more on providing leadership to the various health projects the Church is involved in, such as the Integrated

Aids Program, the Children's Desk, Community Based Rehabilitation for the mentally retarded, the Education department etc. Its main focus is to build capacity in the projects by providing leadership training, management skills, building partnerships and networkings. It's a major wing which facilitates resources for all the health projects. Their offices are strategically located at the Bishop's office, who is the overall authority in the running of the projects.

In this study, the prominence of the leadership provided by the late Bishop of the Catholic Ndola Diocese, Bishop de Jong, led to the contribution that we see the Church is now providing through the health and healing department. In the interview with Mr. Fikansa,<sup>143</sup> he noted how the Bishop reacted to the report from the nuns working in a township in Kitwe of a 'strange disease' that was killing people in a painful way. The Bishop then provided leadership to discover what the 'strange' disease was (HIV and AIDS) by bringing in missionary medical doctors to assess the situation. From then on, the Church has been growing in its response to mitigating the impact of HIV and AIDS.

Further in section 4.4.5 we have shown that the pastors in the church see their role in four categories: as a Facilitator, Counselor, Teacher and Development worker. These roles entail leading and guiding people into their fulfillment. Studies at the Inter Faith Institute for Public Health in Atlanta show that leadership is necessary to community health. In this study, Gunderson observed that boundary leaders must work to align the assets in a community using the 'the most relevant science and the most mature faith'. She/he must be a person that pushes beyond personal comforts to push for systems that care and add value to life."<sup>144</sup> While there is evidence of some of this kind of leadership in the churches in Ndola, overall it would be true to say that they are not providing this kind of leadership. This factor as alluded to before, is due to the fact that pastors and ministers, in my observation from this study, do not see their pastoral leadership as

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<sup>143</sup> Interviewed 16<sup>th</sup> May 2006

<sup>144</sup> Mirriam Kiser, Deborah L. Jones, Gary R. Gunderson "Faith and Health: Leadership Aligning Assets to Transform Communities" in *International Review of Mission: The Global Health Situation and the Mission of the Church in the 21<sup>st</sup> Century*. Vol 95. nos 376/377. Jan/April 2006. Pg. 58

including the need to provide leadership in accessing health and wellbeing in national institutional frameworks.

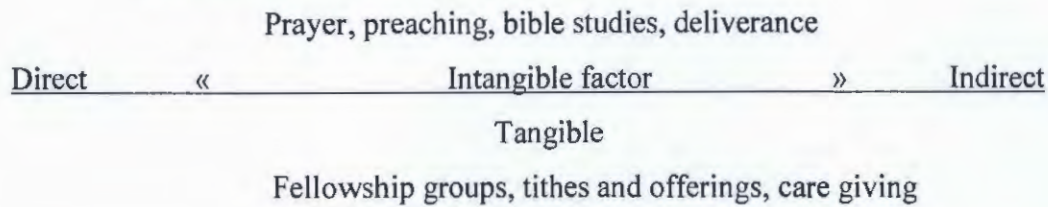
What I observe from this study that the pastors/ministers see preaching as their primary asset to promote health and healing. But it can be assumed from their other responses that the preaching targets mostly individual change of behaviour rather than calling for institutional transformation in systems that hinder the lack of health and wellbeing. An example here in the area of HIV and AIDS is that Zambia today, has no national policy on HIV and AIDS, and the Church is silent about it. In relation to global realization (see Chapter 3) for the need to scale up huge humanitarian efforts to universal access in treatment, prevention and mitigating the impact of HIV and AIDS, the church would enhance this process if its leadership could engage with the national government on how this can be achieved.

### **5.8 Implication of the findings for ARHAP's theoretical framework**

As noted at the start of this thesis, this study has also sought to contribute to ARHAP's theoretical framework. In terms of this, the first conclusion that can be drawn from this study in relation to ARHAP is that the local Church in Ndola is indeed a religious health asset. It is what ARHAP recognizes as a 'religious entity', as the Church in Ndola exhibits tangible assets such as facilities for education and health, a spiritual clinic with practitioners in faith healing, and the HBC programmes that is essentially a Church programme in poorer communities.

Second, the contributions that the Church in Ndola is making to health and wellbeing is both tangible and intangible and has direct and indirect impact on health. This implies that the ARHAP Theory Matrix needs to be adapted as the findings of this study show that there are activities of the church that cannot be entirely separated from each other as is shown in the matrix. For instance, the outreach of the women's fellowship groups, or the caregiver volunteerism, cannot be detached from intangible factors of faith, hope and love, which motivates them to give of themselves to community service.

