

**Local churches and Health: An examination of four  
local churches' contribution to direct health outcomes  
on the Copperbelt Province of Zambia.**

By

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## **DEDICATION**

I humbly dedicate this thesis to my family namely my dear wife Songwe and the my children, Mubanga, Mumba and Theophilus and the church at Grace Reformed Baptist Church; whose encouragement, support and understanding graciously made it possible for me to be away from home and church duties in order to complete my studies.

Kabwe Maybin Kabwe.

## DECLARATION

I, Kabwe Maybin Kabwe, 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 otherwise submitted this dissertation in any form for any degree purpose or examination to any university.

\_\_\_\_\_  
Kabwe Maybin Kabwe

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

As supervisor, I agree to the submission of this thesis

\_\_\_\_\_  
Prof. Steven De Gruchy

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

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## ABSTRACT

The research explores and examines the relationship that exists between religion and health. Four church health related activities were examined as case studies to assert their direct and indirect contribution to health and well being of communities on the Copperbelt Province of Zambia. The main thrust and perspective of the study is a theological position on the contribution of the Christian Church toward holistic health care and provision.

The study is rooted in a large field of study called African Religious Health Assets Program [ARHAP] which has developed a theory to help establish the link that exist between religion and health in health care. The insights from the ARHAP theoretical framework are engaged in this study to identify the religious health assets known as *tangible* and *intangible* in each institution and how they contribute to health promotion and care. Key informants from each of the four religious health institutions were interviewed to establish and examine the kind of religious health assets they have and on how they affect and contribute to health outcomes.

Through these case studies of four Christian religious health institutions, in Ndola and Masaiti districts, the thesis has shown that religious health institutions have diverse assets that enhance and contribute directly and indirectly to better health outcomes. These assets [referring to what is present in these institutions] are labeled as ‘religious health assets’ in this thesis. The findings of the thesis indicate that Christian religious health institutions have assets, which could be aligned and leveraged in public health policy for the well being of people and communities.

## **ABBREVIATIONS/ ACRONYMS**

ABCD	Asset Based Community Development
AIDS	Acquired immunodeficiency Syndrome
ARHAP	African Religious Health Assets Program
ARV	Antiretroviral
ATR	African Tradition Religion
BUSA	Baptist Union of South Africa
CCZ	Christian Council of Zambia
CHAZ	Church Health Association of Zambia
CMAZ	Church Missionary Association of Zambia
CSO	Central statistical Office
DHMD	District Health Management Boards
DHMT	District Health Management Teams
DTCC	Dawn Trust Community Center
EFZ	Evangelical Fellowship of Zambia
FBO	Faith Based Organization
FHMRHC	Fiwale Hill Mission Rural Health Centre
GDP	Gross Domestic Product
HAZ	Hindu Association Zambia
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
ICOZ	Independent Churches of Zambia
ICRC	Isubilo Community Resource Center
ICZ	Islamic Council of Zambia
IGAs	Income Generating Activities
IMF	International Monetary Fund
MOH	Ministry of Health
MMD	Movement for Multiparty Democracy
NBAZ	Northern Baptist Association of Zambia
NFBHNs	National Faith Based Health Networks
OVC	Orphans and Vulnerable Children
PIRHANA	Participatory Inquiry in Health Assets Networks and Agency

PLWHA	People Living with HIV and AIDS
RE	Religious Entities
RHA	Religious Health Assets
SAP	Structural Adjustment Program
SSA	Sub Saharan Africa
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TDRC	Tropical Disease Research Centre
THPAZ	Traditional Healers and Practitioners in Zambia
UKZN	University of Kwazulu Natal
UTH	University Teaching Hospital
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZBA	Zambia Baptist Association
ZCCM	Zambia Consolidated Copper Mines
ZEC	Zambia Episcopal Conference
ZINGO	Zambia Interfaith Networking Group
ZNAN	Zambia National AIDS Network
ZPA	Zambia Privatization Agency

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## CHAPTER ONE

### GENERAL INTRODUCTION TO THE STUDY

#### 1.1 Introduction

This chapter provides a general introduction to the study. The focus of the study is to examine the relationship that exists between religion and health, by undertaking a case study of four church projects that are directly focused on meeting the health needs of the community in the Copperbelt<sup>1</sup> province of Zambia. The study has made use of the theoretical framework of the African Religious Health Assets Program [ARHAP], which suggests (1) that religious bodies have certain ‘assets’ that can contribute to health promotion and care, known as Religious Health Assets; and (2) that assets can be both tangible and intangible. Using this framework, the research is an investigation of the churches’ *intangible religious assets*, which are analyzed to establish how they contribute to the well being of people.

#### 1.2 Background

The relationship that exists between religion and health is an issue, which demands further investigation. In Zambia, this relationship has become even more pronounced as the nation, communities and families struggle with the impact of the prevailing economic, social and health problems. Furthermore, the presence of HIV and AIDS and its devastating impact on the well being of the communities and specifically in the Copperbelt, is a matter that demands holistic attention. For instance, the Ministry of Health in the Zambia National HIV and AIDS policy has declared the pandemic as a national disaster that needs a concerted and multi-sectoral unified response.<sup>2</sup>

Due to the inhumane national economic policies implemented under the Structural Adjustment Programs (SAP), the Copperbelt, province, which used to be the economic hub of the nation owing to its rich mining potential, has been left to struggle economically. The economic policies embraced by the government, have had negative impact on people’s health and livelihood on the Copperbelt.

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<sup>1</sup> Copperbelt Province is situated in the North West of Zambia, it is the economic hub of the country and copper mining and manufacturing are the main economic activities that contribute of the nation’s economy.

<sup>2</sup> National HIV/AIDS policy, Ministry of Health, Ndeke House, Lusaka,2004 p4

Zambia is a religious country, and religion plays a vital role in a number of activities related to peoples' lives. In 1991 the general religious component of society was enshrined in the national constitution in its preamble whereby the nation was declared a Christian nation whose governing principles would be Christian. Apart from this institutional commitment, it is very evident in the lives of many people, both non-Christians and Christians, that in the event of sickness they will resort to some kind of religious solution in search of health remedies. There is a general belief in the 'spiritual world' a force or power that is from without and this is often invoked in the event of sickness.<sup>3</sup> Individuals or families easily connect sickness to some religious beliefs or spiritual aspect of life.

In response to the past and recent developments in the sphere of health and religion, a number of Churches and Faith Based Organizations (FBO) have established programs and projects that run activities related to health. This is particularly so in response to the health matters arising from the HIV and AIDS pandemic and other related illnesses. It is against this background that this research endeavors to survey the relationship that exists between religion and health, and examine the churches' intangible assets and the contribution these make to health and well being of people in the Copperbelt. Four Christian religious health institutions within the Copperbelt were engaged and investigated as case studies of religious health assets.

This study is also part of a wider research project called the African Health Religious Assets Program (ARHAP). The primary focus of ARHAP is to examine the vital role religion and religious entities play in their contribution to health in the communities.

### **1.3 Motivation for the research**

In the attempt to understand the direct contribution of the churches and religious institutions to health on the Copperbelt, four overriding issues serve as a motivation to the study.

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<sup>3</sup> Robert Brandenburg, *Sickness and Healing* a case study on the dialectic of culture and personality. AFEM, Nurnberg. 2003 p.68

Firstly, as an ordained minister working in a local church based on the Copperbelt, I have interacted with people suffering from various illnesses and have counseled both the sick and dying. My ministerial experiences in the area of counseling, have exposed me to the issues of health and religion from the people in the community and church. A common trend among those who are afflicted in body with illness and health crises is that of resorting to religious help for answers. This phenomenon places a challenge on the church and her ministry in the area of responding to the well being of the people.

Secondly, the theological and moral demands placed on the church and her contribution to the plight of people in the world, serves as a motivation for this research. The church is obliged to respond in a holistic manner to the needs of people [health included] based on the belief of a loving God interested in the well being of people. This theological and moral response founded on the biblical witness serves as a motivation in this research.

Thirdly, my academic studies in Theology and Development, and specifically the documents from the African Religious Health Assets Program (ARHAP) have raised an interest that has motivated me to investigate the ways in which religion functions as an asset for the health and well being of people on the Copperbelt. The plight of the people on the Copperbelt that has been accelerated by poverty, HIV and AIDS and other related diseases, demands academic and theological reflection and answers to guide the Church's involvement and contribution to the health and well being of people.

Fourthly, many health problems, including HIV and AIDS, tuberculosis and malaria, are no longer mere medical issues, but are challenges to development and the well being of communities, which require multi-sectoral responses that transcend the health sector.<sup>4</sup> It is clear from the impact that health issues have on society that the response to the health problems demands an inclusive approach that is holistic in nature. The Church in Zambia with its multifaceted resources, abilities, networks and human centered programs plays a vital role in the well being of people. In the field of health, statistics show that over 60% of Rural Health Centers

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<sup>4</sup> Health and development section, Emerging social Issues: 4/20/2005  
<http://www.unescap.org/esid/hds/economy/index.asp>

in Zambia are run and managed by religious institutions.<sup>5</sup> The contribution of the church toward the health and well being of the people is an undeniable fact. However, this contribution has not received the attention and acknowledgement it deserves from government in its public health policy. Thus this research also contributes to the wider ARHAP research program to show why the churches and religious institutions' contribution toward health should be integrated in health policy for holistic health provisions.

#### **1.4 Research Problem and objectives**

The *overriding research question* of this study is: What contributions have local churches or religious organization made toward direct health outcomes on the Copperbelt Province of Zambia? In answer to this research question, four religious health organizations were examined through case studies.

The following indicators in question form were used as a guide to answer the main research objective of the research study:

- To examine the churches' direct contribution toward health.
- To show how religion functions as an asset for the well being of people.
- To consider how religion contributes to the social, economic, and moral well being of communities on the Copperbelt.
- To identify the relationship that exists between religion and health.
- To establish the theological ethos which motivates the health providers in their provision of health.
- To understand what motivates the health seekers to visit religious health institutions.
- To show the impact of Structural Adjustment Program on health provision on the Copperbelt Province.

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<sup>5</sup> CHAZ, Report on Mission rural health centers in Zambia. Lusaka, 2005



In response to the above objectives presented in question form, it was evident, based on the findings and interpretation that churches and religious health institution contribute directly and indirectly to health and well being of communities through the “tangible and intangible”<sup>6</sup> ways.

The *secondary research question* had to do with the implications of the information gathered from the case studies and the impact it has on the ARHAP theoretical framework.

This research has sought to build on the theoretical work being developed by ARHAP and its contribution in the interface that exists between health and religion. The research in this study has particularly interacted with the theory matrix<sup>7</sup> which attempts to clarify the relationship between religion and health. This study has endeavored to highlight and describe the ‘religious health assets’ as illustrated in the theory matrix. The theory matrix suggests that there are both tangible and intangible religious health assets and that these assets have both direct and indirect health outcomes. The details of the theory matrix will be covered in detail in chapter two.

This study, while it assumed the theoretical framework of the matrix as its starting point, has also contributed to the validation and further development of the concept as a working theory on religious health assets. In particular, this research study examined the contribution of churches’ and health institutions to the ‘direct’ health outcomes with special attention on ‘intangible’ religious assets. The case-study approach engaged helped to gain further insight into the relationship between religion and health.

## **1.5 Research Design and Methodology**

The study used a qualitative approach method to collect data. According to Denzin Nornam and Lincoln Yvonna they define qualitative research as;

a field of inquiry that crosscuts disciplines and subject matters. Qualitative researchers aim to gather an in-depth understanding of human behavior and the reasons that govern such behavior. The discipline

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<sup>6</sup> Tangible in this dissertation refers to contributions that religion is making in visible ways such as hospitals, medical personnel or drugs and intangible refers to contribution to health that cannot be quantified or be visibly seen, such as prayer, encouragement or the preaching of God’s word.

<sup>7</sup> James Cochrane and Barbara Schmid, *ARHAP Tools Workshop Report*. (Cape Town, June 6-8, 2004) Available from ARHAP offices, UCT. See chapter two for the details on the ARHAP theory matrix.

investigates the *why* and *how* of decision making, not just *what*, *where*, *when*. Hence, smaller but focused samples are more often needed rather than large random samples.<sup>8</sup>

This study identified four religious institutions of evangelical Christian persuasion which operate health programs and were used to explore the local churches contribution to health on the Copperbelt. These institutions were identified using stratified purposive sampling these are:

- Bethel City Church – faith healing as central to worship
- Fiwale Hill Mission Health Centre – health centre, with clinic and dispensary
- Dawn Community Health Centre – HIV/AIDS, VCT counseling and support
- Isubilo Community Resource Center – local church initiative with health education, nutrition, counseling and clinic programs

These organizations represent a variety of what evangelical religious health institution are doing in health provision, and they were chosen because they would provide a specific and yet diverse contribution to the research problem. Such a limited case study approach will not allow for generalizing the results, but will provide some depth to the analysis of the interaction of religion and health on the Copperbelt.

In qualitative method, several instruments are used to collect data such as *Participant Observation, focus groups and key informant interviews*. This study used the key informant interview method using structured interviews. The choice of this format of data collection was arrived at through purposive selection to help align the study to certain characteristics of the project main research question.

The interview questions were formulated around the main research question and the ARHAP theory hypothesis on religious health assets.

Two coherent methods of data collection were employed.

In the first place, information was gathered through structured in-depth personal interviews. Twenty (20) key informant individuals were interviewed from the above institutions. Eight health providers and sixteen health seekers from each of the respective intuitions were interviewed. The choice of these key informants where from the following categories. (i) health providers, qualified health professionals who are Christians working in religious health

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<sup>8</sup> Denzin, Norman K. & Lincoln, Yvonna S. (Eds.). (2005). *The Sage Handbook of Qualitative Research* (3rd ed.). Thousand Oaks, CA: Sage.

institutions; (ii) Pastors, trained ministers serving in churches; (iii) Christian workers, working in FBOs; and (iv) , youths, widows, and AIDS patients.

The summary of the finding are recorded in chapter four and the narrative details of same interviews are recorded in appendix C.

Secondly, the background information to the historical and organizational structure of each organization was done through the archival material provided by the institutions; some of these are presented in the introduction of each institution in chapter 4.

The data gathered from the above qualitative approach was carefully arranged according to the ARHAP classification of *tangible and intangible assets* under the six main headings namely: spiritual encouragement, compassionate care, moral formation/education, social networks and relationships, curative activities and material support. The results of the findings are presented in chapters five and six under research analysis and theological reflection respectively.

The research study was limited to Ndola town and Ndola rural called Masaiti in the Copperbelt. Data and information collection of the research was done in a period of 8 weeks. Ethical Clearance to undertake this research was provided by University of Kwazulu Natal (UKZN).

## 1.6 Geographical location of the study

The figure below shows the location of the study. It was conducted in Ndola town and Ndola rural called Masaiti, which are part of the Copperbelt Province of Zambia.

**Map of Zambia showing the geographical position of Ndola**



## 1.7 Summary of research findings

We can point to the following key findings from the research.

### i. On the understanding of health

Health is perceived to be more than just the absence of sickness in a person. It includes everything that contributes to the total well being of a person, such as the physical, spiritual, emotional, economic, social and cultural harmony, and environmental well being of the community.

### ii. On the understanding of well being and health

Well being incorporates health [that is physical well being] but the two are not the same. This is best described or understood in Bemba where well being refers to *ubumi ubusuma* [total well being] and health is understood as *ubumi* [sound health]. The Bemba word *ubumi* –health has the

same root as the word well being implying that the two terms health and well being are perceived as an interlocking whole that cannot easily be divorced from each other.

**iii. On the understanding of religion and its relationship to health**

Religion in the generic sense is understood as a conscious belief in a greater being or something that affects one's perception and practices in life. Findings showed that religion plays a huge role in human relationships and well being of individuals and communities. Religion introduces a holistic approach to health both to the health giver and seeker.

**iv. Religion being at the center of health**

The understanding that everything in life revolves around religion sums up the belief that even health matters are determined by religious matters. Religion is perceived as an integral component which is at the center of all human activities even in health seeking and provision.

Alongside these findings, the research identified the following ways in which religion functions as an 'asset' towards the well being and health of people on the Copperbelt. The classification of findings is according to the ARHAP code of interpretation of religious assets.

**i. Spiritual Encouragement: an intangible asset**

This includes aspects of religion such as prayer, prophetic utterances, specialized focus Bible studies groups, sermon delivery, giving of hope, encouragement and accompaniment.

**ii. Compassionate Care:** This includes activities such as giving personalized care and expressions of love through the support groups such as Home Based Care, peer support groups, spending personal time with the health seekers and accompaniment in their fears and grief.

**iii. Moral formation:** This relates to activities such as, counseling, peer focus group Bible studies, guidance, social and moral education, which inform the mind and influence choices and practices.

**iv. Social networks and relationships-** Another aspect which was identified as a religious asset is the presence of real relationships which could be termed as social networks, these are

formal/informal structured meetings where health seekers meet to have fellowship/meetings e.g. talk about a special health or social subject. These networks provide platforms to develop relationships and life skills related to health matters.

**v. Curative activities-** Three of the institutions provide curative medication through dispensaries.

**vi. Material support.** *Material provision such as food, clothes, shelter, water, and farming inputs for food gardens are given to the health seekers. This is regarded as a part of holistic approach to the well being of people.*

## **1.8 Summary of Theological Insights**

This research has also sought to reflect theologically on the findings. These reflections can be summarized as follows.

### **i. Theological teaching on the dignity of human life – imago Dei**

Human beings are created in the image of God; therefore, anything that robs people of this, such as poor health, undermines the very essence of life. Health deals with human lives and must be a concern of all churches and religious institutions. Health and well being are aspects of life that contribute to the wholeness of human beings and consequently contribute to the enhancement of human dignity. The imago Dei provides a theological foundation that should inform these religious institutions' involvement in matters of health, healing and social services.

### **ii. The integral mission of the church in the context of health service – the missio Dei**

The mission of God in the world is visible through the integral or holistic mission of the church. The involvement of the churches and religious health institutions in health provision is a demonstration of integral mission in the world. There is a need for a serious and committed paradigm shift in the mission of the church to holistic or integral mission. The traditional dichotomized vision and mission of the church which promotes a 'secular and sacred' divide, creates an unnecessary tension between 'evangelism and social action' in the ministry of the church to the world.

God has called and commissioned the local church as the instrument for the transformation of all things<sup>9</sup>. The *mission- Dei* encompasses everything that enhances the welfare of human beings. The church is called in her integral mission to engage in health, healing and well being in her demonstration of God's love to the world.

### **iii. Theological reflection on health, - healing, well being and God's kingdom.**

According to the World Health Organization, health is a fundamental human right. Good health gives human beings a sense of worthiness and acceptance. The direct and indirect health outcomes which are a result of the activities and services being offered by religious health institutions contribute to the well being of not just the people but also the communities. The message of the kingdom of God is about the way we live life now, calling us to create people, communities and nations that are healthy, and live to maximize their potential.

The church is the agent of this message and has a theological basis and mandate to be involved in health, healing and well being of people and communities. The religious health institutions' engagement in health, healing and well being is a manifestation of their theological interpretation of the message of Jesus Christ, the good news to the whole person, which message goes far beyond the narrow 'spiritual salvation' but engages all aspects of life.

### **iv. Health and well being an expression of the concept of God's shalom**

Another theological reflection that emerges from this study is the direct and indirect health outcomes which are as a result of the assets offered by the religious health institutions. The biblical concept of shalom is presented in the understanding of well being. Shalom as it is understood in its inclusive meaning refers to a sound relationship of human beings dwelling at peace in all their relationships with God, with self, with fellows and with nature. This understanding is more than just the absence of conflict or hostility.

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<sup>9</sup> Colossians 1:20 ' by him to reconcile all things to himself, whether things on earth, or things in heaven' [ New King James- Bible]

The church is called to share and promote the ultimate vision of God for humanity which is shalom – the enjoyment of one’s relationships with God, with self, with fellows and with nature resulting in wholeness to life. Issues of health address this matter of shalom.

**v. Aligning of religious health assets’ contribution to public health system for holistic health.**

Religious health institutions contribution to the health systems warrants for a developing of new vocabulary in the healthcare systems which will be holistic in nature and practice.

## **1.9 Structure and content of the dissertation**

The thesis is made up of seven chapters.

Chapter one presents the general introduction, background and motivation of the research study and shows the relevance and rationale of the study, research problem and research. The objectives of research, theoretical framework, methodology, research limitations are highlighted in this chapter. The chapter concludes with a summary of research finding and theological reflection on the findings with a summary outlines and content of the research.

Chapter two places the research in its geographical, historical, religious, economic and social contexts. It presents the historical development of health and the causes of decline in health provision in Zambia. The chapter shows the impact of economic policies and especially the privatization of health provision in Zambia in general and specifically on the Copperbelt. The chapter concludes with the impact of health reforms on the livelihood and health of people.

Chapter three introduces the African Religious Health Assets Programme (ARHAP) including its background, objectives, historical and current activities. Detailed working definitions of ARHAP terms and concepts are presented and how they relate to the research study. The chapter also locates and describes the four religious health institutions and their activities that are the focus of this research.



Chapter four deals with the research findings in a summary form, giving the background of each of the four case studies, and their organizational objectives and mission. An overview of each organization operational structure, activities and their contribution to health and well being are highlighted. The findings are presented on the relationship between religion and health.

Chapter five presents the research analysis of the findings. In this chapter the ARHAP theory matrix is engaged to establish the intangible and tangible religious health assets in the four institutions. The analyses of the research finding are presented showing the direct and indirect contribution of religious health assets to the well being of people in the Copperbelt.

Chapter six focuses on the theological reflections on the salient issues that are raised from the research findings. Included in this are issues related to the dignity of human beings, the mission of the church in the world, health, healing and the kingdom of God, and shalom.