This is illustrated in the schema below:



Third, religion, specifically the Christian faith that is the focus of this study, has capacities that can be leveraged for better health and wellbeing. This asset is evident in the mandate of the Church to be a witness of God’s love that heals and transforms the broken hearted (Luke 4:18-19). The prophetic witness of the church has direct and indirect outcomes on health when the church is moved from the pulpit into the community. It is a call for social justice, doing good to all as is mandated in Micah 6:8 “He has told you, O mortal, what is good; and what does the LORD require of you but to do justice, and to love kindness, and to walk humbly with your God?” (NRSV)

Finally, the contributions of the Church in Ndola confirm ARHAP’s promotion of the need to engage in ‘respectful dialogue.’<sup>145</sup> This entails religious leaders and health practitioners approaching issues of health not from a dogmatic stance, but rather seeking to gain insights and wisdom from each other for the benefit of the common outcome, improved health and wellbeing in communities.

## 5.9 Conclusion

This chapter has identified and analyzed the six contributions the church in Ndola makes to health and wellbeing. These are:

1. Presence in the community
2. Spiritual encouragement
3. Direct health interventions
4. Human development
5. Networks and collaboration

<sup>145</sup> See more details in “*Appreciating Assets*”, pg. 130

## 6. Leadership

The contributions confirm the assertion that religion has health assets that can be leveraged for health and wellbeing. The contributions also show that ARHAP's search for RHA's and the need to align them to public health policy makers and practitioners is cardinal for the church to effectively live its witness as a health and healing institution. In the next chapter, we will discuss further how the Church can live its witness by analyzing the theological implications of the findings of this study

## CHAPTER 6

### TOWARDS A THEOLOGY OF HEALTH AND WELLBEING IN NDOLA

#### 6.0 Introduction

The previous chapter presented the interpretation of the findings in the context of ARHAP's search for religious health assets. It showed how the Church in Ndola has tangible and intangible assets that impact directly and indirectly on health and wellbeing. This is so because it is difficult to draw a line between what the church does as their acts of compassion due to their spirituality or doing them out of mere human compassion. This chapter seeks to explore a theological vision and resources to assist the churches in Ndola to be more conscious about their contribution to health and wellbeing in Ndola.

#### 6.1 A Summary of the health situation in Ndola

In considering the theological vision and resources that the Church could use to leverage for better health and wellbeing, I will refocus the socio-economic context in which this study is done.

Zambia is beset in poverty, which reached its climax in the 1990's leading to a change of government and economic policy from a humanist socialist to a democratic capitalist economy.<sup>146</sup> The hopefulness of change soon led to despair as companies were privatized leading to increased unemployment due to retrenchments and the closing down of industries. Copperbelt, and in particular Ndola, the capital of the region was severely hit as it is the hub of mining activities in Zambia. The new government of the MMD with capitalist policies could no longer offer free medical and educational services, and it was at this period that HIV and AIDS was noticeably a crisis, including the increase of deaths due to treatable diseases like malaria and tuberculosis. The health system was not coping

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<sup>146</sup> See Chapter two of this thesis for more details



with the situation which led to an increase of religious activities in health,<sup>147</sup> particularly in relation to mitigating the impact of HIV and AIDS.

The Church's engagement in health and wellbeing has continued to grow which led to ARHAP's quest to identify what assets are in religion that contributes to health. This was also necessitated by the global need identified by policy makers for the need to have unprecedented human effort to curb factors that were hindering achieving health for all.<sup>148</sup> This particular thesis is considering what the health assets are as are located in the Christian Church in Ndola, and I have identified and analysed six of these in chapter five. However, in conducting this study, it is my observation that as much as the pastors in Ndola have a good grasp of health and wellbeing, there seem to lack a more conscious contribution to health and wellbeing in their activities identified, apart from the Catholic Church.

It is for this reason that this I argue that there is need for a greater conscious involvement as health is an important development factor. There is also need for practical engagement in health and wellbeing like the Catholics, though they all have to engage with the structures to transform them for better health. The Church needs to use its inherent resources from the God given mandate that it has to exist as church, and has the greatest example of its founder, Jesus Christ, as a healer, a prophet and a priest, who has commissioned the church to disciple and to heal.

## **6.2 Theological vision and resources for health and wellbeing**

As the pastors interviewed in this study have grasped, health points to healing, having a body free of disease, while wellbeing points to being in a state of being pleased with the life one is leading, a lifestyle that is in harmony with self, others/environment and God.

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<sup>147</sup> *Appreciating Assets*, Pg. 67

<sup>148</sup> See Chapter three of this thesis

Biblical theology points to the fall of humankind (Genesis 3) as the starting point of the need for healing and wellbeing. In the Bible, healing is the restoration act of both the body and the natural resources, particularly the land. In Exodus 15:26, the people of Israel are faced with death due to contaminated water, and when they cried out, God healed the water, and promised not to inflict any diseases on them if they lived in obedience to the commands. In analyzing the theological factors that can enhance health and wellbeing, I will consider three aspects related to this thesis; the mission of God as Shalom, the mission of the Church as humanization, the Church's theology of preaching and the example of Jesus.

### 6.2.1 The *missio Dei* - Shalom

The goal of the mission of the Church is to live the mission of God (here after the *missio-Dei*). The 'missio-Dei' is God at work in creation, revealing God's purpose for humankind and all creation as shown throughout the narrative of the Old and New Testaments. In his creation, God affirmed that it was good, and very good. In creation, I observe a state of wellbeing, of shalom, the way God intended life as it ought to be. Shalom refers to a state of wellbeing, being okay "marked by the presence of physical wellbeing and by the absence of physical threats like war, disease and famine."<sup>149</sup> It is a positive idea that points to the presence of health and wellbeing lived in justice, honesty and integrity. It is a mission that involves engaging with the world to make it a better place as is shown in the mandate of stewardship God gave humanity in Gen 1:28 and 2:15; to be fruitful, to rule over and to take care of the creation. This mandate points to health and wellbeing.

When I consider the findings of this study, particularly in the factors that cause lack of health and wellbeing, the Church in Ndola is aware that life for most ordinary people in Ndola lacks shalom. Shalom as envisioned by God in the Old Testament is a mission for

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<sup>149</sup> Perry Yoder. *Shalom* London: Hodder & Stoughton, 1987, Pg.13

people to live a life they and God would value, hence the giving of the Law<sup>150</sup> which is really a concern for right relationships that would enhance health and wellbeing.

To witness to the *missio Dei* in the community is a *work* of revealing God's love, mercy and justice that is desirable in human health and wellbeing. The Church in Zambia must begin to re-envision as part of their vocation, the promotion of social justice as part of effecting the Shalom of God or the Kingdom of God as it is announced in the New Testament. This is so because it is now recognized that social determinants of health are determined by the distribution of social power<sup>151</sup> and further Sen has shown how health is an indicator of people's substantive freedoms. Lack of health is unfreedom, a denial of people's basic capabilities.<sup>152</sup> The observation made in this study (see Chapter 4: 4.2.1 and Chapter 5: 5.1) is that the pastors did not consciously see themselves as engaged in health and wellbeing in their congregations. This concern is also highlighted in the findings of the ARHAP-WHO research in Zambia, in which de Gruchy writes that "there is a significant absence of a social dimension"<sup>153</sup> in Christianity in particular. This arose out of the responses given as factors that contribute to health and wellbeing in which out of the 315 one word answers, only two referred to engagement with public health, representing, 0.6%.<sup>154</sup>

For the Church to raise their consciousness in social justice issues, it must begin to engage with shalom as the mission of God in the public sphere of health if it has to fulfill its mission of faith and works in a manner that enhances the dignity and value of humanity. ARHAP has also recognized this need by calling for a 'respectful dialogue' and de Gruchy summarizes this need well by saying that "the foundational doctrine of

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<sup>150</sup> The Law is described in detail in the books of Deuteronomy and Leviticus and includes aspects of social-economic laws, food laws, use of land as important determinants of health and wellbeing for the Israelites. Deut. 5:33 "Walk in all the way that the Lord your God has commanded you, so that you may live and prosper and prolong your days in the land that you will possess."

<sup>151</sup> Steve de Gruchy, "Relearning our mother tongue? Theology in dialogue with public health." Paper presented to the AAR, November 2006 for the panel: Religion, Health and Social justice: African Perspectives on a Global issue. Pg.8

<sup>152</sup> See De Gruchy "Relearning our mother tongue?" for a summarized thinking of Sen on this matter, Pg 9-10.