Chapter seven deals with the general reflections on the research objectives; and gives recommendations and conclusions on the overall research.

## **1.10 Conclusion**

This chapter has highlighted the general introduction, background and motivation of the research study. The research problem(s) and research question have been presented with the objectives of research. The chapter has shown the relevance and rationale of the study and given a summary of the research findings.

The next chapter will locate the research study in its context looking at the development and the decline in health provision and the impact of health reforms on health provision with a specific focus on the Copperbelt Province.

## CHAPTER TWO

### AN OVERVIEW OF HEALTH DEVELOPMENT ON THE COPPERBELT PROVINCE AND THE IMPACT OF STRUTURAL ADJUSTMENT PROGRAMMES ON HEALTH PROVISION

#### 2.1 Introduction

This chapter describes the development of health provision in Zambia with a special focus on the Copperbelt Province. The chapter highlights the causes and impact on the decline of health provision in general. The chapter also shows how the Economic Structural Adjustment Program (SAP) impacted on the collapse of the health services. It also shows how other issues such as HIV and AIDS and poverty have affected the health provision. An overview on religion and religious health services in Zambia is documented in this chapter, as a way of preparing the reader for chapter three, which focuses on the ARHAP. The activities of religious health institutions in Zambia are highlighted to show the relationship that exists between religion and health and the relationship and impact they have on the well-being of communities.

#### 2.2 Zambia's Demography and health Statistics

##### 2.2.1 Demography

Zambia is a land locked country situated in South Central Africa and shares borders with Tanzania, Congo, Angola, Namibia, Botswana, Zimbabwe, Mozambique and Malawi. According to the statistics from the Ministry of Finance and National Planning<sup>10</sup>, Zambia has a population size of 11.5 million. The ethnic groups of Zambia's population consist of African 98.7%, European 1.1%, other 0.2%. The official language is English. In total there are 41 documented living languages in Zambia. The most widely spoken is Bemba. Others include Kaonde, Lala-Bisa, Lamba, Lenje, Lunda, Luvale, Lozi, Mwanga, Nsenga, Nyanja, Nyika, Tonga and Tumbuka. About 40% of Zambia's population lives in towns/cities with 60% living in rural areas. In terms of age structure, 46% of Zambia's population is aged 0-14, 52% aged 15-64 and 2.2% aged over 65. The economy is largely depended on copper mining, which accounts for about 80% of export earnings. Although mining is the main source of revenue, about 72% of the

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<sup>10</sup> Ministry of Finance and National Planning. Transitional National Development Plan, 2002-2005, Ministry of Finance and National Planning: Lusaka

country's population survives on subsistence farming. Zambia's Gross Domestic Product (GDP) per capita is \$320.

Zambia is a religious nation with Christianity being the major religion practiced. In 1991 President Fredrick Chiluba declared Zambia as a Christian nation and had it enshrined in the preamble of the national constitution. However, this does not mean that other religions are not being practiced.

### **2.2.2 Health facilities and Infrastructures**

By 1992 there were several government and private hospitals in Zambia. The major hospital is the University Teaching Hospital in Lusaka, with provincial and district hospitals in all the provinces and districts. Zambia also has a major private hospital, Nchanga South Hospital, in Chingola, operated by the mines formerly owned by Zambia Consolidated Copper Mines Ltd. Zambia has a large number of mission hospitals which are coordinated by the Church Health Association of Zambia (CHAZ) formerly known as Church Missionary Association of Zambia (CMAZ) which was formed in 1970. The mission health institutions affiliated to CHAZ provide 60% of health services in rural areas.<sup>11</sup>

Zambia has one School of Medicine in Lusaka , which was opened in 1966. In addition, the University of Zambia offers a postgraduate Masters in Public Health. There is also a school of Public Health at The Chainama Hills College which opened in 1978 offers a variety of short courses in topics related to public health and Diplomas in Clinical Medical Sciences and Environmental Health Technology. There is also The Tropical Diseases Research Centre (TDRC) located in Ndola which was established by the World Health Assembly and Zambian government in 1977. In 1981, the TDRC became a National Institution for research, training, and service in diseases of public health importance in Zambia. It is run as a parastatal<sup>12</sup> under the Ministry of Health with the mandate to conduct epidemiological and clinical research. Activities of the institute include epidemiological and clinical research in malaria, schistosomiasis, trypanosomiasis, HIV and AIDS and micronutrient deficiencies; health systems research, health

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<sup>11</sup> Central statistic office Demographic and health survey Ministry of Finance and National planning, GRZ; 2004.

<sup>12</sup> Parastatal companies were companies, which were semi- government owned and therefore depended heavily on government for funding and subsidies.

impact and evaluation, training and service. The TDRC has 3 scientific departments namely: Public Health, Clinical Sciences and Biomedical Sciences.<sup>13</sup>

### **2.2.3 Development of the health sector during the Kaunda government**

In 1964 Zambia became independent from the British government and the Rhodesian Federation, and Dr. Kenneth Kaunda became the president. After independence, the responsibility of running the health sector was transferred from the Federation to the new Zambian government. At the time of independence there were scant health institutions around the country, with only a handful of district hospitals existing.<sup>14</sup> During the leadership of Dr. Kaunda a health policy was put in place to provide health care to all the Zambian citizens. Emmanuel De Kadt,<sup>15</sup> notes that after five years of independence there was an increase of about 48 percent in the number of rural and urban health institutions. The government built provincial hospitals in all the main provincial towns and health facilities in districts and rural health centers. De Kadt says, by 1984, after 20 years of independence, the government had established rural health centers and clinics with outpatients' facilities and a major hospital in all the districts.

During this same period, the economy of the country, which heavily depended on copper was doing fine. Copper provided Zambia with 90% of its foreign exchange earnings. In addition to this, the Kaunda government had embraced a socialist system of economy and adopted a health policy that provided free medical services to all Zambians.<sup>16</sup> This meant that the government highly subsidized health provision. It is important also to note that during this same period when the copper prices were high the mines had built a number of hospitals and clinics in all the major mining towns. In principal the hospitals were owned by the government under, the Zambia Consolidated Copper Mines (ZCCM ) but were privately managed. The mine hospitals were owned and operated independent of government influence. The mine hospitals offered the best health care services in the country. The table below shows the number of mine hospitals on the Copperbelt before they were privatized.

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<sup>13</sup> Central statistic office Demographic and health survey Ministry of Finance and National planning, GRZ; 2004

<sup>14</sup> Ed. Venkatesh Seshamani, Chris Ngenda Mwikisa. Zambia's Health Reforms selected papers 1999- 2002, p2

<sup>15</sup> Emmnauel De Kadt Gavin Williams, *Sociology and Development:an important phase in the development* 'Routledge; 2003. <<http://www.routledge.com>> p 263 accessed 25/06/2008

<sup>16</sup> Ministry of Health. '*National Health Reform Policies and Strategic Health Reforms.*' MOH Lusaka. 1992.

*Distribution of 1<sup>st</sup> and 2<sup>nd</sup> level Hospitals by Level and Province 2002**Copperbelt Province<sup>17</sup>*

Province	Name of Hospital	Owner	Total number of Beds	
			Beds	Cots
Copperbelt	Konkola Mine	Private –mine owned	104	21
	Nchanga South	Private -mine owned	145	26
	Kalulushi mine	Private -mine owned	99	33
	Nkana mine	Private -mine owned	106	43
	Wusakile Hospital	Private –mine owned	450	28
	Luanshya mine	Private- mine owned	81	150
	Roan Antelope	Private- mine owned	200	150
	Thomson District	Government	81	34
	Mpongwe Mission	Mission owned	109	9
	St. Theresa's Mission	Mission owned	90	3
	Kamuchanga	Government	54	6
	Malcom Watson	Private –mine owned	85	25

The table shows that the ZCCM was the major health service provider on the copperbelt. This was before 2000 when the government sold off the ZCCM and other related institutions such as the mine hospitals.

The decline of copper prices in the 1980s affected the economy of the country resulting in higher inflation. According to the health reform documentation,<sup>18</sup> the government found it practically impossible to offer free good health services due to the poor economy and the health policies of the day. Seshamani and Mwikisa<sup>19</sup> make the observation that with the decline of the country's economy due to poor copper prices, the government could not adequately fund the public health sector, which gradually affected health provision and led to the deterioration of services. There were insufficient drugs and other supporting supplies to run the public hospitals and health centers effectively. Due to the decline in the country's economy, the Kaunda government could

<sup>17</sup> Health Institutions in Zambia, *A listing of health Facilities According to levels and location*, Central Board of health-Zambia 2002.

<sup>18</sup> [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list\\_uids=3541230&dopt=Citation](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=3541230&dopt=Citation)  
Health Reforms in Zambia. download 7/02/2007.

<sup>19</sup> Venkatesh Seshamani, Chris Ngenda Mwikisa. Zambia's Health Reforms selected papers 1999- 2002

not adequately sustain funding to the health services. This had a slow negative effect on the free health policy, which could not be sustained.

### **2.3 The change of government and the new health policies, their impact on health provision.**

In 1991, a new government was elected into power. Dr. Fredrick Chiluba became president under the Movement for Multiparty Democracy (MMD) party. Lawrence Temfwe makes the observation that the Chiluba government reversed the whole focus of governance from a state owned to a liberalized economy.<sup>20</sup> When the MMD came into power, the health sector, social and economic facilities such as transport system and other supporting infrastructures were in a rundown state. It is worth noting also that the free local services offered by the state before 1991 were partially maintained by going into deep debt to pay for the parastatal companies which were not making profits. This led to additional borrowing by the government in order subsidized the services. The new government embarked on a privatization policy. The government's commitment to privatization was supported by passing the Privatization Act in 1992 to set the legislation and regulatory framework.<sup>21</sup> Among other regulatory components, the government established the Zambia Privatization Agency (ZPA) to ensure that there was transparency and effectiveness in the privatization program.

In order to maintain the privatization program, the new government put in motion the Structural Adjustment Program (SAP) under the International Monetary Fund (IMF) conditions and terms.<sup>22</sup> This led to a number of institutions, which were previously state owned or funded, being either privatized or having the funding reduced or completely removed. These policies resulted in the readjusting of national spending and service provision. According to the June 2001 privatization agency report it showed that from the beginning of the privatization program, 1992 to April 2001, out of a working portfolio of 280 companies, 254 privatization transactions were recorded. This showed the government's determination to liberalize the economy. In 2000,

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<sup>20</sup> Temfwe, Lawrence *An analysis of the role of evangelical fellowship on Zambia in the declaration of Zambia as a Christian nation*. Wheaton, MA thesis Dissertation 1999. p18

<sup>21</sup> <http://www.ipanet.net/documents/WorldBank/databases/plink/factsheets/zpa@zpa.org.zm>

<sup>22</sup> International Monetary Fund Report on Zambia, "Enhanced Structural Adjustment Facility, Policy Framework Paper, (Lusaka: 1999-2001)

the country's largest economic giant, the Zambia Consolidated Copper Mines (ZCCM), was sold off.<sup>23</sup>

It is important to note that both the public and private health services including all ZCCM health institutions were not spared in the structural adjustment program. New health policies were put in place to reduce and restrict spending which gave birth to the health reforms.

#### **2.4 Impact of Structural adjustment program (SAP) and Privatization on health provision.**

The introduction of the free market economy and the implementation of the SAP had some directly negative impact on the healthcare systems in the country and more specifically on the Copperbelt. With the sale of the mines, the ZCCM which used to be the main health provider, folded up. The 'mine hospitals' which had provided good health services to its workers were sold off to private companies. ZCCM which used to be the main employer on the Copperbelt provided within its conditions of service health service to its employees. With the sale of the mines, all these privileges and conditions changed. A number of employees were retrenched thereby depriving them of the free health services they enjoyed. The new owners of the previous mine hospitals charged exorbitant service fees. Mark Lynas<sup>24</sup> commenting on the effects of SAP observes that the intended goal of privatization to enhance human life worked directly opposite to that goal. He gives an example of miners who lost this privilege and the introduction of user fees in government hospitals<sup>25</sup> which made it practically impossible for the poor to access medical attention from hospitals. The result was empty hospitals because people were unable to pay user fees. Ann-Louise Colgan captures the whole new scenario of the impact of SAP on human life and health when she says,

The policies of the World Bank and IMF have impeded Africa's development by undermining Africa's health. Their free market perspective has failed to consider health an integral component of an economic growth and human development strategy. Instead, the policies of these institutions have caused a deterioration in health and in health care services across the African continent.<sup>26</sup>

<sup>23</sup> Privatization and Industrial Reform Credit Project, the World Bank, Washington, DC, 1992

<sup>24</sup> Mark Lynas, Structural Adjustments - effects in Zambia "*Africa's Hidden Killers*" 1999 p1

<sup>25</sup> User fees- these are fees that were introduced with the health reforms, see the detailed comments on user fees under the heading on health reforms below.

<sup>26</sup> Ann-Louise Colgan, Hazardous to Health: The World Bank and IMF in Africa, Africa Action, April 18,2002

As a result of the new economic policies, the majority of the poor people who formerly enjoyed the free or heavily subsidized public health service during the Kaunda government were cut off from public health services. The sale of the mine hospitals and introduction of user fees brought about a downgrade in the health services particularly in the Copperbelt mine towns where the mines had provided good medical services. The result of SAP and the privatization policy brought in a great reversal in health services and consequently had great negative impact on the well being of people.

## **2.5 Health reforms and their impact on health services**

Reflecting on the environment under which these health reforms took place, Julie McLaughlin notes that due to the deterioration of the economy, health infrastructure was not maintained and a number of health centers in rural areas were without water or sanitation facilities.<sup>27</sup> With the deteriorating economy, government spending was restricted in general and among the affected departments was the public health care sector. There was a severe shortage of doctors, medicine, medical equipment and supplies. Most of the medical equipment became obsolete.

In addition to this, there was the HIV and AIDS epidemic and an increase of malaria and tuberculosis cases. This scenario saw an increase in the number of people visiting the hospitals, and it was clear that the inefficient, government-financed health care system could not meet demand to provide quality services.<sup>28</sup> It was under these conditions that the government, which was already in the process of economic restructuring, initiated the health care reforms program to address the crisis.

The primary goal of the health reforms was to decentralize the resources and responsibilities to the district level in order to quicken up services, manage the limited resources, maximize quality care and provide quality health care as close to the household as possible.<sup>29</sup> The vision of the health reforms was to “provide equity of access to cost-effective, quality health care as close to

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<sup>27</sup> Julie McLaughlin, World Bank's World Development Report 1993: Investing in Health and Better Health in Africa Findings, Africa Region No 43, July 1995.

<sup>28</sup> Evaristo Mambwe, The Challenge of Poverty for the Church in Zambia: A response to the effects of the Structural Adjustment Programme (Master's Thesis University of Natal, 2002), p.34.

<sup>29</sup> MOH. National Health Reform Policies and Strategic Health Reforms. Lusaka Ministry of Health. 1992.



the family as possible.”<sup>30</sup> According to Seshamani and Mwikisa, in order to realize these health reforms, the Ministry of Health (MOH) worked on a policy document called the ‘National Health Policies and Strategies Health Reforms’ which was approved by Cabinet in 1992. An intensive program of training District health staff began in 1993, and legislation was passed in 1995 with establishment of District Health Management Teams (DHMT). Management boards called District Health Management Boards (DHMBs) were formed to oversee the implementation of these health reforms and services at the district level.<sup>31</sup>

According to Duara Mtonga the health reforms had exempted a category of people such as children under 5 and adults over 65, those with diseases such as TB, HIV and AIDS, STDs, Cholera and dysentery; safe motherhood and family planning services; immunization; and treatment of chronic hypertension and diabetes.<sup>32</sup> However, every able-bodied Zambian with an income was required to contribute toward the cost of his or her health.

In addition to the introduction of user fees, there was a decentralization of responsibilities to the district level, which meant that funding was redirected from centrally managed projects to communities and districts. There was also budgetary reform whereby District Health Management Boards received allocations from the centre to enable them plan and manage their affairs. The government also introduced what they called ‘basket funding’ whereby donor funds would be put in one basket and used in line with government’s priorities.<sup>33</sup>

### **2.5.1 The results of health reforms**

The introduction of user fees in the health reforms had a direct impact on the people’s health and well-being. The result of the health reforms is well illustrated by an investigative article written by Lynas on the impact of structural adjustment and health reforms in Zambia. A lengthy quote is worth recording to capture the results of health reforms on people’s lives:

The World Bank claims that Zambia's reformed healthcare system is a model for the rest of Africa. "It's true that there are no queues," says Dickson Jere, a freelance journalist formerly with the Zambia Post. "But that's because people are simply dying at home." “They're called BIDs - 'brought in dead's. At Casualty in

<sup>30</sup> Daura, M, Mtonga, S. Cost Sharing Brief, Central Board of Health: Lusaka. 2002.

<sup>31</sup> Ed. Venkatesh Seshamani, Chris Ngenda Mwikisa. Zambia’s Health Reforms selected papers 1999- 2002, p55

<sup>32</sup> Daura, M, Mtonga, S. Cost Sharing Brief, Central Board of Health: Lusaka. 2002.

<sup>33</sup> Ed. Venkatesh Seshamani, Chris Ngenda Mwikisa. Zambia’s Health Reforms selected papers 1999- 2002 p55

Lusaka's University Teaching Hospital (UTH), they are an increasingly common phenomenon, especially among children. "If you want to see the impact of Structural Adjustment on Zambia," Emily Sikazwe, director of the anti-poverty group Women for Change, told me: "Go to UTH".

I went to UTH. It is Lusaka's biggest hospital, where those who can't afford private healthcare end up. Enter the children's ward and the smell hits you like a wall. A musty, medicinal odour - the smell of sickness, and of death. Rows of children lie on small beds, slowly passing away from preventable diseases like TB, malaria and pneumonia. On the other side of the building is a cleaner, neater ward, where half the beds stand empty. This is the fee-paying section, where families who can pay a 100,000 Kwacha (\$40) deposit can buy a slightly better chance of life. In World Bank language, this is 'user-responsive healthcare'<sup>34</sup>

The introduction of the referral system<sup>35</sup> in the health reforms is another negative result that impacted on the people. Poor people who needed immediate medical attention from hospitals cannot be attended to unless they were referred by a lower clinic or health center. A failure to do this meant that the patients were subjected to pay a by-pass fee. The new system simply cut the poor people from accessing quality health services. The poor had no choice but to suffer and most of them die at home. Lynas presents the situation so vividly when he writes on the impact of SAP on health he says: "people are dying. Quietly, but in huge numbers, all over Zambia, lives are being wasted. Wasted not because of some accident of nature, but as a direct result of economic policies imposed by faceless Western planners. For example, in 1980, under the former 'socialist' government of Kenneth Kaunda, the infant mortality rate was 97 deaths per 1000 births. It's now 202 per 1000. That means one in five children in Zambia die before reaching the age of five. The average life expectancy has fallen from 54 in the mid 1980s to 45 now."<sup>36</sup>

It is clear that the change in these statistics has come as a result of the health reform under SAP which paid little attention to the plight of the poor.<sup>37</sup> The consequent results of the health reforms, did not meet the intend goals of enhancing the health service provisions. On the contrary, the overall results of health reforms worked in the reverse of the intended purpose of

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<sup>34</sup> Mark Lynas, Structural Adjustments - effects in Zambia *"Africa's Hidden Killers"* 1999

<sup>35</sup> Referral system was a network of health centers and hospitals, which were established in all second and third level referral hospitals. Under this system a patient cannot visit the general or provincial hospital directly only as referrals. Without a referral note from the clinic a by-pass fee would be charged. This system bared the poor from being attended to in bigger hospitals due to a several fees for medical examinations in big hospitals.

<sup>36</sup> Mark Lynas, Structural Adjustments - effects in Zambia *"Africa's Hidden Killers"* 1999 p.4

<sup>37</sup> Mark Lynas, Structural Adjustments - effects in Zambia *"Africa's Hidden Killers"* 1999

SAP. The public health sector, which should have been the main health provider, experienced a decline in the attendees with the introduction of user fee system. Health became a luxury, negating the World Health Organization's objectives of making primary health care available especially to the developing world as stated in declaration of the WHO made in 1978 at Alma-Ata.<sup>38</sup>

However, it is worth mentioning that in rural areas and places where there are mission hospitals or church related health centers there was a hive of activities as they filled the gap that was created due to the introduction of user fees in public hospitals.<sup>39</sup> Mission or church related health hospitals provide over 60% of health in the rural Zambia. According to Godfrey Biemba, "current statistics indicate that the church provides 30% of overall healthcare and approximately 60% of rural health services. Church health institutions fill the gap where government health services are not available while at the same time co-existing side by side with government health facilities."<sup>40</sup> Biemba also notes that these religious health institutions have a strong presence and are known to offer good services which has had proven reputation built on years of experience.<sup>41</sup>

The Copperbelt, which previously enjoyed relatively good health services through the mines, was one of the most affected. People lost jobs through SAP, so it was not just the health that was affected negatively, but the people's livelihoods as well.

## **2.6 Impact of Structural Adjustment Program (SAP) and privatization on livelihood of people.**

Martin Khor highlights the goal of SAP when he says "the basic assumption behind structural adjustment was that an increased role for the market would bring benefits to both poor and rich. In the Darwinian world of international markets, the strongest would win out. This would encourage others to follow their example. The development of a market economy with a greater

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<sup>38</sup> John J Hall and Richard Taylor "Health for all beyond 2000: The demise of the Alma-Ata Declaration and primary health care in developing countries" *The Medical Journal of Australia* 178/3 (2003) 17-20.