<sup>153</sup> De Gruchy, "Relearning our mother tongue?" Pg 5

<sup>154</sup> De Gruchy, "Relearning our mother tongue?" Pg. 8

public health, that health is rooted in public structures of social justice, and therefore that a commitment to engaging in matters to do with access, equity and justice in the economic and political arenas of public life is at the same time a fundamental theological doctrine.”<sup>155</sup> This thesis confirms the need for respectful dialogue between public health and religion for better health and wellbeing. It is also supported by the World Council of Churches’ commission on Church and Society which urges churches “to encourage the training of its people in responsible participation as citizens. It must support laymen who are engaged in critical struggles for values in the public arena.”<sup>156</sup>

### 6.2.2 The Mission of the Church -Humanization

The mission of the Church is best summed up in Jesus announcement of his mission in Luke 4:18-19.<sup>157</sup> This passage reflects a holistic ministry that meets a person’s needs socially, physically, materially and spiritually. It is summed up in Pope John VI description of development, that it involves the “growth of each person and the whole person.”<sup>158</sup> Jesus’ mission, which is the Church’s mission is to liberate and grow a person into the fullness of life that God intended humanity to have, and this Jesus proclaims in John 10:10.<sup>159</sup>

Therefore, in view of the purpose of this study, the Church should be reminded that its primary mission is that of humanization. Humanization, to borrow from Freire, is our “historical vocation.”<sup>160</sup> Biblical history shows that the People of God are called to restore the dignity and value God has given human beings in creation. The story in Genesis 1 shows that human beings are created to reflect God’s glory, to have dominion

<sup>155</sup> De Gruchy “Relearning our mother tongue?” Pg. 2

<sup>156</sup> Prof. C S Banana “Church and Development” in Koegelenberg R (Ed), *Transition and Transformation: A Challenge to the Church*. Cape Town: EFSA, 1994. Pg.56

<sup>157</sup> NIV “The Spirit of the Lord is upon me, because he has anointed me to preach the good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord’s favour.”

<sup>158</sup> Laurenti C. Magesa “Theology of integral development in Africa” in Agbasiere, Joseph T. and Zabajungu B.K. (ed) *Church Contribution to Integral Development*. (Eldoret, Kenya: AMECEA Gaba Publications, 1989 Pg. 113

<sup>159</sup> NIV “I have come that the may have life, and have it to the full.”

<sup>160</sup> Paulo Freire ‘*Pedagogy of the Oppressed*’ Pg 73

over the earth or to rule over it (Gen. 1:28-30). From this study, I do need to acknowledge here that the Church in Zambia has a difficulty to perceive itself as called to this mission of humanization, which is in effect the prophetic mission of the Church.

In Zambia, it is for most part the Catholic Church that is engaged in this prophetic mission, while the Evangelical and Protestants find it difficult to engage because of what we have discussed above and the Christianization of democracy. In this aspect, the Church has been divided in how it engages in the mission of humanization, as those who seem to speak on behalf of the poor are regarded as anti-state, while the evangelical Pentecostals would rather not speak against the 'anointed o f the Lord'. Isabel Phiri illustrates this dichotomy of belief in Zambia in her article on the presidency of F.T.J Chiluba, which shows how the social-economic infrastructures of the country have been maligned in corruption and the evangelicals were caught in the web of it through receiving gifts from the president. Through that, they could not speak against the negative impact the economy was having on the health and wellbeing of ordinary citizens.<sup>161</sup>

In the light of the above, the Church in Zambia must realize that its mission to humanize, to restore the dignity and value of God on humanity is rooted in what Cochrane rightly calls as 'the political economy' of health. The integral mission of the church in health and wellbeing must take into consideration the "totality of human values, material and spiritual, including those in the politics that must be re-appropriated."<sup>162</sup> The argument here is that the Church's mission in health and wellbeing cannot be effective if it does not take into consideration the power dynamics of a community/nation. It's for this reason that the political economy of health must be part of the integral mission of the Church as

"the link between disease, poverty and a caring faith acutely aware of the social and environmental conditions of health, is of seminal importance. It raises the fundamental questions about who acts, who suffers, who bears responsibility for the wellbeing of society as a whole...it calls for an alteration to society and its

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<sup>161</sup> Isabel A. Phiri, "President Fredrick J. T Chiluba of Zambia" in Expressions of Christianity in Zambia in the *Journal of Religion in Africa*, Vol. 33.4, 2003.

<sup>162</sup> Mageza , "Theology of integral development in Africa" Pg.115

political economy, such that the capacities of people are enhanced through public agencies”<sup>163</sup>

It is when the church understands its mission that its assets will be better leveraged to impact on health policies that impact positively on health and wellbeing. An observation that can be made in this study is that the Church’s engagement in health and wellbeing is focused in socio-economic contexts that are poor (see Chapter 4). This in itself shows that the Church is aware of poverty as being a key factor to lack of health and wellbeing, and poverty is a structural matter. The fact that people die of treatable diseases like malaria and tuberculosis, and that many people continue to die of HIV and AIDS despite the availability of ART, point to the need to engage with public structures of governance to affect the way public policies impact on people’s health and wellbeing.

### 6.2.3. Preaching and the example of Jesus

One of the factors that has been identified to contribute to health and wellbeing is the work of preaching. Most of the pastors considered it the primary source of what they contribute to wellbeing and health but the problem that has been acknowledged is that perhaps it is the poor presentation of the gospel that impacts negatively on health and wellbeing. Neither the integral mission of the church, nor responding to the *missio-Dei* can be achieved without preaching, the proclamation of the word of God. Its significance is located in Romans 10:14-15, part of which reads;

And how are they to hear without someone preaching...As it is written, how beautiful are the feet of those who preach the good news!

In the introduction to his book, the “*Vitality of the Word of God*”,<sup>164</sup> Klaus Nurnberger shows how the Bible is dynamic, versatile and diverse in character and reclaims how it is powerful and living and involves its hearers as its witness of its authority in their changed

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<sup>163</sup> James r. Cochrane, “Caring for the Canary: Religion and the Political Economy of Health,” in ARHAP International Colloquium 2007 Concept papers, Monkey valley Resort, Cape Town. Pg 66

<sup>164</sup> Klaus Nurnberger. *Biblical Theology in Outline: The Vitality of the Word of God*. Pietermaritzburg: Cluster, Pretoria: c B Powell Bible Centre 2004

relationships and building of new communities in their time. He continues to portray the primacy of the Word of God as life, and that it is “God’s response to *all human needs* in all dimensions of life. God’s vision for creation is wellbeing of the whole human being, and of all human beings, in the context of the wellbeing of their entire social and natural environments.”<sup>165</sup>

The underlying tone of most of the churches in this study in Ndola is that it is not doing enough as much as they would want to. Part of the reason could be what has already been alluded to in 6.4.1 above, the Christianizing of democracy. However, the church need to reclaim the vitality of the word of God as a tangible asset that has indirect impact on health. The Kingdom of God announced in the New Testament is all about experiencing shalom. It is for this reason that in preaching, the primary end is for its hearers to experience life as it ought to be. In Jesus ministry, healing and wellbeing were his primary focus which announced the presence of the Kingdom of God, the shalom of God, in the miracles of healing, the restoration of dignity as in the woman who was about to be stoned, or the one that bled for twelve years, and in the provision of food for the hungry. He further commissions and mandates the believers in Mark 16:15-18, now the Church, to continue the work of preaching accompanied by signs and wonders as part of the proclamation of the Kingdom of God.

In order to proclaim the shalom of God, the ministers and pastors of the Churches in Ndola have a task to reinterpret their biblical theology in the realities of the communities they preach to. For instance, the prosperity gospel as it is proclaimed portrays a sense of ‘God rewards the giver, so bring your tithes and be blessed.’ It does not portray the fact that giving is an act of service grown out of the love God has bestowed on humanity, in considering all the works that God has done in one’s life, be they poor or rich. The prosperity gospel perpetuates an outward worldview of life, instead of considering the inner capacities one can use to glorify God in their giving, wit qualities of stewardship, integrity, justice and mercy as being at the core of humanity living a kingdom life. The

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<sup>165</sup> Nurnberger. *Biblical Theology in Outline*. 2004 Pg. 6

work of interpretation in preaching must be contextually relevant to the needs of communities if it has its impact indirectly on health.

#### **6.4 Conclusion**

This Chapter has engaged some of the theoretical and theological issues that arose out of this study. Primary in these are the issues of poverty, Gender in relation to sexuality and HIV and AIDS, and environmental factors that hinder health and wellbeing. The chapter has also considered some theological issues that arise out of this thesis which includes the re-conceptualizing the mission of the Church in the mission of God , and the need to redefine its theology of preaching to be contextually relevant to the needs of its time.