<sup>39</sup> CHAZ 'History and activities of CHAZ' project proposal. 2005

<sup>40</sup> Godfrey Biemba, "Value-Added and Invisibility of Religious Health Assets", ARHARP collection of concept papers, 2007 International Colloquium, Cape Town p21

<sup>41</sup> Godfrey Biemba, "Value-Added and Invisibility of Religious Health Assets", ARHARP collection of concept papers, 2007 International Colloquium, Cape Town

role for the private sector was therefore seen as the key to stimulating economic growth.”<sup>42</sup> Clearly the goal of the IMF and the World Bank, who are behind SAP, was that the economic adjustment was a way to enhance peoples’ livelihood and create an environment that would increase the wealth of a nation. However, the reality on the ground was the very opposite of the intended purpose. A number of people lost their jobs with the privatization of companies. Khor further makes an observation on SAP and its impact on people’s livelihoods; he says ‘half the companies sold out of the state sector are now bankrupt. Over 60,000 people have lost their jobs as a direct result of the economic liberalization program introduced after 1991. With many mouths dependent on one breadwinner, this has thrown an estimated 420,000 into destitution’<sup>43</sup> Emily Sikazwe a woman engaged in women and gender issues says, "SAPs cause poverty and poverty has a woman's face." Women shoulder the main burden of providing for families, and girl children are the first to be withdrawn from school when a father loses his job.<sup>44</sup>

It is clear that the impact of SAP added misery to a number of Zambians who were already living in poverty. It is important to note that at the time when these economic adjustments and reform programs were being implemented, the majority of people in Zambia were living in extreme poverty. The diagram below shows the levels of poverty indicators at the time of SAP.

**Overall and extreme poverty in Zambia, in rural and urban areas, 1991-1998<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

<sup>42</sup> Martin Khor, Structural Adjustment Explained , Structural Adjustment a major - cause of poverty- global issues- July 2005. <http://www.doublestandards.org/sapl.html#Zambia>

<sup>43</sup> Martin Khor, Structural Adjustment Explained , Structural Adjustment a major - cause of poverty- global issues- July 2005.

<sup>44</sup> Martin Khor, Structural Adjustment Explained , Structural Adjustment a major - cause of poverty- global issues- July 2005.

<sup>45</sup> Venkantesh Seshamani, Chris Ngenda Mwikisa, *Zambia’s Health Reforms*, selected papers 1995-2000. Department of Economics, University of Zambia, 2002.p57.

As can be seen from this table, the health reforms were implemented during a time when the social and economic life of the people was not sound. In 1993 when these policies took effect the table shows that the country poverty indicators were at 60.6%, implying extreme poverty. Besinati Mpepo Phiri gives even more recent statistics that about 73% of Zambians live below the poverty line and that 71% of Zambians today live in abject poverty. Because of this poverty in Zambia, many people are prone to sicknesses and disease<sup>46</sup>.

The living conditions of the people during this period according to the Living Conditions Monitoring Survey of 1998<sup>47</sup> showed significant changes in the survival strategies employed by some of the people. Some women involved themselves in prostitution as a survival strategy which consequently compromised their health. The consequent result is seen in the increase of a crisis like HIV and AIDS during the same period of health reforms.

It's also worth noting the comments of Joseph Stiglitz, former World Bank chief economics, who observes that the IMF and World Bank admit that some of its policies do not work to alleviate poverty or improve people's livelihood. He says that, "structural adjustment didn't benefit the poor, it is almost as though the Bank tries to subtly absolve itself by sort of blaming the poor for not benefiting from this. When structural adjustments have required cut backs in health, education and so on, then what would one expect?"<sup>48</sup>

The results of SAP on education are illustrated by Khors's observation in this quote, "They are a direct result of cuts in public spending and the introduction of school fees. For example, whereas in 1991 the Zambian government spent about \$60 per primary school pupil, it now spends just \$15. Cuts in public spending - the slimming down of a 'bloated' public sector - are a central plank of structural adjustment, as promoted by the World Bank and the IMF. In one of SAP's greatest ironies, the World Bank is now recasting itself as a 'Knowledge Bank' - at the same time as it

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<sup>46</sup> Besinati Mpepo Phiri, 'The path away from poverty: an easy look at Zambia's poverty reduction strategy paper' (Lusaka: Civil Society for poverty reduction), 2004.

<sup>47</sup> Venkantesh Seshamani, Chris Ngenda Mwikisa, *Zambia's Health Reforms*, selected papers 1995-2000. Department of Economics, University of Zambia, 2002.p 61-62 The survey covered a number of areas such as demographics characteristics, migration, health, education, income, expenditure, child health and nutrition, food production, access to various facilities, household assets and poverty..

<sup>48</sup> Joseph Stiglitz, *Globalization and its Discontents*, Penguin Books 2002. p40-41

condemns millions of children across Africa to a lifetime of ignorance and illiteracy”.<sup>49</sup> Although the cutting on spending was a necessary move, it nevertheless demonstrated some of the negative impact of SAP on the livelihoods of people. It is also worth noting that the spending on the part of the government in order to subsidize these services, had led the government to be indebted with continual borrowing.

## **2.7 HIV and AIDS and its impact on health services.**

It is also important to note that during the period of the health reforms, the HIV and AIDS pandemic began to take its toll on the community. Many lives have been lost due to the AIDS pandemic with its related diseases such as malaria and tuberculosis (TB). HIV and AIDS therefore has become a major challenge to health provision. The National HIV and AIDS STI/TB/ policy, has declared HIV and AIDS as a national disaster.<sup>50</sup> The document states that ‘the fight against HIV and AIDS requires a coordinated national response. In order to do this and to attain the highest level of social mobilization and purpose, the government shall declare HIV and AIDS as a national Disaster.’ HIV and AIDS has contributed to the health crisis in the land. The impact of HIV and AIDS on health service and peoples’ well being has been acknowledged even by the leadership of the country. In one of his speeches the past president of Zambia, Levy Patrick Mwanawasa, said that “HIV and AIDS and poverty in Zambia are threatening the economic growth the country has achieved since gaining its independence in 1964. We must be aware that the AIDS pandemic is capable of reversing all the gains we have made since independence<sup>51</sup> This speech was made in a context of a nation whose population according to the official statistics, shows that one in five of the country's 11.5 million residents is HIV-positive.<sup>52</sup>

The problem of HIV and AIDS has continued to devastate the lives of many people, families and the nation at large. This has invariably affected health provision and health seeking in the nation. The statistics indicate that more than one million people are now living with HIV and about 350

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<sup>49</sup> Martin Khor, Structural Adjustment Explained , Structural Adjustment a major - cause of poverty- global issues- July 2005.

<sup>50</sup> Zambia - National HIV/AIDS/STI/TB policy Document, p 21..

<sup>51</sup> <http://today.reuters.com/news/articlenews.aspx? 2006-10-23>. In a speech on the eve of Zambia's 42nd anniversary of independence on 23<sup>rd</sup> October 2006.

<sup>52</sup> Zambia National Aids Alliance, National report on Zambia, accessed 15/12/2007.

<<http://www.aidsalliance.org/sw7211.asp>>

000 people die per year from HIV related illness. The impact is severe among adults in the prime working ages and among children under the age of five<sup>53</sup>. The disaster has negatively affected the health services in the land. For instance it is estimated that over 25 % of pregnant women are HIV positive and about 40% of the babies born to these HIV+ mothers are infected.<sup>54</sup> These statistics clearly show the impact of HIV and AIDS on Zambians and the crisis it has caused on the health services.

The country statistic on the HIV prevalence shows that next to Lusaka province with a prevalence at 26.5 %, the Copperbelt province is next a prevalence of 23.4%.<sup>55</sup> One of the reasons attributed to this is the economic collapse and the consequent results of the sale of mines and mine hospitals. This affected the health services previously provided by the mines to their workers.

It is worth mentioning that the HIV and AIDS crisis has created a number of socio- economic problems. The National AIDS impact interventions assessment mentions several main areas of concern which are as a result of the AIDS crisis<sup>56</sup>. These include the increase in orphaned children and children born to HIV infected mothers with the chance of these children also being infected. These children are more likely to die thus raising the child mortality rate.

Furthermore, the treatment of opportunistic infections like TB resulting from AIDS has placed a lot of strain on the delivery of quality health services. The expenditure on AIDS keeps on increasing annually and the statistics show that while in 1990 the bed occupancy of patients in hospitals was 94% non- AIDS beds to 6% AIDS beds, in 2005 the ratio had changed quite dramatically to 57% non-AIDS beds to 47% AIDS bed. A further area where the pandemic has had an impact is on the economic and sectoral sphere. Deaths related to AIDS often affect companies by increasing health care costs, burial fees and recruitment and training for replacement employees. Throughout all of this, one must remember the negative impact of the gender factor in that women are more vulnerable to HIV infection than men.<sup>57</sup> It is clear from the

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<sup>53</sup> National HIV/AIDS intervention strategic Plan- 2006 to 2010

<sup>54</sup> Zambia National Aids Alliance, National report on Zambia, <<http://www.aidsalliance.org/sw7211.asp>>

<sup>55</sup> HIV and AIDS in Zambia, Central Board of Health, *Back ground projections impacts interventions* (Lusaka: Ministry of Health, 2002)14.

<sup>56</sup> HIV and AIDS in Zambia, Central Board of Health, *Back ground projections impacts interventions* (Lusaka: Ministry of Health, 2002).

<sup>57</sup> HIV and AIDS in Zambia, Central Board of Health, *Back ground projections impacts interventions* (Lusaka: Ministry of Health, 2002)p.29-43

impact AIDS has on the community that it poses a number of challenges to the health services and the livelihood of people.

We have now provided an overview of health provision in Zambia, drawing attention to the way in which it is currently under tremendous strain owing to the impact of Structural Adjustment Program policies, including privatization, and then the health sector reform with the introduction of user fees, and finally the HIV and AIDS pandemic. In this context, this raises the question of what religion and religious entities can offer to health care. Before we examine this in more detail in chapter three, we need to provide an overview of religion in Zambia.

## 2.8 Religion in Zambia

In Zambia, religion is an integral component found everywhere in the life of communities at large.<sup>58</sup> Christianity is the dominant religion in Zambia as over 85% of the population identifies themselves with the Christian faith. 12% of the population adhere to Traditional ethnic religions, 1.5% are Muslims, and the final 2.5% include Baha'i, Hindu and no-religion.<sup>59</sup> Patrick Johnson makes a breakdown of churches in Zambia by percentage as follows: Pentecostals 36%, Roman Catholic 34%, Independent churches ( this includes no Pentecostal Evangelicals or Protestants) 17%, Anglicans 3%, marginal African Traditional 6%, unaffiliated 4%<sup>60</sup>. Although the percentage of African Tradition Religion (ATR) may be low, it is worth mentioning that a number of people use some of the traditional religious practices, especially in the use of traditional healers who divine by contacting the spirits in their treatment.

It is important to note that prior to the change of government in 1991, the church was very instrumental through the work of advocacy and contributed to political change in the country. When Dr. Fredrick Chiluba came into office, he declared Zambia to be a Christian nation and in December 1991 the declaration was enshrined in the national constitution. The declaration of Zambia as a Christian nation meant that the Christian faith became the major national religion. In addition to this, a ministerial portfolio at state house called the Religious Desk was established.

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<sup>58</sup> Steve De Gruchy et al. "Appreciating Assets: The contribution of Religion to Universal Access in Africa – Executive Summary," in, *The Journal of Theology for Southern Africa* 2, no. 126 (2006), p.122

<sup>59</sup> Evangelical fellowship of Zambia, *Church survey 2003: Challenging the church on Unreached people and localities Ndola and Kitwe cities*, EFZ, Lusaka 2005.

<sup>60</sup> Patrick Johnson, Operation World-Zambia, [www.operationworld.org](http://www.operationworld.org)



The government also started to fund some of the religious organizations' projects such as the construction of church buildings.<sup>61</sup>

Lawrence Temfwe makes the observation that during the period of political change, there was also a revival of religious activities in the country. There was an emergence of new churches being planted, and the majority were independent charismatic churches. This new trend saw a number of new Faith Based Organizations (FBOs) being registered with the Society of Registrar. Several of these organizations were involved in humanitarian activities responding to poverty and HIV and AIDS. This enhanced the churches participation and activities in community and public life of the nation.<sup>62</sup> Blas and Limbambala make an important observation that the health reforms took place during the period of political, economic and religious changes.<sup>63</sup> This explains why a number of FBOs religious activities mushroomed at an unprecedented rate in Zambia.

## **2.9 An overview of religious health services and Networks in Zambia**

Faith based health services are scattered all over the country. Godfrey Biemba states that churches or missions provide 30% of the overall healthcare and approximately 60% of rural health services.<sup>64</sup> A report from the ARHAP research team funded by the Gates Foundation reports that, religious healthcare services provide 40% and 28% of first level and second-level hospital beds respectively.<sup>65</sup>

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<sup>61</sup> Temfwe, Lawrence *An analysis of the role of evangelical fellowship on Zambia in the declaration of Zambia as a Christian nation*. Wheaton, MA thesis Dissertation 1999.

<sup>62</sup> Temfwe, Lawrence *An analysis of the role of evangelical fellowship on Zambia in the declaration of Zambia as a Christian nation*. Wheaton, MA thesis Dissertation 1999.

<sup>63</sup> Erik Blas and Me Limbambala, "User-payment, decentralization and health service utilization in Zambia," *Health policy and planning* (Oxford: Oxford University Press, 2001),

<sup>64</sup> Godfrey Biemba, Value-added and invisibility of religious Health assets; ARHARP collection of concept papers, 2007 International Colloquium, Cape Town. p.21

<sup>65</sup> ARHAP report 2008, '*The contribution of religious entities to health in sub-Saharan Africa*'

<<http://www.arhap.uct.ac.za/publications.php>> p108.

**Figure 6. Health institution in Zambia<sup>66</sup>**

System Level	Partner	No	Beds	Cots	Total	Percentage
1 <sup>st</sup> Level Hospitals	Government	30	2383	344	2727	36%
	Mission	28	2755	316	3071	40%
	Private	12	1323	491	1814	24%
	<b>Total</b>	<b>70</b>	<b>6461</b>	<b>1151</b>	<b>7612</b>	<b>100%</b>
2 <sup>nd</sup> Level Hospitals	Government	12	3334	741	4075	67%
	Mission	5	1590	163	1753	28%
	Private	1	209	84	293	5%
	<b>Total</b>	<b>18</b>	<b>5133</b>	<b>988</b>	<b>6121</b>	<b>100%</b>
Rural Health Centers RHC	Government	980	8467	569	9036	82%
	Mission	68	1695	141	1836	17%
	Private	24	96	4	100	1%
	<b>Total</b>	<b>1072</b>	<b>10258</b>	<b>714</b>	<b>10972</b>	<b>97%</b>

It is clear from the table above that mission Hospitals have a significant contribution to healthcare in Zambia.

Several religious health activities and networks operate in Zambia. A typical example is CHAZ, which was established in 1970, with the main objective to serve as an umbrella organization to manage and represent activities done by religious and ‘church’ health institutions at a national level. CHAZ has a membership of 129 affiliates of health institutions and community-based church organizations. These represent 16 different churches and church organizations, with a total of 32 hospitals, 60 health centres and clinics, as well as 33 community-based organizations.<sup>67</sup> CHAZ plays a major role as a network of networks; it provides overall coordination, networking for member organizations, access to funding and resources and is a link to the policy makers and donors at a national level. CHAZ plays a major role in the coordinating and networking in pursuit of its mission statement which is “to provide technical, administrative and logistical services for affiliate members to serve communities with holistic quality health

<sup>66</sup> ARHAP report 2008, ‘*The contribution of religious entities to health in sub-Saharan Africa*’  
<<http://www.arhap.uct.ac.za/publications.php>> p108

<sup>67</sup> CHAZ web sites-[http://www.zamcart.co.zm/new\\_chaz/](http://www.zamcart.co.zm/new_chaz/)

services that reflect Christian values, so that people live healthy and productive lives.’<sup>68</sup> CHAZ is a recognized and respected entity at a national level and has a good working relationship with the government. CHAZ sits on various national policy and implementation committees such as the National AIDS Council, the Central Board of Health, the General Nursing Council, the Medical Council of Zambia and the Pharmacy and Poisons Board. CHAZ has the responsibility to represent the interest of member institutions to the government through the Ministry of Health and international donors.<sup>69</sup>

Another network that represents the churches activities in healthcare is the Zambia Interfaith Networking Group on HIV and AIDS (ZINGO). It was formed in 1997 as a national faith based non-governmental organization with the sole purpose of coordinating and articulating and FBO response to HIV and AIDS. It is a network of local congregations affiliated to religious ‘mother bodies’ in Zambia.<sup>70</sup> The following is a list of existing members of ZINGO:

- Council of Churches in Zambia (CCZ)
- Evangelical Fellowship of Zambia (EFZ)
- Zambia Episcopal Conference (ZEC)
- Independent Churches of Zambia (ICOZ)
- Hindu Association of Zambia (HAZ)
- Islamic Council of Zambia (ICZ)
- National Spiritual Assembly of Baha’is in Zambia<sup>71</sup>

ZINGO brings together all the above major faiths in Zambia in the fight against HIV and AIDS. It exists to ‘coordinate and spread ideas and lessons learned among its members and through a holistic and compassionate approach, contribute to the quality of life and reduction of new infections in the communities.’<sup>72</sup> ZINGO also mobilizes resources, materials and human resources to support initiatives against AIDS for its affiliate members.

Another church activity in health services is an organization called ‘Expanded Church Response’, this is a Religious Entity which is exclusively Christian in nature providing networks

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<sup>68</sup> ARHAP report 2008, ‘*The contribution of religious entities to health in sub-Saharan Africa*’  
<<http://www.arhap.uct.ac.za/publications.php>>

<sup>69</sup> CHAZ web sites-[http://www.zamcart.co.zm/new\\_chaz/](http://www.zamcart.co.zm/new_chaz/)

<sup>70</sup> Note that ‘Mother Bodies’ is the formal title used in Zambia for these organisations.

<sup>71</sup> ZINGO broucher, partnerships in HIV and AIDS p.2

<sup>72</sup> ZINGO broucher, partnerships in HIV and AIDS p.2

for HIV and AIDS interventions. The other related organization involved in health is the Traditional Healers and Practitioners in Zambia, THPAZ. Even though THPAZ is not directly a religious entity, in practice some of its affiliate members, such as traditional healers, consult spirits [that is divination] in their healing procedures. THPAZ provides a network for traditional healers; it serves as a link between government and traditional healers. THPAZ is also presented on National bodies such as the National AIDS Council.

The above shows the various ways in which religious activities are engaged in the provision of healthcare and healing in Zambia.

## **2.10 ARHAP research and its relationship to this thesis**

As already stated above, this study is part of the bigger research under the umbrella of ARHAP. The research finding and analysis presented in chapter four and five of this thesis is part of the ongoing work in establishing the role of religious entities in health provision. This research will engage with the ARHAP theory and endeavor to show from the case studies how religious health assets contribute to health and well being of people on the Copperbelt of Zambia.

## **2.11 Conclusion**

This chapter has provided an overview of the health system on the Copperbelt and the decline in its service. It has also shown the challenges the Economic Structural Adjustment Program contributed to collapse of health services in both the public hospitals and the ZCCM during the privatization period. This chapter has clearly shown the indirect and direct relationship that exists between the socio-economic factors and health provision and their impact on peoples' well being. We noted how the health reform impacted on the poor and their health. In addition, we have seen how poverty and HIV and AIDS have also contributed to poor health outcomes on people's lives.

Then in the second part of the chapter we have seen the activities and services from the religious sector showing their contribution to health. The next chapter will locate the research study in its context of ARHAP and present the conceptual framework and how it relates to the wider research on religious assets program in Africa. In addition, the chapter will present the religious health activities and institutions dealing in health programs on the Copperbelt.

## **CHAPTER THREE**

### **AFRICAN RELIGIOUS HEALTH ASSETS PROGRAM (ARHAP) AND RELIGIOUS HEALTH INSTITUTIONS IN ZAMBIA**

#### **3.1 Introduction**

This chapter will provide an overview of the ARHAP vision, objectives and its historical background. It will also give the definitions of terms as used by the ARHAP project such as health, religion, assets and agency. An explanation of the ARHAP conceptual framework of the theory matrix illustrating Religious Health Assets (RHA) is highlighted. The theory matrix seeks to identify religious health assets as both tangible and intangible and identify their relationship to health outcomes. The ARHAP matrix will be engaged later in Chapter 5 to analyze the findings of this research and specifically to engage its concept of tangible and intangible assets that contribute to health. This chapter also shows an account of activities which ARHAP has undertaken in Africa and in Zambia.

#### **3.2 Descriptive overview of ARHAP**

The African Religious Health Assets Program (ARHAP) is a research program involving scholars at the Universities of Cape Town, Witwatersrand and KwaZulu-Natal in South Africa working in partnership with scholars and practitioners from other universities and institutions in the USA and Europe and African researchers and religious organizations in a number of different countries.<sup>73</sup> The research program is aimed at engaging religious health institutions and health policy makers around the understanding of how religion functions as an asset for the well being of communities.

##### **3.2.1 The vision of ARHAP**

The vision or goal of ARHAP is articulated in the following statement:

The purpose of this program is to develop a systematic knowledge base of religious health assets in sub-Saharan Africa so as to align and enhance the work of religious health leaders and public

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<sup>73</sup> The details on the history and current work of African Religious Health Assets program can be accessed on the ARHAP web page. <<http://www.arhap.uct.ac.za/homepage>>

policy decision-makers in their collaborative effort to meet the challenge of disease such as HIV/AIDS, and to participate in the creation of health, especially for those in poverty<sup>74</sup>

Alongside the more obvious and tangible contribution of religious groups to health, ARHAP endeavors to bring to light the hidden or intangible aspect of religion and its contribution to individuals' health and the well being of communities. The program through its research and engagement aims at making visible in tangible ways how religious assets help to align resources and build health communities. James Cochrane, commenting on religious health assets, says:

There has been a greater focus on the negative impact of religious messages and traditions (especially in the context of HIV/AIDS), than in the potential solutions and strengths religious organizations and traditions could provide. Consequently, very little is known, in Africa for example, about what FBOs do, about how they do it, about how they are aligned with public health systems (if at all), about how they might be leveraged to scale up their work and push down, to grassroots level, public health interventions at the major crisis points. What is known is fragmented and often ambiguous<sup>75</sup>.