## CHAPTER 7

### CONCLUSION

#### 7.0. Introduction

This study is set in the wider context of the African Religious Health Assets programme. ARHAP is a research programme seeking to locate religious health assets in Africa and to align them to health service providers and policy makers. Since its inception in 2002, ARHAP has conducted a number of studies which has made concrete its assertion of health assets in religion. This study is part of the continued search for RHA's and in particular, in the city of Ndola, in Zambia. The purpose of this study was to examine to what extent the local churches in Ndola contribute to health and wellbeing.

#### 7.1 Summary of research

In Chapter one, the thesis set out to introduce this study's research agenda which focused on the contributions the local churches in Ndola make to health and wellbeing. In order to examine the extent of the contribution the Church makes to health and wellbeing in Ndola, this study located the research in the social-political-economic situation of health in Zambia and in particular in Ndola in Chapter two.

Chapter three located the study in the wider ARHAP focus, looking at how ARHAP began, its mission, theoretical assumptions and the studies and findings that have been achieved since then. Of particular interest to this thesis is the findings of the WHO-ARHAP study in Zambia, which highlighted the socio-economic context of how ordinary people struggle for health and how religion is a factor to health and wellbeing.

In Chapter four, I presented the data of my research, giving a descriptive background of the churches involved and what activities promote health and wellbeing.

Chapter five identified and analyzed the findings in the research data, pointing out the six key contributions that the churches in Ndola make to health and wellbeing, namely, presence in the community, spiritual encouragement, direct health interventions, human development, networks and collaboration, and leadership.

In the light of the finding of how the local pastors themselves failed to recognise their contribution to health and wellbeing, chapter six then provided a theological framework to assist them by reflecting on the mission of God, the mission of the Church and the preaching of the holistic gospel. Chapter seven is a summary and conclusion.

## **7.2 Conclusion**

As noted in section 1.2. above, this particular study project sought to assess to what extent local churches in Ndola, Zambia recognize and make use of their assets to promote health and wellbeing in their community.

**The key questions** that this study asked were:

- In what ways does the Church understand itself as contributing to the health and the wellbeing of its community?
- What assets does the church have that contribute to community health and wellbeing?
- Do its ministers recognize and appreciate the assets that are in their churches? If so, how do they enhance them?
- How can these assets further be enhanced so as to contribute to community health and wellbeing in this time of HIV and Aids, TB and malaria?

**The key objectives** of the research were therefore:

- To investigate and assess the understanding of the church's contribution to health and wellbeing.
- To analyze the relationship between these church activities and increased wellbeing.

- To contribute to ARHAP search for an adequate theoretical model to understand religious health assets.

I am now in a position to draw the thesis to a close by noting that I have managed to answer these questions and meet the objectives. This study was conceived in the theory that the religion has assets that impact on health and wellbeing. It used the pastors/leaders of churches to examine this assumption. From the findings of this study, the church indeed has tangible and intangible assets that impact on health and wellbeing, and I have identified these as presence in the community, spiritual encouragement, direct health interventions, human development, networks and collaboration, and leadership.

My research has also enriched the ARHAP theoretical model for understanding religious health assets in two important ways, namely, (i) questioning whether the rigid divisions of the matrix are the best way of portraying the way in which tangible and intangible assets impact upon health and wellbeing in direct and indirect ways, and (ii) providing more detail into the actual activities on the ground that religious entities – in my case, Christian churches – do that contributes to health and wellbeing.

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## APPENDIX 1      CONSENT AND RELEASE AGREEMENT FORM

I..... (full names of Interviewee), have been approached by Mary Zulu Mwiche, a student at University of KwaZulu Natal for an interview and have been informed of the following:

That the interview is for the purpose of the students' requirement to obtaining her Masters degree in Theology and Development. The information from this interview will be used solely for academic purpose. That I have a right to withdraw from the interview at any time.

I acknowledge that the interview material may be catalogued and stored at the University of KwaZulu Natal Library. I acknowledge that should the interviewer wish to use the interview material for any other reason other than that of cataloguing, release and publication, the interviewer is to secure my written permission to do so.

Contact details of Interviewee:

Full  
Name.....  
Address.....  
Phone.....Email.....

I hereby agree to the above stipulations of this release agreement in conjunction with the Interviewer.

Full Names: Mary Zulu Mwiche

Address: Flat 2, Block 3, Maybin Flats, Yembe Avenue, Kanini, Ndola

Phone: 0955450710/0977423117 Email: [mariazm548@hotmail.com](mailto:mariazm548@hotmail.com)

Interviewee

Date.....Signature.....

Interviewer

Date.....Signature.....