Its clear from the above statement that the general perception of religion and its relationship to health has not been fully investigated and few health practitioners appreciate the positive contribution religious assets make to the mitigation of disease. ARHAP as a research program has identified this gap and has set out to investigate the potential that lies in religious health assets and how they can be aligned with public health delivery.

### **3.2.2 Goals and objectives of ARHAP**

The goal of ARHAP then is to render help in aligning and enhancing the work of religious leaders, public policy makers, and other health professionals and institutions to meet the challenge of disease and to foster health in its holistic understanding as defined by World Health Organization, WHO. ARHAP has formulated objectives to meet its vision as follows:<sup>76</sup>

- To understand and objectively assess the impact and growth of religious health assets in fostering health in all its dimensions as defined by the World Health Organization.

<sup>74</sup> ARHAP Background and Conceptual Frame work 2005.

<sup>75</sup> ARHAP Article Cochrane Religion, Public Health and a Church for the 21<sup>st</sup> Century. 2006 p5.

<sup>76</sup> African Religious Health Assets programme. <<http://www.arhap.uct.ac.za/homepage>>

- To fuel research that will promote a greater and more complete understanding the role of religion and religious institutions in health promotion.
- To strengthen leadership and organizational capacity to advance health and ameliorate suffering.
- To provide evidence that can influence health policy and health resource allocation decisions made by governments, religious leadership, inter governmental agencies and development agencies.<sup>77</sup>

These goals and objectives drive and guide the program of ARHAP in its endeavor to develop a systematic knowledge base of religious health assets. These are meant to enhance the work of religious health leaders and public policy decision-makers in their collaborative effort to meet the challenge of disease and to participate in the creation of healthy communities.<sup>78</sup>

### **3.3 Definition and understanding of terms used in this study**

This study engages the definitions used by ARHAP. These encompass a specific understanding of the terms in the ARHAP research project such as African, religion, health, agency and assets. These terms are defined in a manner that helps to facilitate a wider framework and appreciation of the concepts ordinarily understood in a narrow traditional way. The terms described below elaborates the concepts and understanding of certain terms in the language of ARHAP.<sup>79</sup>

#### **3.3.1 Religion.**

It is worth noting that the use of the term religion in this study embraces the general understanding of the word which is wide and inclusive in nature. According to Webster's dictionary religion is defined as 'a set of beliefs concerning the cause, nature and purpose of the universe usually involving agreed upon beliefs and practices containing a moral code governing the conduct of human affairs soliciting for devotional and ritual observances'.<sup>80</sup>

Religion therefore includes any system of sacred beliefs and practices, upheld by various religious groups such as Christianity, African Traditional religions, Hinduism, Islam and other

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<sup>77</sup> ARHAP Background and Conceptual Frame work 2005

<sup>78</sup> James R. Cochrane et al. et al. ARHAP tools workshop report

<sup>79</sup> The definitions are drawn from the basic ARHAP understanding of the terms it engages in its approach to religion and health. This is summarized in the ARHAP-International Case Study Colloquium which was held in Pretoria 13-16<sup>th</sup> July 2005.

<sup>80</sup> Webster's Revised Unabridged Dictionary. <http://dictionary.reference.com/browse/religion>

religious groups. The understanding of religious health assets is therefore determined by this broader and inclusive definition of religion which impacts on various aspects of human social and spiritual life. Religion is understood in terms of relationship to and or with something or a being that is outside the person, which is perceived to be higher and powerful. Christopher Grundmann states that ‘religion is the lived relationship toward an ultimate. This ultimate might be perceived of in personal terms (God, a deity, or a number of them, ancestors).’<sup>81</sup> Religion is therefore, presented as something more than a set of beliefs but a lived relationship. Although religion has a broader and inclusive understanding, this study however, focuses on Christianity as a religion with its religious assets. Going by this definition, any facilities, organizations, beliefs, practices and networks that have a religious orientation are termed as religion in ARHAP.

### **3.3.2. Health**

The World Health Organization (WHO) defines health as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.’ The WHO definition of health clearly demonstrates that health is more than just the physical well being of an individual. This understanding of health is what the ARHAP research endeavors to show that in Africa, the meaning of health is broader than mere physical well being but refers to a comprehensive well being of an individual and everything that sustains such health<sup>82</sup>. Therefore, a broader perspective on health is embraced including the personal, communal, social, economic, environmental and spiritual dimensions of health. This understanding of health incorporates everything that contributes to the well being of people such as hospitals, medical facilities and all medical therapies. This broad understanding of health, which is more than the absence of illness but including the well being of an individual and everything that contributes to the same is what ARHAP defines as health in its research study.

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<sup>81</sup> Christoffer H. Grundmann, *Health Assets of Religious practices and Convictions: the impact of the immaterial*, ARHAP international Colloquium 2007, collection of concept papers, p.31.

<sup>82</sup> Paul Germond and Sepetla Molapo, “In search of Bophelo in the time of AIDS...” *The Journal of Theology for Southern Africa*, 26, (2006), p.27– 47.



### 3.3.3. Assets

The term ‘assets’ refers to what communities and people already have, which are present in a given community or organization. This kind of approach to enhance human life engages the community’s and institution’s *assets* and not their needs or deficits.<sup>83</sup> The concept of *assets* would include things such as the capabilities, skills, resources, links, associations, and institutions that can be built on to enhance better health. In ARHAP research project, the positive contribution which religion brings to health is what is referred to as an *asset*. This specifically relates to what religion ‘has’ which can make a positive impact upon people’s lives and well-being’.<sup>84</sup> ARHAP places strong emphasis on this ‘assets’ based approach. Cochrane crystallizes this when he says: ‘by “assets”, we mean something quite distinctive. The language of assets, in the context of contemporary development theories about sustainable livelihoods and people-centred development practices, points to what people have available to them, no matter how disadvantaged they may be materially, politically and in other ways,’<sup>85</sup> It is these assets that are mapped, pulled together and aligned for the promotion of the health and well-being of people.

The *asset-language* provides a frame work upon which ARHAP builds its focus on Religious Health Assets (RHA) which is different to the traditional approach that focuses on deficits or needs. It is these religious assets according to Steve de Gruchy, that can be mobilized to help mitigate disease in a proactive preventative measures.<sup>86</sup>

### 3.3.4 Agency

Agency is the capacity to “do”, to move into action, to utilize the assets one has, to seek and achieve desired goals, within the context of social and environmental conditions.<sup>87</sup> This goes hand in hand with an asset based approach to development or health mitigation because it focuses on the capacity to utilize what is already present by local agency to create positive change. ARHAP in its approach to health and well being puts the emphasis on the people’s capacities to do things, as agents of change with the ability to bring about the desired outcomes in matters of health.

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<sup>83</sup> John Kretzmann and John McKnight, *Building communities from the Inside Out: A Path Toward finding and Mobilizing a community’s Assets*, Chicago. ACTA Publication 1993

<sup>84</sup> ARHAP –participant information sheet, PIRHANA workshop Ndola, 2005 p13.

<sup>85</sup> James Cochrane ARHAP Article *Religion, Public Health and a Church for the 21<sup>st</sup> Century*. 2006 p7

<sup>86</sup> Steve de Gruchy, ARHAP article, Why agency? Why assets? Why appreciation? 2003.

<sup>87</sup> Steve de Gruchy, ARHAP article, Why agency? Why assets? Why appreciation? 2003.

### 3.3.5 Religious Entities

The term ‘religious entities’ (RE) addresses a broad range of tangible Religious Health assets, such as clinics, dispensaries hospices, hospital beds and care groups like the Home Based Care support groups. Religious entities include religious facilities, organizations, and medical practitioners, from both bio-medical and traditional. According to ARHAP glossary<sup>88</sup> the all encompassing understanding of religious entities provides a platform to address both the conventional religious entities such as faith-based organizations, as well as those that are less recognized entities such as traditional healers. ARHAP feels that FBO’s is not broad enough to include national church organizations, worshiping congregations, small projects, key individuals, etc. So the use of the term RE to refer to this wide range of assets found among RE helps to address any activity that goes under the name ‘religion’.

### 3.4 ARHAP research project activities in general- the bigger picture

ARHAP has undertaken a number of research activities from the time it was established. After five years of work in the research of African religious assets, ARHAP has conducted case studies and research work in Lesotho, Zambia, Mali, Uganda, Kenya, Malawi, Congo DR and South Africa.<sup>89</sup> In 2005/6 ARHAP undertook research for the World Health Organization (WHO), in Zambia and Lesotho.<sup>90</sup> The research sought to assess and map Religious Health Assets (RHAs) and how they can influence national policy makers, in the context of a society struggling with poverty and HIV and AIDS challenges.<sup>91</sup> The following are a summary of the key findings from this research.<sup>92</sup>

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<sup>88</sup> ARHAP international colloquium *Collection of concept papers*. March 13-16, 2007, Cape Town p123

<sup>89</sup> ARHAP current activities report, news letter May 2008. <<http://www.arhap.uct.ac.za/publications.php>>

<sup>90</sup> ARHAP full report of the study can be accessed on this research study -See the ARHAP website for more details <<http://www.arhap.uct.ac.za/publications.php>>

<sup>91</sup> Steve De Gruchy et al. “Appreciating Assets: The contribution of Religion to Universal Access in Africa – Executive Summary,” in, *The Journal of Theology for Southern Africa* 2, no. 126 (2006), p.120.

<sup>92</sup> Steve De Gruchy et al. “Appreciating Assets: The contribution of Religion to Universal Access in Africa – Executive Summary,” in, *The Journal of Theology for Southern Africa* 2, no. 126 (2006), p.122-123

1. Religion is ubiquitous in Zambia and Lesotho, yet often hidden from western view. Given this, an engagement with religiously informed *healthworlds*<sup>93</sup> is vital for the shaping of public health policy in Southern Africa.
2. Religion, health and well being 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 exploration.
4. Religious entities are perceived as contributing to health, well being and the struggle against HIV and AIDS through tangible and intangible means. It is this combination that distinguishes and gives them strength. Some of the 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.

Another major research conducted by ARHAP was the recent study on Faith Based Health services in Sub Saharan Africa (SSA). In 2007 the Gates Foundation commissioned ARHAP to conduct research in SSA on health services provided by religious communities. The focus was on describing the services provided, their ‘comparative advantage,’ the way they network and collaborate with each other and public health agencies. Three cases studies were undertaken in Zambia, Uganda and Mali. The detailed report on the findings and specific recommendations on the research study are posted on the ARHAP web page.<sup>94</sup> It is worth mentioning that this research also gave opportunity for ARHAP to study RHAs in a predominantly Muslim country

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<sup>93</sup> Paul Germond, *Bophelo: Towards a working definition- finding alternatives to the words “religion” and “health”* *Healthworld-* is a term used in ARHAP that encompasses all elements that create and sustain a health world. 2005.p2

<sup>94</sup> ARHAP, <<http://www.arhap.uct.ac.za/publications.php>>

(Mali). The aim of the study was to explore the role of Religious Entities in contributing to health in SSA with a view of identifying areas for future investment. The following is a summary of the findings.

1. Religious entities (REs) make a significant and unique contribution to health services
2. Faith-based health services in SSA show great variety in type and extent
3. National Faith Based Health Networks (NFBHNs) play a crucial role in enabling facility-based services, yet their rightful place within national health systems is not always acknowledged.
4. There have been significant shifts in ownership/funding/responsibility regarding faith-based health facilities over recent years from the historic mission model to local and agency funding, leaving huge discrepancies.
5. Faith-based health services work under severe constraints, especially regarding their workforce
6. REs provide a wide range of non-facility-based services in response to immediate local needs, playing a very important role under serious constraints.
7. Mixing of multiple healing modalities (African traditional, bio-medical, faith healing, alternative therapies) is a common reality across SSA with mostly very little mutual acknowledgement and collaboration.
8. While the important potential of religious leaders for health promotion has been channeled into some creative initiatives, it is generally underutilized.

ARHAP has also conducted research in South Africa in the Eastern Cape, at the Masangane HIV and AIDS program in 2005.<sup>95</sup> The title of the report is “*Let us embrace*” *The role and significance of an Integrated Faith-Based Initiative for HIV and AIDS.*’ The Vesper Society in USA commissioned the study. Masangane is a faith based organization involved in the service of Anti Retroviral Treatment (ART) in a rural community. The focus of the study was to evaluate and assess the impact of this faith based organization and to assess the “value added” in its services due to it being faith based.<sup>96</sup> The results of the research are best summarized in the quote from the report which notes that the Masangane services “represents something that has become increasingly part of public health thinking, namely, the need for a far more *holistic response to illness and disease*. In the case of Masangane this includes its comprehensive range

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<sup>95</sup> Masangane-means – ‘let us embrace’ it is this name which characterizes the atmosphere at Masangane- where the normal routine of taking the ARVs drug is accompanied with daily Bible reading of giving hope and encouragement derived from support groups- this approach has helped address issues of stigma. ARHAP report *The Journal of Theology for Southern Africa* 2, no. 126 (2006) p117

<sup>96</sup> ARHAP report, Documentation *The Journal of Theology for Southern Africa* 2, no. 126 (2006), p.116

of response to prevention, care, and support beyond its bio-medical activity.”<sup>97</sup> The example of Masangane, ART services in the context of the continuum of care shows what kind of value faith based activities add to health and well being.

In addition to the field work, ARHAP has conducted a number of colloquiums and seminars where academic and research papers have been presented on religion, health and religious health assets.<sup>98</sup>

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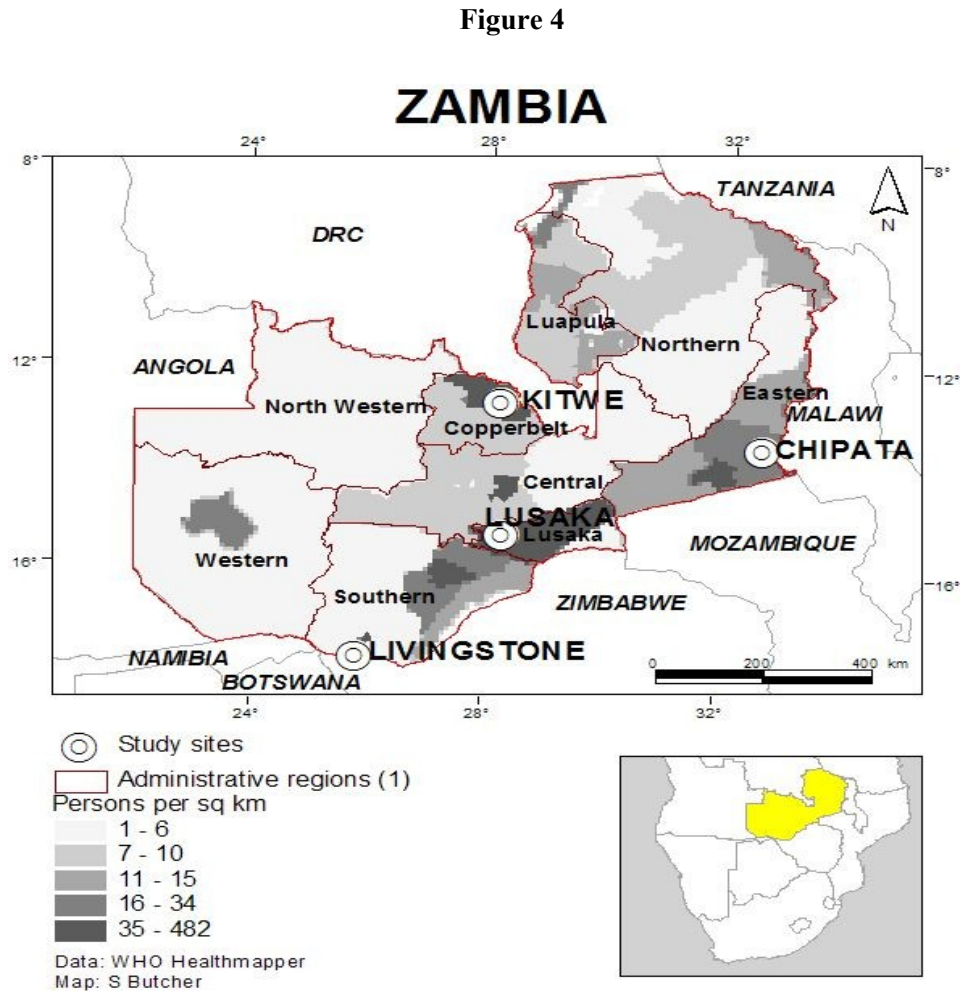
<sup>97</sup>ARHAP report, Documentation *The Journal of Theology for Southern Africa* 2, no. 126 (2006), p.118

<sup>98</sup> ARHAP report papers and proceedings- Assets and Agency, Colloquium 2003. International Colloquium, 2007, collection of concept papers. <<http://www.arhap.uct.ac.za/publications.php>>

### 3.5 ARHAP activities in Zambia

ARHAP as a research program has engaged in a number of activities and research in Zambia. A couple of seminars and participatory studies were conducted within the Copperbelt and in other towns namely Lusaka, Chipata and Livingstone (see the figure 4 showing sites of workshops). Below is a map showing where the ARHAP research studies have taken place in Zambia.

**The map showing sites where the ARHAP workshops took place in Zambia.<sup>99</sup>**



<sup>99</sup> ARHAP-WHO report 2006 <<http://www.arhap.uct.ac.za/publications.php>>

The chart shows the towns where ARHAP workshops have taken place in Zambia<sup>100</sup>.

Figure 5

Country	Province	Community Site	Area/ Regional Site	National Site	Dates	# Participants
Zambia	Copperbelt	Mushili and Kitwe	Ndola /Kitwe		31Oct-2Nov	27/17/29 = <b>73</b>
	Southern	Maramba	Livingstone		10-11 Jan	24/21 = <b>45</b>
	Eastern	Chipata	Chipata		04-05 Apr	21/26 = <b>47</b>
	Lusaka	Bauleni	Lusaka	Lusaka	07-08 Apr	20/10 = <b>30</b>
						<b>Total 195</b>

From the research, ARHAP sought to develop a database and information on the work of religious health institutions, leaders, public policy decision-makers and health providers. The goal was to investigate and establish religious health assets and see how they can be aligned to improve health policy and service delivery in a holistic manner. The preliminary ARHAP studies demonstrated that meaningful mapping and engagement of religious health assets must take into account the capacities and agency of religious health structures and people, their social/political context, and the wide range of medical, non-medical, and faith services provided.<sup>101</sup>

Another study entitled ‘the contribution of religious entities to health in sub-Saharan African was undertaken. Zambia was taken as a case study. The Gates Foundation sponsored this research study.<sup>102</sup> Another level of ARHAP’s activities in Zambia is the research by masters’ students from the University of KwaZulu-Natal, in the school of Religion and Theology. Four students have engaged religious leaders, religious health practitioners, FBOs and public health policy makers as a part of the Zambia ARHAP research project.

<sup>100</sup> ARHAP-WHO report 2006

<sup>101</sup> Steve De Gruchy et al. “Appreciating Assets: The contribution of Religion to Universal Access in Africa – Executive Summary,” in, *The Journal of Theology for Southern Africa* 2, no. 126 (2006)

<sup>102</sup> ARHAP, <<http://www.arhap.uct.ac.za/publications.php>>

### 3.5.1 Findings from the ARHAP research in Zambia

For the WHO research project, ‘Appreciating Assets: mapping, understanding, translating and engaging religious health assets in Zambia,’<sup>103</sup> ARHAP conducted 4 workshops called Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA) in different towns. Below is a summary of the key findings which explored the question: *What is the contribution of religion and religious entities to health and well being in a time of HIV and AIDS?*

Concerning *religion within the Zambian social, economic, political and cultural context* it was found that religion plays a major role among ordinary Zambians in their struggle for health and well being in the context of poverty, weak public health capacity and the HIV and AIDS pandemic. It was further established that religion and religious entities (REs) are perceived to play an important role in the struggle for health and wellbeing in Zambia, with REs are ranked higher than other health facilities.

On the findings about the *nature of the religious contribution to health and wellbeing in Zambia*, the research showed that religion is perceived to contribute in six key ways - tangible and intangible - to health and wellbeing. The intangible factors are spiritual encouragement, knowledge giving and moral formation. The tangible factors are compassionate care, material support and curative interventions. The research also revealed that there is little recognition and appreciation of the role of religion in advocacy and policy formulation around health and well being.

On the findings about the *nature of the contribution of religious entities to health and well being* The results showed that Religious entities operate within a network of relationships. REs are integrated with secular entities and public health facilities. Religious entities which may be situated outside the local context often play the role of being a significant “intermediary” group. The research also found out that the Christian REs are integrated in these networks more than REs of other faiths.

The second major ARHAP research in Zambia was for the Gates Foundation- on the ‘*Contribution of religious entities to health in the sub-Saharan Africa*’ The main objective of the

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<sup>103</sup> ARHAP full report of the study can be accessed on this research study -See the ARHAP website for more details on the findings <<http://www.arhap.uct.ac.za/publications.php>> p67



research study was ‘to provide a description of the contribution of faith based organizations (FBOs), institutions, and networks to the health of vulnerable populations in poor areas of sub-Saharan Africa (SSA). And to identify key areas for investment that would accelerate, scale up and sustain access to effective services, and/or encourage policy and resource advocacy among and in African countries’<sup>104</sup>. The research was divided under two main parts namely:

- 1) To give an overview for SSA of the coverage, role, and core health related activities of religious entities, including major networks, vis a vis public and other private sector health services delivery, and their relationship to government and to each other.
- 2) To give more detailed case study on Zambia:
  - a) describing the capacity of faith based organizations to deliver health services and impact on health behavior; the financial and/or material support they receive and how they are perceived by stakeholders;
  - b) characterizing key faith based networks and describing how they work;
  - c) describing how faith based organizations collaborate with each other and with governments.<sup>105</sup>

A summary of the findings in light of the above objectives showed that there is a presence of Faith Based Networks (FBNs) in Zambia. These provide coordination and networking among the members in the area of service delivery and funding. Some of the existing FBNs are organizations such as CHAZ, Zambia Interfaith Networking Group on HIV and AIDS (ZINGO), Expanded Churches Response dealing specifically in HIV networks among Christian communities, THPAZ a network for traditional healers in Zambia and Zambia National AIDS Network (ZNAN). It was clear that these networks provide a bridge between health networks as well as links to government and donors<sup>106</sup>

It was further established that there is a healthy relationship and corroboration of religious entities with the government and among themselves. There are formal memoranda of understanding and agreements in place between REs and government. CHAZ acts as the main

<sup>104</sup> ARHAP report 2008, ‘*The contribution of religious entities to health in sub-Saharan Africa*’ <<http://www.arhap.uct.ac.za/publications.php>> p9

<sup>105</sup> ARHAP report 2008, ‘*The contribution of religious entities to health in sub-Saharan Africa*’ <<http://www.arhap.uct.ac.za/publications.php>> p.9

<sup>106</sup> ARHAP report 2008, ‘*The contribution of religious entities to health in sub-Saharan Africa*’ <<http://www.arhap.uct.ac.za/publications.php>> 110

link between the Government and REs at the national and district levels.<sup>107</sup> It was also noted that government appreciates the contribution and efforts of the REs to health and well being of communities. The following quote on the perception of FBOs contribution to health captures the spirit of appreciation of REs services

‘World Vision had a very positive view of the role of FBOs providing health services. One of the differences identified between government and FBO health facilities was the quality of care and especially the trust in individual health workers that patients had developed, as well as the long-standing name of a facility as being a place of good care over the years.’<sup>108</sup>

The appreciation by the government of the involvement of REs in health provision is publicly illustrated in the National HIV and AIDS policy.<sup>109</sup> The involvement and appreciation of religious health institutions in health services in the country become more prominent during the decline of government health services (as noted above) This situation created a platform for the religious health institutions’ contribution to health to become more prominent and appreciated by Government even in policy matters. The research also found some common constraints and challenges among the FBOs in the area of inadequate funding, shortages of skilled and qualified staff, especially in rural areas.

### **3.6 Conceptual framework of ARHAP on religious health assets and health**

As we have seen, ARHAP research has covered a range of issues to do with Religious Health Assets in Africa. One of the key issues that has emerged has to do with the nature of these assets. Very early on, it was hypothesized that these assets could be both tangible and intangible, and that they could impact in both direct and indirect manner upon health outcomes. We need to examine this in more detail, as this relates directly to the research presented in the following chapters, and creates the theoretical framework in which to examine the research findings. The

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<sup>107</sup> ARHAP report 2008, ‘*The contribution of religious entities to health in sub-Saharan Africa*’ <<http://www.arhap.uct.ac.za/publications.php>> 111-112

<sup>108</sup> ARHAP report 2008, ‘*The contribution of religious entities to health in sub-Saharan Africa*’ <<http://www.arhap.uct.ac.za/publications.php>> 114

<sup>109</sup> A case in point is the statement in the National HIV/AIDS/STI/TB policy commenting on Traditional and alternative remedies on the impact of the HIV and AIDS policy on prevention and care states that ‘Home based care in Zambia is implemented in two ways: (b) Community initiated programs(horizontal). These are quite often initiated by non-governmental organizations, faith based organizations and other voluntary organizations. Community based volunteers and support from faith based organizations (FBOs), religious and health facilities form the backbone of these programs’ 2006, p11.

ARHAP conceptual framework of Religious Health Assets (RHAs) suggests that there are two basic kinds of religious health assets namely, tangible and intangible assets. These RHAs contribute to direct and indirect health outcomes.

The Theory Matrix is developed in a manner that provides a tool to assess religious assets and how they impact on health outcomes. The matrix illustrates possible avenues showing how religious health assets interplay at various levels such as the intangible and the tangible religious health assets and how they function and impact on health in either direct or indirect outcomes. It is important to understand that this theory matrix has at this stage only been proposed and ARHAP is undertaking field research to clarify and develop the theory. The research in this thesis is part of the process of evaluating the understanding and contribution of religious assets to health outcomes. Therefore, while this research assumes this theoretical framework as its starting point, its findings may also lead to the further development of the same framework.

The matrix as shown below has the following four quadrants comprising:

- 1 Tangible religious assets and their Direct health outcomes
- 2 Intangible religious assets and their Direct health outcomes
- 3 Tangible religious assets and their Indirect health outcomes
- 4 Intangible religious assets and their Indirect health outcomes

## ARHAP THEORY MATRIX<sup>110</sup>

**Figure3.**

<b><i>Intangible religious assets</i></b>	<p>Possible factors include: <b>1</b></p> <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>	<p>Possible factors include: <b>2</b></p> <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><i>Tangible religious assets</i></b>	<p>Possible factors include: <b>3</b></p> <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>	<p>Possible factors include: <b>4</b></p> <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><i>Direct health outcome</i></b>	<b><i>Indirect health outcome</i></b>

### 3.6.1 Tangible and intangible religious health assets and their direct and indirect health outcomes.

The ARHAP matrix presents two 'forms' of religious health assets, namely tangible and intangible and how these assets impact on health outcome directly or indirectly on the well being of people and communities. These assets show how faith based or religious health activities and institutions respond to health challenges.

<sup>110</sup> James Cochrane and Barbara Schmid, *ARHAP Tools Workshop Report*. (Cape Town, June 6-8, 2004) Available from ARHAP offices, UCT.

### 3.6.2 Tangible Religious Assets and their direct and indirect health outcomes.

Looking at the matrix in quadrants 3 and 4 we have tangible religious assets. These are visible structures and activities operated by religious health institutions, individuals and/or Faith Based Organizations (FBOs) which are religious in nature and practice. These would include health institutions, mission hospitals, clinics, care groups, hospices, dispensaries, and health networks. These activities affect the health outcomes in a tangible or visible manner. They enhance health outcomes directly or indirectly. Religious health activities, such as conducting healing sessions, FBOs that run health institutions such as hospitals, clinics, health care groups and hospices are classified as tangible RHAs in the ARHAP theory matrix.

An example of indirect outcome would be activities such as fellowship that takes place in the church among different age and sex groups, Christian education on lifestyle and moral behavior, fellowship and support in times of the joys and difficulties, support received during funerals. In the church set up activities such as the presence of unity and family found around sacraments as the Lords supper and other communal rituals. These religious assets may not directly focused on health and healing, but eventually contribute to the well being of people and communities. Cochrane makes an important observation and comment on the role RHAs when he says;

Existing literature on FBOs concentrates on hospitals, clinics, and other visible facilities accounted for in national public health systems that are either run by or funded by religious bodies. No-one has a sense of their combined scale and contribution to public health, and they often go unrecognized. Even when recognized, they are likely to be misunderstood, sometimes overestimated, and sometimes undervalued in terms of their contribution to health.<sup>111</sup>

Cochrane also notes that in response to the HIV and AIDS pandemic 30% to 70% of organizations involved in the response to the pandemic are FBOs.<sup>112</sup> These tangible religious assets contribute to health in a direct manner visible to the human eye. They often transcend the ordinary public health provision as they engage assets that are religious and comprehensive in nature and practice having direct health outcomes.

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<sup>111</sup> James Cochrane, *Religion, Public Health and a Church for the 21<sup>st</sup> Century*. ARHAP Article, 2006 p9

<sup>112</sup> James Cochrane, *Religion, Public Health and a Church for the 21<sup>st</sup> Century*. ARHAP Article, 2006.

### **3.6.3 Intangible Religious Health Assets and their direct and indirect health outcomes**

In quadrants 1 and 2 of the ARHAP matrix, a second set of religious health assets are identified, as intangible assets these are not visible structures such as mission hospitals, clinic dispensaries and hospices. They are labeled as an intangible or invisible component of religious health assets, which operates at the unseen or invisible level. Conventional health care providers rarely appreciate these intangible assets because they cannot be quantified scientifically in health care provision. These would include activities such as prayer, support groups, faith, hope, motivation, trust, love and all other invisible qualities, which contribute to the well being of individuals and communities.

These intangible religious activities create a positive component to those seeking for health and healing. It is this missing or neglected dimension of human health seeking component found in intangible RHAs, which provides resilience and power to withstand sickness and harsh conditions. Intangible RHAs are activities such as praying and anointing the sick for healing, advocacy or prophetic ministry speaking against vices that dehumanize people and encouraging the sick to keep hoping for the best in times of affliction.

In addition to this, the matrix also present intangible religious assets and their indirect health outcomes. These outcomes impact on the well being of people as indicated in quadrant 2 of theory matrix. In this quadrant the matrix shows important elements such as the core value and meaning of life and the need for people to belong to a community or church family. In these communities, people derive encouragement through shared life experiences. It is argued that all these assets, though not measurable, contribute to better health outcomes in and indirect way.

### **3.7 Research findings from Zambia and Lesotho, which strengthen the ARHAP hypothesis.**

As stated above, ARHAP developed a theory matrix, which is applied to locate and establish religious assets. The findings from Zambia and Lesotho's 'Participatory Inquiry into Religious Health Assets, Networks and Agency' (PIRHANA) workshops confirms some of the assumptions in the theory matrix. The findings strengthen the hypothesis claim on intangible religious health assets and their positive contribution to health outcomes. The findings from

Zambia on WHO research program under the heading, ‘*The Nature of the Religious Contribution to Health and Wellbeing* in Zambia and Lesotho is summarized in finding number five.<sup>113</sup> Finding number five states that; “Religion is perceived to contribute in six key ways - tangible and intangible - to health and well being in Zambia. The intangible factors being spiritual encouragement, knowledge giving, and moral formation, and the tangible factors: compassionate care, material support, and curative interventions”. Similar research findings were found in Lesotho PIRHANA. The full report on findings number five on ‘how religion (*borapeli* ) is perceived to contribute to holistic wellbeing (*bophelo*) in tangible and intangible ways’ can be accessed from the WHO report 2006<sup>114</sup>.

The figure below shows the Zambia PIRHANA findings on the question, ‘what does religion contribute to health’ and illustrates the nature of tangible and intangible religious health assets contribution to health.

#### Zambia PIRHANA findings<sup>115</sup>

Figure 4

Maramba	Chipata	Bauleni	ARHAP Cluster	Total
Hope (13)	Spiritual care (8)	Faith (6)	Spiritual	41
	Hope (4)	Trust (5)	Encouragement	
	Prayer (1)	Hope (3)		
		Encouragement (1)		
Care (6)	Care and support (16)	HBC (6)	Compassionate care	28
Education (16)	Education (5)	Education (2)	Knowledge giving	24
	Training (1)			
Material support (7)	Commodities (4)	Support (6)	Material Support	17
Morals (2)	Behavior change (1)	Self control (7)	Moral Formation	10
Facilities (3)	Reduce illness (2)	Healing (4)	Curative Interventions	9
47	42	40	Total	129

<sup>113</sup> Detailed information on the PIRHANA findings from Lesotho and Zambia can be accessed on ARHAP website, [www.arhap.uct.ac.za](http://www.arhap.uct.ac.za) p76.

<sup>114</sup> ARHAP-WHO report 2006 <<http://www.arhap.uct.ac.za/publications.php>> p 111

<sup>115</sup> ARHAP-WHO report 2006 <<http://www.arhap.uct.ac.za/publications.php>> pp76,77

The results show that top on the list of the findings is the category marked as ‘*intangible assets*’ referring to issues such as, prayer, hope, spiritual care and encouragement followed by care, compassion and home based care and thirdly education and training.

At the regional level the findings show a similar trend see figure 5 below.

Figure 5<sup>116</sup>

Participant Term	Copperbelt	Livingstone	Chipata	Lusaka	Total	ARHAP Cluster Total	Total
Hope	9	12	9		30	Spiritual Encouragement	68
Faith	8	2	9		19		
Spiritual counseling/ support		8	4	3	15		
Prayer			3	1	4		
Care and support/compassion		9	8		17	Compassionate Care	57
Love	14	16	6	4	40		
Behavior change	8		3		11	Moral formation	22
Life/positive living	6		1	1	8		
Patience			2		2		
Temperance			1		1		
Healing/health services	5	6	1	4	16	Curative Interventions	19
Infrastructure			2		2		
Human resources		1			1		
Sensitization/teaching	8	3		2	13	Knowledge giving	13
Material support/OVC Support		1	1	5	7	Material support	7
Advocacy		2			2	Public engagement	2
<b>TOTAL</b>							<b>188</b>

From the regional findings, it is very clear also that the ARHAP cluster of *intangible assets* under ‘Spiritual encouragement’ and *tangible assets* such as care, support and compassion are

<sup>116</sup> ARHAP-WHO report 2006 <<http://www.arhap.uct.ac.za/publications.php>> pp76,77



presented in ‘compassionate care’ category are at the top of the list, indicating the appreciation of these assets in health services.

### 3.7.1 Definition of ARHAP cluster from the PIRHANA findings

ARHAP has worked out definitions for the six clusters of their findings. This thesis will engage and interact with these definitions of ARHAP cluster in chapter five. The following are the six clusters from PIRHANA findings:<sup>117</sup>

**i. *Spiritual encouragement*** this refers to aspects in which religion works to give people an inner strength to proceed with resilience, courage and determination in the midst of ill health, poverty, and misfortune. This includes the terms “hope, spiritual care, prayer, faith, trust, encouragement” and “hope, faith, spiritual counseling, prayer”. This category falls under the *intangible assets* in ARHAP theory matrix.

**ii. *Compassionate care*** clusters refers to the activities such as, “care, care and support, Home Based Care”, and “care and support, compassion, love”. It describes the way in which religion is seen to respond to situations of difficulty with a desire to help and be of assistance. This falls in the category of *tangible assets*.

**iii. *Knowledge giving*** describes the contribution of religion in the areas of “education, “training”, and “sensitization, teaching”. This is an *intangible asset*

**iv. *Material support*** clusters together the terms “material support, commodities, support” and “material support, OVC support”. It refers to activities such as providing food parcels for the sick and clothing for orphans. This is a *tangible asset*.

**v. *Moral formation*** this refers to activities in which religion contributes to the shaping of human behavior and lifestyle, “morals, behavior change, self control”, “behavior change, life/positive living, patience, temperance”. This is an *intangible asset*

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<sup>117</sup> ARHAP-WHO report 2006 <<http://www.arhap.uct.ac.za/publications.php>>pp 77-78

vi. *Curative interventions* this refers to a number of ways in which religious health activities intentionally intervenes to cure ill health in either a biomedical or alternate way, and includes the terms “facilities, reduce illness, healing”, and “healing/health services, infrastructure, human resources”. This is a *tangible asset*.<sup>118</sup>

The findings from PIRHANA research in Zambia and Lesotho shows that religion contributes to health in both tangible and intangible ways. The research report and analysis in the next two chapters will engagement with the ARHAP theory further.

### 3.8 Conclusion

In this chapter, we have noticed the basic principles, which govern the ARHAP framework, and the definitions of terms as used by ARHAP. We have also noted ARHAP’s activities in the recent past and some of the findings on REs and their contribution to health outcomes and well being of communities. In addition this chapter has also highlighted the PIRHANA research and its findings on tangible and intangible assets and how they impact on health outcomes. As we have noted, the issue of tangible and intangible assets is the focus of this thesis. The following chapter presents findings on case studies of religious health institutions in which the main question on how religion contributes to health is examined and thereby establish the tangible and intangible assets in each institution and how they impact on health outcomes.

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<sup>118</sup> ARHAP-WHO report 2006 <<http://www.arhap.uct.ac.za/publications.php>>pp

## CHAPTER FOUR

### RESEARCH FINDINGS

#### 4.1 Introduction

This chapter presents the findings from the four religious health institutions based on the Copperbelt. The data presented in this chapter is the outcome from the research interviews conducted among 20 participants from the various organizations. A brief description on the background, objectives and operational structure of each organization is presented. The findings are presented in a summary form. The detailed verbatim, narrative recording on the research findings are in appendix C. The first findings are from the health care givers and the second from the health seekers. The overall research question of the findings attempts to establish ‘the churches or religious health institution contribution toward the direct health outcomes on communities in the Copperbelt Province of Zambia.’

A qualitative approach was used in data collection from four religious health institutions. Twenty individuals were interviewed, two health providers and three health seekers from each institution. The interviews were both written down and recorded on a voice recorder.

The following institutions were involved in the research.

1. Bethel City Church – faith healing as central to worship
2. Fiwale Hill Mission Health Centre – Religious rural Health Centre, with in and outpatient services and dispensary
3. Dawn Trust Community Centre – HIV/AIDS, VCT counseling and support
4. Isubilo Community Resource Center – local church initiative ministry with health education, VCT counseling, Clinic and disaster management.

#### 4.2 Background and profile of the institutions

Under the following head, each institutions’ background and profile is presented. The history and religious activities related to health are given.

#### 4.2.1 Bethel city church:<sup>119</sup>

The church belongs to the Apostolic church in Zambia, which came to Zambia in 1947, through some missionaries from Denmark. Most of their church planting work focused among the low income communities and rural areas. In 1984 a Bible school named Kaniki Bible college offering a diploma in theology was opened to train men and women for church planting and pastoral ministry. In 1990, Bethel City church was planted by one of the graduates from Kaniki Bible College, who is still serving as senior pastor.<sup>120</sup>

The church operates as a worship center in the inner city of Ndola with its focus in the work of evangelism, teaching, discipleship and church planting. As part of its response to the health needs and other needs of its members and the community, the church runs a ministry called '*deliverance clinics*.'<sup>121</sup> The church mobilizes teams from the church members who are trained in the art of spiritual deliverance. The primary tool used in these deliverance sessions are prayers and counseling from the Bible. It is believed and taught that all kinds of illnesses and spiritual bondages are delivered through such means. The church operates deliverance clinics every week on Tuesdays and Thursdays at the church premises and are open to everybody seeking better health within Ndola and outside.

The procedure of the operations functions just like what would normally happen in a medical hospital. A client is first seen by the trained staff that has an initial interview with him/her and the persons details are taken and records made. A personal file is made, the client is given a file number and according to the illness or case, the client is directed to meet a specialized trained staff in the area of need identified. The client would then be counseled and sent for special deliverance prayers of exorcism to a designated classroom. Each time the client visits these deliverance clinics she/he presents the file number and the similar process is engaged until the person is delivered from whatever bondage.

Bethel City church has grown numerically as a church through the ministry of deliverance. The statistics from the church records indicate that in 1999 the membership of the church was slightly

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<sup>119</sup> The following information was collected from pastor Chris Chanda, pastor at Bethel City Church and from the write up of '50 years Golden celebration of Apostolic church in Zambia August 2007.'

<sup>120</sup> Bethel city church archives 1993.

<sup>121</sup> Deliverance clinic which are specifically meant to deal with bodily and inners burdens of the people ranging from all sickness such as AIDS, Diabetes, body aches and all sickness related to demonic influences. The modus operandi is similar to that of a medical clinic except that here the means of healing is prayer and counseling from the Bible.

above 100 and has to date [2007 September] grown up to 2500 members.<sup>122</sup> This leap in growth is attributed mainly to the ministry of deliverance, which often addresses the physical needs of the people. According to the senior pastor, a total of 3,715 people attended the healing and deliverance sessions from January to September of 2005.<sup>123</sup> A good number of the people delivered from burdens and sickness under this ministry often take up membership in the church. It is clear from the numbers visiting the faith healing and deliverance services that this has given the community an alternative to health seeking and services in comparison to the acceptable conventional hospital visitations.

#### **4.2.2 Fiwale Hill Mission Rural Health Center**

Fiwale Hill Mission Rural Health Center (FHMRHC) was established in 1938, by the Baptist Union of South Africa [BUSA]<sup>124</sup>. The need to have a health center was prompted by the number of illness and deaths experienced by the church members and people living near the mission center. This resulted in FHMRHC being established to cater for both the local community and the missionaries serving around Fiwale and Kafulafuta Mission stations in Masaiti district. Fiwale and Kafulafuta missions are 35 and 45 km from Ndola respectively. The health center has seen a lot of development in terms of infrastructure and the management of its operations for the past 70 years. The administration of the health center changed hands in 1970 from the BUSA to the Australian Baptist Association, which works in partnership with the Northern Baptist Association of Zambia (NBAZ).<sup>125</sup> The clinic receives most of its medical supplies from the Australians through the Australian Baptist Mission.

The rural health center operates just like any other rural health clinic except that the condition for any member of staff seconded to the center is that they must be an Evangelical born again Christian. This is a requirement because of the nature of the clinic being a Christian health center. The activities that take place at the center, such as praying for the patients, having Bible

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<sup>122</sup> Bethel City Church International, church records 2007.

<sup>123</sup> Albert Bwalya, Bethel City Church International, *counseling and deliverance ministry records*, church records (2005).

<sup>124</sup> Kemp R.F. South African Baptist Missionary Society in Zambia-A Missiological Evaluation Doctoral Thesis, University of South Africa, 1987 p57

<sup>125</sup> Fiwale Hill Missions- RHC records archives- history of Fiwale Hills mission 1999.

studies and biblical counseling of the patients and daily morning devotions demands that the members of staff to be Christian.

The primary objective of the rural health center is to provide medical health to the community as a practical means of serving the community with the love of Christ. It is believed that the various activities that take place at the center such as dispensing of medicines, counseling, prayers, support through health and nutritional education reflect the ministry of Christ to the whole person.<sup>126</sup>

#### **4.2.3 Dawn Trust Community Center**

In 2002, the Zambia Baptist Association [ZBA]<sup>127</sup> initiated plans for the formation of an organization within its broader ministry to the community to engage in integral mission. In 2005 Dawn Trust Community Center (DTCC) was established as a FBO that seeks to demonstrate God's love to the underprivileged and HIV and AIDS infected people through holistic community based interventions regardless of gender, race, color ethnicity, or religious affiliation.<sup>128</sup>

The goal of the center is primarily to mitigate the impact of HIV and AIDS pandemic and reduce poverty. The center provides a range of integrated activities as it facilitates the development and implementation of community based interventions for sustainable empowerment of the infected and affected people within and outside Mushili community.

The main objectives of the center are to:<sup>129</sup>

- Provide services in spiritual counseling to HIV and AIDS infected and affected people
- Provide VCT services and disseminate materials for HIV and AIDS control and prevention
- Involve local churches in HIV and AIDS awareness and formation of community support groups.
- Empower local community through Income-generating Activities (IGAs) and skills training for poverty reduction among the infected and affected.

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<sup>126</sup> Sister In charge Fiwale Hill Mission Rural health center, interview, 2007.

<sup>127</sup> ZBA is one of the Baptist Association with over 200 membership of Baptist churches in the country, it also runs a rural health center in Kasama-Mungwi in the Northern province of Zambia

<sup>128</sup> Dawn Trust Community Care-Brief Historical background, p1.

<sup>129</sup> Dawn Trust Community Care-Brief Historical background p2.

- Establish a community based sports and recreation infrastructure to promote the physical, mental and spiritual well being of the people.
- To improve access to education and health care for orphans and vulnerable children (OVC) in the community.

#### **4.2.4 Isubilo Community Resource Center**

Isubilo Community Resource Center (ICRC) is an interdenominational Faith Based organization, established in May 2000. Isubilo was born out of a passion of a Christian couple, who run an independent church based ministry, to establish a center to meet the holistic needs of the people in order to respond to the accelerating spiritual and physical problems in the community. The center was established to give ‘hope’ to the people, and takes its name from the Bemba word for hope, *Isubilo*<sup>130</sup>.

The dream was realized in the establishment of Isubilo Community Resource Center to contribute to the welfare and well being of the people in Chifubu and Kawama townships and beyond. This is a joint venture of concerned Christians in the community responding in a holistic manner with the practical love of Christ to the plight of the people in the community. The catchment area of Isubilo program is Chifubu, Kawama and Pamodzi a population of about 160, 000+ people.<sup>131</sup> Isubilo exists to give hope to the afflicted in the community through its practical message of the love of Christ. The vision of the institution is to see poverty reduced and the health of the people improved in the community.

ICRC has a number of activities which run as supporting entities to the primary core of the center; Home Based Care [HBC] is the core activity of the center. The HBC activities led to responses to other needs in the community, such as Orphans and Vulnerable Children [OVC], widows support programs and agricultural program and backyard gardens.

Isubilo runs a specialized clinic for the HIV and AIDS clients. The clinic was established in order to provide a religious health environment to meet the unique needs of the people in the community. The center operates a Volunteering Counseling and Testing (VCT) programme, along with provision of ARVs.

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<sup>130</sup> Mr. Mwansa, Program Coordinator-Isubilo-Documentation 2007.

<sup>131</sup> Ndola District AIDS task force 2007 HIV and AIDS projects in the Chifubu constituency.2007.

The center also has a grinding mill where its clients who are supported to grow maize bring their maize produce for grinding. This venture has reduced the expenditure of buying maize meal by half the prize. The grinding mill is also open to the rest of the community as well.

Isubilo believes that water is life therefore; among its other services to the community, it has sunk a bore hole within its premises for the community to draw water with no restrictions. To appreciate this, Chifubu is a community that scarcely has running water.

### **4.3 Category of the interviewees**

This research was undertaken with key informants from certain categories. These are (i) health providers, qualified health professionals who are Christians working in religious health institutions; (ii) Pastors, trained ministers serving in churches; (iii) Christian workers, working in FBOs; and (iv) , youths, widows, and AIDS patients.

### **4.4 Summary of responses from the interviewees on specific questions on religion and health.**

The data collected from the interviewees is summarized and grouped according to the institutions in the tables below. The grouping of data and research findings according to the organization and questions helps to present the diverse answers and makes it easier to compare for analysis purposes. The questions are also meant to identify and establish religious health assets which are present in religious entities, including churches.

The following questions provided a guide to the health providers in order to draw information on health and religion:

1. What is your understanding of health?
2. Is well-being and health the same thing? Explain your answer?
3. What does religion mean to you?
4. How would you explain the relationship between religion and health?
5. Can religion be at the center of health? Why, How?
6. Can you identify what you perceive as religious assets in your health activities?
7. What would you describe as your institution's direct contribution to the health and well being of people on the Copperbelt?



#### 4.5 Key findings from the *health providers*- from the four different religious entities.

In answer to the under girding research study question: *What contribution does religion and religious entities make to health outcomes?* The findings below presented in the tables capture the summary of the interviews conducted in the four religious entities. There were two respondents from each institution, and these are identified as 1 and 2 in the table.

##### Summary responses to question one: *What is your understanding of health?*

Bethel City Church	Dawn Trust Center	Fiwale RHC	Isubilo RC
1.Both spiritual and physical	1.Physical mental spiritual-person is a whole being	1. Physical, mental, emotional soundness- whole person	1.Good nutrition and sound mind & inner being
2. Total well being includes cultural and environmental aspects as well.	2. physical, mental, spiritual and sound economy	2. psychological, spiritual & social harmony	2. physical, psychological, social, spiritual & economical- <i>ubumi</i> [Bemba] <sup>132</sup>

Question on the understanding of health: the summary responses from the health care givers shows that health is understood to be more than a mere physical soundness but rather includes the person's total well being encompassing the cultural, social, economical, psychological, spiritual and his or her relationship to the rest of human life called *ubumi* [Bemba]. The responses show that human life and health is understood as an integrated thing which cannot be treated in isolation of the other factors which make life complete.

<sup>132</sup> Ubumi- [Bemba] refers to total well being that encompasses everything that makes life meaningful and enjoyable.

**Summary responses to question two: *Is well being and health the same thing? Explain your answer?***

Bethel City Church	Dawn Trust Center	Fiwale RHC	Isubilo RC
1. Yes in general sense no in specifics health in body but sick in moral and social aspect	1. No well being is more broader than health	1. health focuses on physical, well being includes everything that makes life meaningful- being in harmony with everything to enjoy life- <i>Tulimakola</i> <sup>133</sup>	1. well being is more than just having a good health although health is a vital part to well being- well being is wholeness
2. No well being incorporates health	2. No, well being is a sum total of all life and health is just a part to that.	2.health includes well being there is no difference	2. the two are interlocked health brings about well being- and well being results from good health- <i>ubumi ubusuma</i> <sup>134</sup>

On the question on whether health and well being are the same the responses show that well being is understood as being wider in meaning than health. Health is understood to be an integral part of well being. Notice the response 1 from Fiwale Mission Rural health, she says that health focuses primarily on the physical aspect of human being while well being includes everything that makes human life meaningful- being in harmony with everything to enjoy life- *Tulimakola*<sup>135</sup>. Well being is perceived to be more than health- though it is an indispensable component of well being. Respondent 2 from Isubilo Resource center elaborates this in the statement below that: *‘the two are interlocked, health brings about well being- and well being results from good health- ubumi ubusuma’*<sup>136</sup>

<sup>133</sup> Tulimakola [Tumbuka- language from Eastern Zambia] referring to a total well being of an individual whereby there are no encumbrances to lessen the enjoyment of life- physical, emotional, social and economical.

<sup>134</sup> Ubumi ubusuma- [Bemba] refers to complete welfare of life with no or less worrying concerns – wholeness.

<sup>135</sup> Tulimakola [Tumbuka- language from eastern Zambia] referring to a total well being of an individual whereby there are no encumbrances to lessen the enjoyment of life- physical, emotional, social and economical.

<sup>136</sup> Ubumi ubusuma- [Bemba] refers to complete welfare of life with no or less worrying concerns – wholeness.

**Summary responses to question three: *What does religion mean to you?***

Bethel City Church	Dawn Trust Center	Fiwale RHC	Isubilo RC
<p>1. Spiritual aspect of any human being- regardless of creed and confession.</p> <p>2. it is the inner belief that constitutes any spiritual aspect of life</p>	<p>1. it refers to having a belief in some greater being and relating to that being at a personal level</p> <p>2. What one believes in that influences attitudes, perceptions and practice of one's' daily life.</p>	<p>1. A conscious belief in God and having a personal encounter and relationship with Jesus Christ.</p> <p>2. Having belief in some higher being which one chooses to relate to voluntarily.</p>	<p>1. Religion is an ideology or belief in something or someone that affects ones perception and practices in life.</p> <p>2. Religion implies a belief in a being such as God and having a life that revolves around those beliefs.</p>

Responses on the understanding of religion reveal a clear assumption that the individuals interviewed had an understanding on religion. From the responses, religion is perceived as a conscious belief in a supreme or greater being and having a relationship with such a being. This belief and relationship with such a being, ultimately affects someone's perceptions, attitudes and practices in life. The findings from the interviews reveal that religion is seen as central to human life in Zambia despite the hardships encountered, notice respondent 2 from Isubilo RC says that religion in the belief of a being like God entails that a persons' life revolves around such a being. This perception on religion inevitably influences the peoples' lives and behavior in health seeking and practice.

**Summary responses to question four: *How would you explain the relationship between religion and health?***

Bethel City Church	Dawn Trust Center	Fiwale RHC	Isubilo RC
<p>1 There is a strong relationship which is inseparable- a health body and sound spiritual life completes a person's well being.</p> <p>2. Religion and health are back to back in terms of a person's well being the two are inseparable in the understanding of health. First as an African and second as a Christian people are made up of body and spirit.</p>	<p>1. Yes there is a relationship when a Christian is sick, they often resort to God or other Christians for help</p> <p>2. There is a relationship, religion is the basis upon which people exercise their faith in God and when they are sick, the majority of people resort to some higher being for comfort</p>	<p>1. A relationship is more evident when a person is very sick, people often turn to religious hope. Some diseases are dealt with spiritually.</p> <p>2. For a Christian, there is a clear relationship, when one is sick prayers are conducted implying that religion plays a very important role</p>	<p>1. The relationship that exist between religion and health is portrayed in the inseparable relationship that exist between the body and spirit of a person the two make the person whole.</p> <p>2. The relationship exists. The example is when one is sick we pray- prayer is something intangible but the results are tangible good health – so there is a relationship.</p>

The findings from the question on the relationship between religion and health, shows that (in the perceptions of these health providers) religion is an added value which contributes positively to health. The finding demonstrates that there is a strong and inseparable relationship between religion and health. This relationship between religion and health becomes noticeable usually when people fall sick there is a common tendency to seek for prayers and spiritual help such as support, care and comfort during illness period. Respondent 2 from Isubilo RC captures this idea saying that *'the relationship exists, the example is when one is sick we pray- prayer is something intangible but the results are tangible good health – so there is a relationship'*

**Summary responses to question five: *Can religion be at the center of health? Why, How?***

Bethel City Church	Dawn Trust Center	Fiwale RHC	Isubilo RC
<p>1. Yes, all health issues revolves around religion. Religion whether acknowledged makes the primary basis of human existence. So it is at the center of all health matters.</p> <p>2. Yes religion is at the center of health, this is even so in our African traditions and beliefs everything has a link to the spiritual, for example the <i>Ngangas</i><sup>137</sup> in the African concept of human life, religion is at the center of all health matters whether explainable or not.</p>	<p>1. Religion, that is the ‘Christian faith’ should be at the center of all healthy life, in fact most of the illness people have e.g. HIV and AIDS is a result of some careless choices and way of life which hinges on one’s religious moral life.</p> <p>2. No I do not think so religion and health are two different things – although religion can affect ones health, it cannot be at the center of health. Because there are healthy people who do not subscribe to any religious practices.</p>	<p>1. Religion is at the center of all matters of health once we remove it, we remain without the true meaning of health or well being.</p> <p>2. Religion is at the root of all human existence as a health practitioner I know that each time I dispense medicines, ultimately it is God who brings about healing. That’s why we pray for the sick because religion sits at the heart of human life and health.</p>	<p>1. For me I replace religion with God, God is at the center of any good health. Religion in this case occupies a central place in the well being of people</p> <p>2. Religion is the thing that gives meaning and purpose to health</p>

Question five looked at the perception as to whether religion is at the center of health and well being of people. The responses from the health providers indicate that they understand that religion is at the centre of health and that everything, including health, revolves around religion or religious activities. Religion is understood as an entity which informs human behavior in matters of health outcomes. For example respondent 1 from Dawn Trust Center attributes some of the prevailing health challenges to religion, note the statement ‘*religion, that is the ‘Christian faith’, should be at the center of all healthy life, in fact most of the illness people have e.g. HIV and AIDS is a result of some careless choices and way of life which hinges on one’s religious moral life.*’ This statement shows the strong relationship between religion and moral agency that

<sup>137</sup> Nganga- [traditional diviners]- often consult the ancestors relating to the invisible spiritual-world for direction in the diagnosis and application of medicines

it creates in the people's choice and behavior. Respondent 2 from Dawn Trust Centre has a more uncertain view, given that there are healthy people who do not subscribe to any religious beliefs or practices. This response shows that though religion is perceived to be at the center of religion by a number of Zambians, it is not always the case in other communities where religion is not appreciated as key to human life. However the general perception from the finding is best summarized by one of the Christian health providers from Fiwale Mission Rural health centre, that:

'Religion is at the root of all human existence. As a health practitioner I know that each time I dispense medicines, ultimately it is God who brings about healing. That's why we pray for the sick because religion sits at the heart of human life and health.'<sup>138</sup>

**Summary responses to question six:** *Can you identify what you perceive as religious assets in your health activities?*

Bethel City Church	Dawn Trust Center	Fiwale RHC	Isubilo RC
<p>1. prayer, counseling, exorcism, prophetic utterances, care and support, meeting physical/material needs</p> <p>2. offering of hope and assurance, creating continued relationships with the clients, providing material necessities to the needy.</p>	<p>1. Psychosocial counseling, Biblical counseling, specialized focus Bible studies, socializing through sport, prayers, health talks, support groups, fellowship of peer groups</p> <p>2. tangible assets- buildings, the center is in the community, provide clients with farm and back yard garden inputs.</p> <p>Intangible assets- we offer: hope, encouragement, fellowship, spiritual counseling, prayer, Bible studies, specialized clinical counseling, social therapy</p>	<p>1. Prayer, counseling, encouragement, sermon delivery-Bible studies, material support, sharing love- personal time spent with clients,</p> <p>2. Presence of chaplain, prayers, counseling, encouragement, accompaniment through illness, guidance, fellowship.</p>	<p>1. sharing practical love, care and support, counseling-both spiritual and psychosocial, our presence in the community sign of hope, spending personalized time with clients, fellowship, feeding and giving of material support.</p> <p>2. pastoral counseling [spiritual], prayer, Bible reading, share the good news of Christ and encourage and giving hope through support groups of HBC. We provide transport to the needy to go to the hospital. We dispense prescribed medicines.</p>

<sup>138</sup> Respondent 1 Fiwale Mission rural health center: interview response, September 2007.

Question number six sought to identify religious assets in the four organizations. The findings from the religious assets identified are classified in two categories namely the tangible and intangible assets. The tangible assets identified from the four institutions are: meeting the physical needs of clients, such as material support, provision of farm and back yard garden inputs, the presence of buildings in the community, feeding, provision of transport to the needy to go to the hospital, dispensary of prescribed medicines and hands on activities by the HBC groups. The intangible assets are: prayer, counseling [spiritual, psychosocial and educational], prophetic utterances, offering of hope and encouragement to clients, relationships, support groups, educational health talks, specialized Bible studies, guidance, accompaniment through illness. It is clear that these institutions do have an understanding of religious assets and the contribution they make to health outcomes.

**A summary of responses to question seven:** *What would you describe as your institutions' direct contribution to the health and well being of people on the Copperbelt?*

Bethel City Church	Dawn Trust Center	Fiwale RHC	Isubilo RC
<p>1. offering voluntary free services to the community, delivered people are able to work and be productive, restoring broken marriages and health of individuals helps to build healthy communities</p>	<p>1. presence in the community, offer free testing and post testing support and care, provide support systems to clients, this enhances resilience, hope to the PLWHA. They are taught life skills and give food supplements, we teach our clients conservation farming and back yard gardens, provide maize seed, fertilizers, training and technical support in food production to PLWHA.</p> <p>2.the open doors to the community and the fact that we address the whole person namely the spiritual and physical aspects of</p>	<p>1. The presence of health center, medical facilities, a religious institution gives hope and security of love and care,</p>	<p>1. creates a network for both church, health and community workers in the community, provides a presence of hope in the community, empowers the volunteers in the community in HBC, center has a grinding meal that caters for a population of over 3000 people, provide school necessities to 250 orphans.</p> <p>2. Water tank for community,</p>

<p>2 the people we pray for become better and are enabled to work and earn a living that is a direct contribution to health and well being</p>	<p>human life. The holistic approach to health is a contribution to well being which is often absent and not recognized by other health institutions</p>	<p>2. Presence of health facilities lead to health people and health people are more productive and consequently results in a health community.</p>	<p>provide shelter for 8 orphaned children, feeding program for OVC, old people, and the underweight babies.</p>
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The last question of the interviews had to do with the investigation and description of the four institutions' direct contribution to the health and well being of people in the community. One of the common findings from the religious organization is their 'presence' in the communities. The mere fact that these religious entities are present in the communities is in itself a direct contribution to the well being of communities. In addition to this the provision of almost free health services with a specialized attention and care is recognized and appreciated as a contribution to the well being of the communities. These institutions also see themselves as providing a special link between government health institutions and the private or religious health institutions. The summary from Isubilo RC captures some of the direct contribution these religious entities contribute to well being of communities. .

the institution creates a network for both church, health and community workers in the community, provides a presence of hope in the community, empowers the volunteers in the community in HBC, the Center has a grinding mill that caters for a population of over 3000 people, provide school necessities to 250 orphans. Has put a water tank for community, provide shelter for 8 orphaned children, feeding program for OVC, old people, and the underweight babies<sup>139</sup>

<sup>139</sup> Summary of findings from Isubilo RC see detailed response from Appendix A on narrative report.



#### 4.6 Key findings from health seekers

Below is a summary of responses from the *health seekers* on the role religion and religious health assets contribute to health and well being. Three health seekers were identified from each of the four entities, using randomized sampling.

The questions for the health seekers focused mainly on their understanding of health and the role religion plays in their health seeking endeavors.

1. Why do you consult this institution? Does it make a difference that it is religious? Why?
2. How would you define health?
3. What is your understanding of well-being?
4. Is well-being and health the same thing? Explain your answer?
5. Does your faith/religious belief serve as a motivation in your health seeking?

The full answers to the questions are presented in the Appendix C. For the purposes of the analysis, summarized answers from the respondents are presented in the tables below.

**Question one:** *Why do you consult this institution? Does it make a difference that it is religious? Why?*

Bethel city church	Dawn Community	Fiwale RHC	Isubilo RC
Yes very much, the kind of attention one receives is very personal and goes beyond the healing time. Relationships are built in the process of receiving healing.	Yes the difference is there, for example people suffering from AIDS are treated with dignity and care. Here at the centre the providers see more than just patients or clients but a human being. This is a big difference when one compares this with the government public institutions.	Yes there is a big difference, the nurses and other health workers see their work as a calling in life and the institution is known as a mission health center, so people come with hope and faith to receive specialized care and treatment.	Coming to Isubilo is like being among family members. Because it is a Christian organization one can easily trust and entrust his/her life to the health providers with a lot of confidence that the treatment will be full of care and special attention.

From the summary of the findings it is clear that the health seekers find religious health institutions to be better than the public government health institutions in terms of service and care. The findings from the responses also show that health seekers have a positive perception

about religious health institutions and churches when it comes to care and treatment. One such observation is the manner in which the clients are treated, namely, with dignity and care. In addition to this, the findings show that the seekers appreciate the continued relationship which is built between the health seekers and givers. This is particularly clear in the comments from the health seekers at Isubilo center and Bethel City Church. The findings show that from the health seekers interviewed, that there is a difference between consulting a religious health institutions and other non religious health institutions.

**Question two:** *How would you define health?*

Bethel city church	Dawn Community	Fiwale RHC	Isubilo RC
Wholeness, <i>umweo</i> <sup>140</sup> -life,	Physical fitness, <i>ubumi</i> , wholeness [food, shelter, sound mind]	Physically fit, free mind, <i>ubumi</i> , inner well being	Physical fitness, good food, shelter, wholeness

The second finding from the health seekers on their understanding of health shows that health is perceived to be a sound [that is lack of illness] wholeness of human life. It is referred to as wholeness, *ubumi*- or *umweo* – life in Bemba. Health is understood as something that is closely related to life- *umweo*. Without good health, life is threatened. Although it is closely related to fitness of life, it is however seen as wholeness.

**Question three:** *Is well being and health the same thing? Explain your answer?*

Bethel city church	Dawn Community	Fiwale RHC	Isubilo RC
Well being Includes everything, health is limited to physical	Completeness, being in harmony with all that exist, <i>ubumi</i> that makes life enjoyable and meaningful	Completeness- body, soul and spirit, well being includes health and results in enjoying life as a whole.	Well being includes both health plus other things which make life meaningful.  The two are not the same, health is limited to the body; well being is beyond physical health.

<sup>140</sup> Umweo- bemba meaning life, that is functioning well without any major difficulties.

The findings on the understanding of well being, shows that well being is an all encompassing term that includes everything that gives human beings respect and meaning. This includes soul, spirit and body and therefore anything that threatens the wellness or soundness of any aspect of life undermines wellbeing. Well being and health are not the same although health is understood as being an integral part of well being. On the other hand, we cannot talk about well being part from health. The finding shows that although they are different, they are however closely linked in the perceptions of these health seekers.

**Question four:** *What is the relationship between religion and health ? Explain your answer?*

Bethel city church	Dawn Community	Fiwale RHC	Isubilo RC
Religion and health are a reality that coexist, faith relates to all aspects of life so there is a relationship	The relationship exist in the fact that faith gives hope in times of sickness the true meaning of <i>ubumi</i> incorporates religion as a vital component  Religion keeps one hopeful in time of sickness the two cannot be divorced.	The person is made up of body soul and spirit, religion relates to these areas of human health does so also.	The two are interrelated; religion is the thing that under girds the well being of a person the relationship is there.

A summary finding shows that there is a perceived relationship between religion and health; the health seekers acknowledge the fact that human beings are more than just bodies but soul and spirit. The spiritual aspect of human beings relates to issues of religion. For example a summary response from Fiwale Mission clinic indicates that religion and health both relate to the same make up of a human being body, soul and spirit. It is argued that this is the reason why people turn to religion and religious activities when they are sick.

**Question five:** *Does your faith serve as a motivation in your health seeking?*

Bethel city church	Dawn Community	Fiwale RHC	Isubilo RC
<p>Faith /belief in a supreme being is the driving aspect of health seeking – hope and healing.</p> <p>Faith in God creates hope and resilience in sickness</p>	<p>Faith in God helps one to endure in sickness and have hope, confidence and peace.</p> <p>Religion is at the center of all activities and therefore it determines ones response to sickness and health matters</p>	<p>Health and religion are both gifts that come from God, therefore faith is closely related to health, when one is sick there is a belief of receiving healing from the giver of health, so prayer and hope are a result.</p> <p>Bad health affects ones spirituality.</p> <p>Visiting a religious health center serves as a motivation of hope and trust of good care.</p>	<p>Faith is key to any break through in health crisis it gives hope for healing, endurance.</p> <p>Visiting Isubilo which is a Christian organization creates confidence, hope and faith in my health seeking.</p>

All the respondents believed that religion or a belief in a divine and Supreme Being serves as a motivation for health seeking. The presence of faith or a belief in God helps a person to develop resilience and hope in time of sickness or affliction. The finding shows that faith or belief in a supreme God is perceived to contribute to seeking health treatment at a religious entity or attend to faith healing sessions conducted by churches.

#### 4.7 Conclusion

The information gathered from the interviews clearly shows the diversity of experience and understanding of health, well being and religion. It is clear from the responses that the relationship that exists between religion and health seeking is deeply seated at the center of health seeking particularly among those who profess faith in God. Another aspect noted from the responses is that a visit to a Christian or religious health institution provides a positive motivation for peoples' well being. Faith or religion underlies elements of agency in health seeking interventions and decisions. The other thing observed from the findings particularly with the health providers is their awareness of the direct contribution they make to the well being of the people. There is a general perception from the people interviewed that they feel comfortable and confident to visit a religious health institution because of the holistic services they offer and receive. The detailed analysis of the findings from the interviewees is addressed in the next chapter.

## CHAPTER FIVE

### RESEARCH ANALYSIS AND INTERPRETATION OF THE FINDINGS

#### 5.1 Introduction

This chapter will interact with and analyse the findings. In doing so, the ARHAP theory matrix will be engaged focusing on intangible and tangible religious health assets and their direct contribution on the well being of people. The findings will also be interpreted to give an understanding on the relationship and the value of religious health assets in health seeking and service. In addition to this, an analysis of salient issues identified from the research findings such as the impact of gender, poverty, literacy, and HIV and AIDS in the well being of people will be addressed. The main argument in the analysis of the findings is to investigate the value of religious health assets contribute to holistic understanding of health and well being of people and communities.

#### 5.2 Analysis of the possible factors that could have affected the responses and outcome on the study

There are some obvious factors that were direct cause to the responses given by the various participants in the research study. Twenty people were interviewed ranging from 26 to 57 years 13 were female, 8 male. Eight of the interviewees were HIV positive, 12 were unemployed, and 8 could not express themselves in English and of these 8, five were women. All the interviewees professed a faith in God and said that they were Christians who were members in some evangelical church.

From the information given above it is clear that there are obvious factors that contributed to the response and outcome on perceptions are things, such as gender, poverty, literacy, HIV status and their spiritual beliefs and perceptions.

- The gender factor- in each institution: three women were interviewed and two men except at Dawn Community Center where four women interviewed. From the responses and statistics given it was clear that women were the most affected in terms of visiting the

religious health institutions. Women were also more open in answering the questions and in the area of telling their stories as compared to the men.

- The poverty factor: as stated above, out of all the health seekers who were interviewed only one was in formal employment. Their economic status obviously contributes to the type of health services they seek for when sick. Their social and economic status inevitably affects their livelihood and health in general and specific terms. A case in point is the testimony of one of the health seekers at Isubilo Resource Centre who confessed that when he was in formal employment, he used to attend a private clinic and the government hospital but ever since he lost his job, the only place he was able to receive meaningful and careful medical attention is at Isubilo RC.
- Literacy factor: it was very clear that educational and literacy levels among the health seekers was very low. This was evident in the struggle some of them had to express simple facts on their understanding of issues and in their perception on matters of health and hygiene.
- The HIV and AIDS factor: as mentioned above, eight of the interviewees are HIV positive and are on ARVs. It was clear that their HIV status contributed much to the responses related to the value of religion and the contribution the religious health institutions are making in the area of health services.
- The religion factor: a personal faith in God as noted above all the participants both health seekers and health providers were professing Christians belonging to evangelical churches. Their perception on the role of religion to health and the value it adds to peoples well being was clearly influenced by this factor where religion is well appreciated as an integral aspect of life and well being of society.

A combination of these factors contributed positively and to some extent negatively to the outcomes and perceptions on the understanding of the role of religion on health.

### **5.3 Analysis of the findings**

The analysis of the findings focuses on the salient issues highlighted by the interviewees. A one by one analysis of the findings is presented and classified accordingly on the issues identified. The identified issues serve as a basis for the overall analysis of the findings on the role and

contribution of religious health assets as perceived by both the health providers and the health seekers.

#### **5.4 An analysis of the responses by the *health providers* from the four religious entities.**

The first data being analyzed is information collected from the religious health providers on their understanding of the role religion has on health as an asset in the well being of people.

##### **5.4.1 On the understanding of health**

The similarities in the responses given to the understanding of health clearly show that health is perceived to be more than just the absence of sickness in a person. It includes everything that contributes to the total well being of a person, such as the physical, spiritual, emotional, economic, social and cultural harmony, and environmental well being. The holistic understanding of health includes a spiritual component, which means that a mere dispensing of pills to address the medical malady does not address the whole health needs and concerns. Health should therefore be perceived and responded to in a holistic manner and not in compartments of physical and non physical.

This is best captured by the statement from Dr Biemba as he comments on the Australian Aborigine's definition of health that: 'health does not just mean the physical well being of the individual but refers to the social, emotional, spiritual and cultural well being of the whole community'.<sup>141</sup> This perception of health is from a holistic approach that encompasses body and spirit and includes the outside world in which the individual lives- the community.

##### **5.4.2 On the understanding of well being and health**

The concept of well being and health creates a problem in the understanding of the two terms. The responses given indicate that there is a thin line between the two, whilst it is very clear that well being incorporates health –[that is physical well being] the two are not the same. This is best described or understood in Bemba where well being refers to *ubumi ubusuma* [total well being]

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<sup>141</sup> Godfrey Biemba, 'Value-Added and invisibility of Religious Health Assets,' *ARHAP International Colloquim2007* (March 2007), p.23.

and health is understood as *ubumi* [sound health]. The Bemba word *ubumi* –*health* has the same root as the word well being implying that the two terms health and well being are perceived as an interlocking whole that cannot easily be divorced from each other. It is interesting however to note that in answer to question 1 on the understanding of health, (see above), the respondents all gave a much more expansive definition of health. It seems to me that when you analyse the answers to questions 1 and 2 on the understanding of wellbeing, the respondents are all saying that in the *Zambian* context, health has to be understood as wellbeing

Health as it refers to physical soundness contributes to well being, which means the total soundness of life encompassing everything. Well being is perceived as the sum total of all life. Health is simply part and parcel of this sum total which includes anything that makes life meaningful and enjoyable.

### **5.4.3 On the understanding of religion and its relationship to health**

Religion in the generic sense is understood as a conscious belief in a greater being or something that affects one's perception and practices in life. The responses from the case studies indicate that religion is understood to be an integral spiritual component of human life that relates to a higher being, so that one may have a personal encounter and relationship with the divine. It is very clear from this understanding of religion, that religion plays a huge role in human relationships and well being of individuals and communities. The understanding of religion from the case studies also shows that religion cannot be divorced from all human experiences. This is well captured by one of the responses that 'what one believes in influences ones attitudes, perceptions and practice in everyday life.' This concept and understanding of religion, presupposes that religion is locked up in the outcome of everyday lifestyle.

As a result of this understanding of the role of religion, it becomes clear that health outcomes have religion at the core of human life. It is this understanding of the relationship that exist between religion and health that contributes to the forms of health seeking and services. Religion therefore introduces a different dimension in the understanding of health. A comment by one of the interviewees states that 'religion and health are back to back in terms of a person's well being, the two are inseparable in the understanding of health. First as an African and second as a Christian, people are not made up of compartments but as a whole body and spirit.' So to address



matters of health outside religion would present an inaccurate and incomplete understanding of *ubumi*- well being. Paul Germond conceptualizes this understanding when he says that, “distinctions between religion and health, between body and spirit, between different forms of healing practices do not reflect the conceptions and practices of health and healing”. He further comments that:

in this view [referring to the wholeness of life and health world] society as a whole is a single organism, which functions pretty much as the human body as an organism functions. Health is social and organic. It is therefore also fundamentally relational<sup>142</sup>

This holistic and relational understanding of health and religion is what results in the relationship that exists between religion and health and consequently determines and feeds into the forms to health seeking and services.

#### **5.4.4 Religion being at the center of health**

The understanding that everything in life revolves around religion sums up the belief that even health matters are determined by religious matters. For instance the respondent from Bethel city church<sup>143</sup> on the question whether religion is at the center of health says that all health issues revolve around religion. Religion gives human life meaning and purpose. In the African concept of life, all traditions and beliefs are linked to the spiritual world which is referred to as religion. The example given of the ‘*ngangas*,’ traditional diviners who consult the invisible spiritual world for diagnosis and applications of traditional medicines, justifies this concept.<sup>144</sup> Religion is perceived as an integral component which is at the center of all human activities even in health seeking and provision.

This is illustrated in the figure below, adapted from the Lesotho ARHAP research on Bophelo<sup>145</sup>, which explains the intertwined understanding, and relationship that exists between religion and health.

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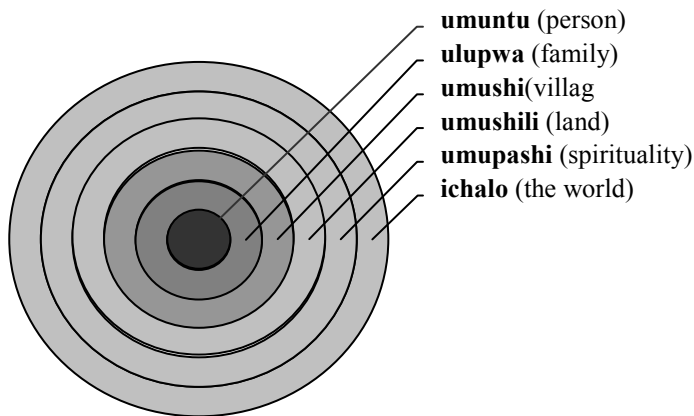
<sup>142</sup> Paul Germond, ‘Of Healthworlds and Agency: Recasting Conceptions of Health in an African World’ *ARHAP* Lesotho, *Draft working Document* 2005.p44-46.

<sup>143</sup> Refer to the appendix B...

<sup>144</sup> Bethel City church ‘health provider’ see table1, summary of responses.

<sup>145</sup> ARHAP, WHO research chapter 4 on ‘Translating Religious Health Assets’- Lesotho research pg 98-122. 2006.

## The intertwined relationship that exists in the understanding of well being, health and religion<sup>146</sup>



This diagram is adapted from the ARHAP Lesotho research on the understanding of the wellbeing and its relationship to the rest of human relationships. The Sesotho words have been replaced with the Bemba words, indicating the same understanding of life, health and well being.

The diagram above show how well being is understood and perceived by those who participated in the research. Well being is perceived to be an intertwined and holistic thing, which related to all human relations, such as the family, the village, land , the world and ones spirituality. The total of this is what defines well being and health - it relates to the rest of the human activities and entities. Therefore, the role of religion, from the understanding of the diagram above shows that it is impossible to dismantle the wholeness of the human being, when it comes to well being and health matters. From the diagram, the person is closely linked to his or her family and the family is linked to a village of a given community, which inhabits a given portion or piece of land on the earth or country. Well being from this perspective cannot be talked about outside any of the above entities of life. It is important to note that this holistic perspective of life and well being determines the patterns of health seeking and provision.

<sup>146</sup> Adapted from the Lesotho ARHAP research on the understanding of the relationship that exist between religion and health. For details report and concept refer to the ARHAP, WHO research chapter 4 on 'Translating Religious Health Assets'- Lesotho research pg 98-122. 2006.

### **5.4.5 Religious assets identified in the organizations**

From the responses of the health providers, it is very clear that the organizations knew and understood the religious assets that their institutions have which contribute to the health. The following religious assets were identified in the following categories which are aligned to the ARHAP terms:<sup>147</sup>

#### **i. Spiritual Encouragement: an intangible asset**

Spiritual encouragement includes aspects of religion such as prayer, prophetic utterances, specialized focus Bible studies groups, sermon delivery, giving of hope, encouragement and accompaniment, presence of chaplain in health giving, fellowship, spiritual guidance through bible studies. This aspect of spiritual encouragement is a religious asset to health which directly and indirectly creates in the health seekers an inner strength to continue trusting and hoping in spite of the illness and difficulties. One of the institutions simply prays for healing and practices exorcism as a means to deliver people from all manner of illness and they see this as a healing asset which is religious in nature and practice

#### **ii. Compassionate Care: a tangible asset**

The compassionate aspect of the religious assets identified include activities such as giving personalized care, expression of love through the support groups such as Home Based Care, peer support groups, spending personal time with the health seekers and accompaniment in their fears and grief. This component of religious assets provides a platform for the health givers to support their clients with a human face and in a more holistic compassionate manner.

#### **iii. Moral formation: an intangible asset**

The moral formation is a component of religious asset which is offered to the health seekers in the area of morality in matters of making decisions and choices in life. Some of these assets identified include activities such as, counseling, peer focus group bible studies, guidance, social and moral education. All these are conducted in the context of health care provision.

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<sup>147</sup> The ARHAP cluster of has defined the categories of religious assets under seven terms; spiritual encouragement, compassionate care; respectful relationships; moral formation; knowledge giving; curative interventions and material support. See the ARHAP Theory matrix and research findings ARHAP, Lesotho report 2007, p112.

#### **iv Social networks and relationships- an intangible asset**

Another aspect which was identified as a religious asset is the presence of real relationships which could be termed as social networks. These are formal structured working relationships such as health support groups, which come up due to similar activities or illnesses. These networks provide a sense of belonging and acceptance and are in themselves a therapy. Activities identified such as support groups, sport, social therapy through sharing personal stories, fellowship/meetings over a special health or social subject matter. These networks in the end provide a platform to develop relationships and life skills related to health matters. These social intangible networks are promoted as an asset by the religious health providers, which help to develop networks and relationships to foster a sense of belonging.

#### **v. Curative activities- a tangible asset**

Three of the institutions researched provide curative medication through dispensaries. However alongside these conventional medicines they also provide prayers to health seekers who so wish. This combination of clinical medicine and treatment of diseases and belief in the power of prayer for healing was identified as a religious asset.

#### **vi. Material support- a tangible asset**

Another component that contributes to the well being of people is the material support given to the health seekers. This is in the form of food, clothes, shelter, water, and farming inputs for food gardens. This is conceived as part of a holistic approach to the well being of people.

### **5.4.6 The direct contribution of religious assets to health and the well being of community**

The last of the interview questions had to do with the institutions' understanding of their direct contribution to the health and well being of the community. From the responses gathered it is very clear that these religious entities believe that they are giving a meaningful and indispensable contribution to the well being of people in the community from a holistic aspect.

One of the factors that stands out as a major contribution to the well being of the community is the provision of free health services in a context of relationships. The other aspect is the presence of such religious health assets within the community, which gives hope, together with the love and care. The presence of these religious health institutions also creates a network for the church, health institutions and the community. The contribution of these religious health institutions is best captured by the response from the health provider from Fiwale Hill Rural Health Center, that the presence of religious facilities leads to healthy people who are productive and the consequent result of this is a healthy community.

### **5.5 An analysis of responses from the *health seekers* on the understanding of the role religious assets play in the health and well being of the community**

The questions for the health seekers focused mainly on their understanding of health and the role religion plays in their health seeking endeavors. We turn now to analyse these findings.

#### **5.5.1 On the understanding of health.**

Health is perceived as the wholeness of a person, which includes the physical, emotional, mental and spiritual. It also involves having a sound relationship with anything that contributes to the health of a person such as the environment and healthy relationships with other people. Health is understood to be a situation that is more than just the absence of illness in the body.

#### **5.5.2 On well being and health.**

Well being encompasses everything; this includes health in its narrow definition. Health is therefore an integral part of well being. Well being refers to completeness, being in harmony with all that exist. In Bemba the word is *ubumi* referring to the aspect of having a meaningful and enjoyable life as a whole. Therefore the two are not the same. Well being is much wider than health in its understanding and application. Well being is beyond physical fitness called health. In well being an individual is said to be healthy when there is peace at all levels of human relationships and environment.

### **5.5.3 On the relationship between religion and health**

Religion and health are a reality that coexists with a very thin line of demarcation. Religion is intertwined in everything that happens to human life. Religion gives hope in times of sickness so that the true meaning of *ubumi* incorporates religion as a vital component. The relationship that exists between religion and health is also seen in the understanding of human beings who are made up of body, soul, and spirit. Religion relates to all these aspects of life. This holistic understanding of human being creates a relationship between religion and health.

### **5.5.4 On religion being a motivation for health seeking**

The responses show clear that faith or belief in a supreme being serves as a driver for agency in health seeking. Faith in God creates resilience and hope. The belief that both health and religion are gifts from God makes it an inevitable thing not to divorce religion in health seeking. Another thing that was clear is that visiting a religious health institution for health seeking gives greater hope and confidence in the health seekers simply because of the religious component. Religion therefore serves as a motivation for health seeking among a number of people.

### **5.6 Interpretation of the findings in the context of the ARHAP Theory matrix.**

The interpretation of the research findings will interact with the ARHAP Theory matrix, with a focus on the quadrant 1 the ‘intangible religious assets’ and their direct health outcomes, together with engagement with other literature. The purpose is to establish the nature of religious assets’ contribution to health and well being.

Quadrant 1 in the ARHAP matrix addresses the intangible religious assets as those which cannot be quantified or seen and yet have such a huge contribution to the health outcome. In the theoretical framework, it was hypothesized that this quadrant in the matrix includes things such as:

- Prayers – praying for the sick, or the sick praying for their own healing
- Resilience –the ability to hold on and believe that good will ultimately come at the end
- Health seeking behavior- the inner convictions provoked by ‘faith’ or religious affinities in health seeking.

- Relationships: care giving- aspects of health which are motivated by compassionate care.
- Responsibility –the role religion plays in guiding life choices.
- Advocacy/prophetic action- speaking against oppressive laws, immoral acts and providing information on health issues.
- Commitment and sense of duty- a call to showing love to the needy and extend a hand to them.

The following is the interpretation of the findings about the contribution of religious assets to health and well being from the research done among the religious health institutions.

### **5.6.1 Finding 1. The holistic understanding of health and its implications on healing**

The finding from both the health givers and seekers, on their understanding of health shows that health is conceived as something that is holistic in nature. The understanding of health goes far beyond the narrow physical life. From the holistic concept, health includes everything that makes humans to exist in relation to the rest of life. According to the healthworld,<sup>148</sup> a concept developed by ARHAP research done in Zambia and Lesotho, health is a multi faceted concept:

A person's healthworld expresses and guides health-seeking behaviour, choices and actions, in respect of illness or dysfunction in health, towards a comprehensive well-being. Culturally and linguistically constituted, spiritual and corporeal, it addresses the condition of the whole body - understood as the ecology of the individual body in relation to the social body under particular material conditions - and thus includes the social and environmental determinants of health.<sup>149</sup>

Looking at the responses from the participants on the understanding of health, the research clearly shows that a holistic understanding and meaning of health has direct implication on health seeking and healing. Health includes the physical, psychological, social, spiritual &

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<sup>148</sup> A detailed elaboration of the healthworld concept is well articulated in a paper by P. Germond and J.R. Cochrane, "Healthworlds: Ontological, Anthropological and Epistemological Challenges on the Interface of Religion and Health", Paper for *Reasons of Faith: Religion in Modern Public Life*, Conference of the Wits Institute for Social and Economic Research (University of Witwatersrand, 2005).

<sup>149</sup> ARHAP, WHO research chapter 4:XIII on '*Translating Religious Health Assets*' - Lesotho research p.95.

economical and relational aspect of human life it is what we call *ubumi* [Bemba].<sup>150</sup> *Ubumi* is an equivalent to *bophelo* [Sotho] which has a wide range of range of meaning and encompasses from biological life of humans, social life of individuals, families, villages and communities. This perception of health is different to and creates a challenge to the traditional or scientific understanding of health and healing.

### **5.6.2. Finding 2. Religion plays a major role by impacting on the agency of health providers and health seekers.**

An important finding on the role of religion in the context of health showed that religion plays a very important role impacting on the agency of health seekers and health providers. In answer to the question on the role of religion in health, it is very clear that religion is perceived and treated as a positive agency that contributes to health and well being of people. It is interesting to observe from the response given by both the health seekers and providers to the above questions in Table 1 and 2 for the health seekers to mention the role which religion plays or serves as a motivation for health seeking and for the health providers to locate the place of religion in their health provision.

The observation from the responses shows that religion is not just perceived as playing a very important role but it is consciously treated as an indispensable entity in health matters. Note for example a response from one of the health seekers when she says that “faith or belief in a supreme being is a central driving aspect of health seeking, because health and religion are both gifts from God, these two are closely related, so when one is sick, there is an inner belief of receiving healing from the giver of health –God, so prayer and hope are consequent results of this belief in a supreme being.”<sup>151</sup> Another response from a nurse at Fiwale Mission clinic says that one thing she has observed in the 18 years of practicing as a Christian health worker at a religious health institution is that whenever patients receive medical attention, they also ask for

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<sup>150</sup> *Ubumi*- [Bemba] refers to total well being that encompasses everything that makes life meaningful and enjoyable.

<sup>151</sup> Fiwale Missions Clinic- response from health seeker in answer to question five on ‘the role of religion to health seeking’.



prayers from nurses. This is so because patients know that the clinic is a religious health institution and so praying for them is perceived as part of the healing therapy.

This perception and attitudes toward health seeking behavior where religion is central, is what makes religion contribute to agency, as the capacity to “do” — to move into action, to utilize the assets in this case ‘religion’ one has, to seek and achieve desired goals and choices in health seeking. The findings show that religion is something that cannot be ignored in health seeking and provision.

Amartya Sen, in his book *Development as Freedom*<sup>152</sup> argues for the application of this ‘agency’ the capacity to ‘do’ in that the afflicted should be allowed to take positive action in their plight in order to contribute in dealing with their affliction. This enables them to play a significant role in the healing process of anything that depresses or undermines the well being of people. Kretzmann and McKnight also echo this concept in their workbook *Building Communities from Inside Out*, on the importance of appreciating the assets and agency that is present in human beings regardless of their state. They argue that the assets the afflicted in this case the sick people have ‘are absolutely necessary, but usually not sufficient.’<sup>153</sup> The findings show that its not just the health providers that have these assets but health seekers as well, this is seen in the confidence these people have in religious health institutions and the role their religious faith plays in health seeking at a personal level.

### **5.6.3. Finding 3. The nature of religious assets and the contribution they make to health and well being of people.**

The study has brought to light the nature or type of religious assets that are engaged in health and well being by both the health seekers and providers. It is clear from the responses given by those who participated in the research that intangible and tangible religious assets positively impact on the health and well being of people. It is worth noting that the value contributed by religious intangible assets is difficult to measure, however the research shows that its contribution and results cannot be missed.

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<sup>152</sup> Sen Amartya. *Development as Freedom*. New York, Anchor books, 2000. p191.

<sup>153</sup> Kretzmann and McKnight, *Building communities from Inside Out*, p8

The very nature of religious assets specifically the intangible ones which are not open to human eye, makes it difficult to appreciate them. However, the research shows the positive religious assets to health, an example from the responses on the question, What value does religion add to health and well being? A range of positive responses to health outcomes were attributed to religious assets, the leading ones had to do with the encouragement religious assets bring in the area of resilience, the moral formation of character which consequently impacts on health, the prayers offered for recovery and a sense of belonging and acceptance in the circle of relationships that express care and love.

This study shows that the strength of these religious health institutions lies in the richness and diversity of religious assets they offer to health outcomes through such assets as praying for the sick, specialized counseling, accompaniment, guidance, fellowship, sharing of love through care and support, material support and support groups such as Home Based Care teams. It is important to note that this aspect of health giving promoted by religious health institutions brings with it assets that are not obvious to the general health systems. The appreciating of the religious assets in health providers and seekers agrees with the theory of assets appreciation taught by Kretzmann and McKnight in their workbook *Building Communities from Inside Out* on the importance of appreciating the assets and agency that is in people regardless of their state. The assets the afflicted or poor people in this case the sick have ‘are absolutely necessary’ to the well being of people.<sup>154</sup>

#### **5.6.4. Finding 4. The religious health entities add value to health and well being of communities.**

Though the presence of religious health entities is not immediately recognized in health systems, this study has shown that the presence of these religious health entities adds a unique value to the well being and health of people. Some of the important findings on the value added to health services by the religious health institutions are, firstly that Religious entities offer voluntary and free services to the community and have ready personal willing to offer services of compassion and care, which is not the practice among the public health system.

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<sup>154</sup> Kretzmann and McKnight, *Building communities from Inside Out*, p8

Secondly, the kind of health care offered by these religious entities is comprehensive and holistic, for example at Isubilo Resource Center, they offer both spiritual and psychosocial counseling to their clients and to People Living with HIV and AIDS (PLWHA). They also provide food supplements to the needy and they have volunteers who have teamed up in HBC groups in order to visit and support those who are bed ridden. The center also has a grinding mill with a subsidy system. They provide school necessities to 250 orphans and have a feeding program to the under nourished babies and supply free water to the community. The public or non-religious health providers do not offer this kind of services. It is this aspect of holistic and comprehensive services which adds value to the health and well being of the community.<sup>155</sup>

Another value these institutions add to health and well being is the presence they provide in the community as religious entities. In other words, the very fact that these institutions are locally based within the communities and are closely related to the people within the community adds value to health. Take for example, Dawn Community Center it is strategically and deliberately located within the community as part of their ethos and objective to be community based and create a presence. The impact of this is that a number of people who in normal circumstances would not visit the Hospital for VCT, find it easier to walk to the center, which is within the community and the atmosphere is caring and user friendly to the clients.

#### **5.6.5 Finding 5. The collapse in the government and mine health service provision due to SAP accelerated a positive appreciation of religious health entities.**

As indicated above, the health reforms in Zambia had a negative impact on health provision in both the government and mine hospitals. As we noted, the SAP led to high levels of unemployment and poverty, and in addition this was also a time when there was an increase in the levels of HIV infections and AIDS patients. During this same period of time the government had declared Zambia to be a Christian Nation, and openly acknowledged the contribution of religious institutions to the well being of society. They had established a desk at state house to address religious matters and provide funding for their activities. This led to the emergence of a number FBOs, particularly to address issues of HIV and AIDS and related problems to do with

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<sup>155</sup> See the response from the Isubilo project manager on the institution's direct contribution to health and well being of the Chifubu community, Table 1, question 7

orphans and widows. This period also saw an increase in the faith healing Pentecostal churches as a response to the health crisis and the general collapse of public health services.

As indicated above the peoples' response to the collapse of public health services due to health reforms and SAP program, especially those from among the poor, started to seek for alternatives health services particularly among the religious health institutions. It is also evident that a number of FBO which were established to come up with multifaceted activities in response to the AIDS pandemic, such as VCT, HBC, orphanages and health educational programs.

It is therefore clear from these activities and responses that there was an increase in the appreciation of the religious health entities toward health provision. The finding shows that the presence of these religious health activities and their contribution has been appreciated most in the recent past and considered as an integral part of health provision.

#### **5.6.6 Finding 6. That there is a perceived strong relationship that exists between religion and health which contributes to total well being of the community**

The research study shows that there is a strong relationship between religion and health and that this relationship is understood to contribute to the total well being of the community. This is clearly articulated from the participants' responses on the relationship that exists between religion and health. The study has shown that when they are sick most of the people turn to God or other Christians, or seek some religious hope for help. One of the participants responded to the question with the following answer that 'there is a strong relationship between religion and health which is inseparable- a healthy body and a sound spiritual life completes the well being of a person, the two are back to back in terms of a person's well being.'

Another aspect in which religion relates to health is on the moral aspect of life. A case in point is the observation made by the coordinator from Dawn Community Center. She points out that if religion - referring to the Christian faith - could be put at the center of all human activities and allow the decisions in a persons' life to be informed by the Christian principles that promote morality, a number of illness related to HIV and AIDS would be prevented and reduced. Here we see the perception of the moral agency which religion contributes to well being, in that it serves

as a deterrent to careless living often leading to people indulging in activities that impact negatively on their health and well being.

Another observation made has to do with the perceived strong relationship that exists between religion and health revealed in the concept of *ubumi* – a belief that is held largely by all the respondents - that religion is at the center of human life. In an African understanding of life, the spiritual world is cardinal to the completeness or wholeness of life and well being. *Ubumi* [Bemba] is an all encompassing concept. This concept is ably articulated by ARHAP research on ‘healthworld’ and as it presents *ubumi* [Bemba] -or *bophelo* [Lesotho] in the three realms of life namely the objective world of propositional truth, a social world of interpersonal relationships and a subjective world of personal experience where religion fits in.<sup>156</sup> Religion is therefore considered as a key element in the well being of human beings and in health services.

#### **5.6.7 Finding 7. Religious health assets - though not usually acknowledged in public health systems - have a positive influence in public health outcomes.**

According to the statistics from CHAZ there are at present 129 health institutions and community based church organizations affiliated to CHAZ representing 16 different churches and church organizations. Together these institutions are responsible for more than 50% of formal health services in the rural areas of Zambia and about 30% of health care in the country as a whole.<sup>157</sup> These statistics clearly show that religious health institutions contribute to the health outcomes of communities. A case in point is that the Fiwale Mission Rural Health center, which was established in 1938, is still the only health center providing health care 45km from Ndola town covering a catchment area of about over 80km<sup>2</sup>.<sup>158</sup>

The personalized health support programs such as HBC in the context of HIV and AIDS are predominantly managed by Religious Entities. The very nature of the work demands compassion, care and love, which describes the call of religious work. The impact of the

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<sup>156</sup> The details in P. Germond and J.R. Cochrane, paper on "Healthworlds: Ontological, Anthropological and Epistemological Challenges on the Interface of Religion and Health", Paper for *Reasons of Faith: Religion in Modern Public Life*, Conference of the Wits Institute for Social and Economic Research (University of Witwatersrand, 2005).

<sup>157</sup> CHAZ ‘*History and activities of CHAZ 2005*’ project proposal.

<sup>158</sup> Interview respondent Fiwale Hills Mission Clinic sister in charge Sept 2007.

religious health assets in this area is slowly being made visible and appreciated by health policy makers. For example the National HIV and AIDS policy has acknowledged this fact.<sup>159</sup> Under article 2.7.4. which deals with Home based care, the policy states that: Home- based care in Zambia is implemented in two ways:

- a) Outreach program initiated by health institutions (vertical programs) that reach out to communities and eventually fuse into community–level activities; and
- b) Community initiated programs (horizontal program). These are quite often initiated by non-governmental organizations, faith based organizations..... Community-based volunteers and support from faith-based organizations (FBOs), religious and health facilities form the backbone of these programs.

The government through the national HIV and AIDS policy also acknowledges the ability and work of home based care providers and the contribution of volunteers in the health services. . In addition to this, the weak linkages between and among health institutions and community home based care programs and activities compound these limitations. The policy document states that ‘home-based care has been found to be an effective complement or alternative to hospital services’.<sup>160</sup>

It is therefore clear that when these religious health assets are leveraged by health policy makers and aligned to the public health systems, they result in a positive influence on public health outcomes in the communities.

#### **5.6.8 Finding 8. Some of the religious health assets found among faith healers – have the potential to be unhealthy to people.**

It is clear also from the findings that some of the religious health assets present among those that practice faith healing can be a source of danger to the well being and health of people. A case in point is the finding from one of the health seekers from Bethel city church. I response to the deliverance practices, the health seeker was made to believe in healing through prayer and asked to stop taking some of the conventional medicine and seeing the medical doctors until he died. See appendix C on the question7. ‘Does your faith serve as a motivation in your health seeking’? Pages 27-28. It is true that whilst a number of people are healed through prayer, it is equally true

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<sup>159</sup> Republic of Zambia, National HIV/AIDS/STI/TB policy 2006.p11.

<sup>160</sup> National HIV/AIDS/STI/TB policy 2006.p11.

that a good number of people are not healed through prayer. It also remains an issue of concern on how some of the religious institutions involved in faith healing operate. The findings show that there is need to create some form of accountability by those religious institutions such as churches engaged in faith healing activities to protect them from abuse and unhealthy practices that can endanger peoples' lives.

## **5.7 Engaging the ARHAP theory matrix on the findings- intangible and tangible assets**

The ARHAP theory matrix presents in the first and second quadrant intangible religious assets and their direct and indirect outcomes on health. The findings from the study show that religious assets contribute greatly to health outcomes although they are often hidden from the eye to see or even to be measured scientifically. The quote from the ARHAP research study executive summary on 'Appreciating Assets' captures this in the following statement:

Though often hidden from Western view, religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives.<sup>161</sup>

The findings when placed in the context of the intangible assets in the ARHAP theory matrix reveals this concept of deeply woven relationship that is entwined in the African values, attitudes, perspectives and decision making which feed the mind in health seeking by people. These assets, though not visible to the eye, make a great contribution to health outcomes and well being.

### **5.7.1 The intangible assets which the religious entities contribute to health and well being.**

As indicated in the findings, religious entities contribute to health and well being through a number of intangible ways. The findings highlight the following intangible assets, which the

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<sup>161</sup> African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa", Report for the World Health Organization, (Cape Town: ARHAP, October 2006).p1

researched institutions contribute to health in their service: prayers and personalized counseling stand out as a common asset - the presence of a chaplain or spiritual leader such as a pastor or psychosocial Christian counselors to give prayers, biblical and specialized counsel. The nature of assets given is intangible and yet rich in the outcomes. The prayers and the specialized counseling provide to the patient or client the resilience, hope, information on health-seeking behavior, motivation to trust and hope for healing and a sense of belonging and acceptance which ultimately creates a positive attitude in health outcomes and the peoples well being. It is worth noting that love and acceptance are virtues that are richly present among the religious entities especially in the context of HIV and AIDS which the religious entities contribute to well being.



### 5.7.2 The tangible religious assets present among the religious entity

Apart from the intangible religious assets, these institutions have infrastructures that create a presence in the community. They also provide tangible things that promote health such as, the buildings where the activities take place. For example Fiwale Mission has a clinic, with admission beds and dispensary; Bethel City church has a special building where the faith healing and counseling activities take place, Dawn Community Center has its buildings within the community where they offer training, counseling and specialized counseling in pre and post HIV testing. The care support groups meet at the center. Isubilo Resource center has converted a former bar into a health, development and training center- the center as indicated in the findings provides food supplement to the undernourished, has opened the center to the community for youth activities such as sport and educational health talks. These are visible or tangible ways in which the religious entities contribute to health and well being of people.

A summary of these findings on the tangible and intangible shows the rich health outcome, which is holistic in nature and appreciates the role religion, plays in health seeking and the value of religious assets in health and well being.

The four quadrants of the theory matrix illustrates the multifaceted response to health matters as is highlighted in the spiritual counseling which produces *–encouragement*, the work of compassion and care which results in *–hope* the giving of awareness and capacity building which leads to *health education*, and the provision of food, shelter, cloths which contributes to *material support*.

Engaging of the theory matrix in this research study has clearly helped to locate the religious health assets and the contribution they make to the well being of people. This also has shown the value and the practical use of the matrix in the area of investigating and locating the religious assets. These findings confirm the hypothesis made by the ARHAP theory matrix and agrees with the findings made by the PIRHANA research in Zambia and Lesotho on the contribution of religion to health outcomes.

## 5.8 Conclusion

This chapter has sought to interpret and analyze the findings of the research noted in the previous chapter. The ARHAP theory matrix has been engaged to locate the religious health assets in the health provision and their contribution to health and well being of society.

It has been established from the interpretation and analysis of the findings that religious entities add value to the well being of people and complement the public health system. It is also observed that religious health entities on several occasions serve as the alternative to the public health system. This chapter has also endeavored to analyze some of the salient issues which have affected the outcome of the study such as the impact of religious beliefs, gender, poverty, literacy, and HIV and AIDS among the health seekers. The main argument in the analysis of the findings has shown that religious health assets add an indispensable value to health portrayed in the holistic manner that encompasses everything that promotes the well being of people and communities. The following chapter will give the Christian theological perspective on the relationship that exists between religion and health and some of the challenges these factors pose on the religious entities involvement in health service.

## CHAPTER SIX

### THEOLOGICAL REFLECTION ON ISSUES IDENTIFIED IN THE STUDY

#### 6.1 Introduction

The study has thus far highlighted the relationship that exists between health and religion from a sociological perspective. This chapter endeavors to present a theological reflection on the study because if it is true that some Christian religious entities are contributing in positive ways to public health then it is important that more such entities are encouraged to do so. Providing a theological motivation for this will be important.

It is therefore necessary to show in this chapter some of the theological grounds that inform these religious entities' involvement in matters of health, healing and social services. Going by the responses to the interview questions on the role of religion in health seeking and to what extent the religion contributes to health seeking, it is clear that there are theological issues that lie behind the activities of the religious entities and health seekers. Alastair Campbell encourages serious theological and biblical engagement in matters of health when he writes that:

Health has both personal and social dimensions, each related to the holistic account of health and illness as the fulfillment or frustration of human aspirations and intentions. These dimensions come together in the concept of health as liberation; setting free which each individual must seek for him or herself but which also requires a transformation of social values and a redistribution of political power.<sup>162</sup>

Campbell shows that health is both a personal and social problem, which demands a holistic response that will call for transformation at individual, social, spiritual, economic and political levels. This study being a social, spiritual and theological in nature, it is necessary to give theological reflection on the study and findings. Four salient theological reflections identified are presented in this chapter; firstly we will discuss the theological teaching on the dignity of human beings – *imago Dei*. Secondly, we will discuss the theological reflection on health and human dignity- . Thirdly, we will look at the mission of the church – the *missio Dei* and the

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<sup>162</sup> Gary Gunderson *Deeply woven roots* Minneapolis, Fortress Press. 1997 p6

challenge of integral mission. Finally, we will deal with the concept of *shalom* and human redemption in the context of sin and as a wider concept which should influence holistic approach to health interventions. We conclude this chapter with the challenge these theological factors pose on the ministry of religious institutions and the government policy makers.

## 6.2 Theological teaching on the dignity of human life – *imago Dei*

Health deals with human lives and anything that dehumanizes the well being of peoples' lives undermines the very essence of life. As we have seen above, the sum total of life encompasses a number of factors that go far beyond what a human eye can see or even prove empirically. In order to understand what it means to be human we need to go back to the beginning of human existence and ask the question –what does it mean to be human? Hans Kung makes a statement that ‘what is truly human and humane is not at all obvious.’<sup>163</sup> Being human is correctly understood by examining the human anatomy in light of the teaching that human beings are created in the image of God- *imago Dei*. Human beings are created in the very image of God and this is what gives them the dignity. Human beings are image bearers of the divine. This image according to Jurgen Moltmann is more than just the spiritual aspect of human nature but the whole of the person. He argues that:

The whole person, not merely his soul; the true human community, not only the individual; humanity as it is bound up with nature, not simply human beings in their confrontation with nature – it is these which are the image of God and his glory.<sup>164</sup>

Looking at Moltmann's understanding of humanity it is clear that humanity can only exist in reality in relation to the rest of God's creation. The fact that the image and likeness of God in humanity has suffered corruption and distortion because of sin, does not rob human beings of their dignity. The presence of sin has deprived humanity the full enjoyment of Gods' intended plan for humanity, but it does not make human beings less human. Sin has impaired and clouded the spirit and mind of human beings, and impacted upon their relationships with God and other

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<sup>163</sup> Kung, Hans. *On being a Christian* ( Glasgow; Fount paperback. 1978) p559.

<sup>164</sup> Moltmann, Jurgen. *God in creation; An Ecological doctrine of creation* (London: SCM, 1985) p 221.

people. However, the mark of God –*imago Dei* - still remains in their lives and it is this that gives humanity dignity and respect.

Therefore, anything that works to undermine the image of God and that dehumanizes peoples' lives such as illness poor health and social structures that contribute to such must be a concern to be addressed by the church and religious institutions. Things such as inhumane economic structures, health policies and public health services, which contribute to the dehumanizing of people, need the attention of the church. The religious health institutions and churches have assets such as networks, advocacy and education, which they should constantly employ in order to give or promote wholesome health.

Health and well being are aspects of life that contribute to the wholeness of human beings and consequently contribute to the enhancement of human dignity. The *imago Dei* is a theological grounding that should inform these religious institutions' involvement in matters of health, healing and social services.

### **6.3 The integral mission of the church in the context of health service – the *missio Dei***

The mission of God in the world is made visible through the integral or holistic mission of the church. The involvement of the churches and religious health institutions in health provision is a demonstration of this integral mission in the world. A brief look at the profile of the four institutions which participated in the research<sup>165</sup>, reveals that the under girding motif in their involvement in health is their commitment to integral mission.

The research study clearly demonstrates the fact that the *missio Dei* is a holistic mission to which the church is called to and commissioned to be an instrument for the transformation of all things.<sup>166</sup> The mission is holistic because it depends on the mission of God, which includes the rest of all creation and human life.

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<sup>165</sup> See chapter 4, 4.1.1 on the Institutional background profile, all of them started with the narrow spiritual response to the salvation of 'souls' until they realised that human beings live in a real world which affects all aspects of life economic, political, social, cultural and spiritual. And the church has to respond in a holistic manner to address the needs of humanity.

<sup>166</sup> Colossians 1:20 'by him to reconcile all things to himself, whether things on earth, or things in heaven' [NKJV-Bible]

There has been a paradigm shift in the call of the church to its mission in the world - a call to holistic or integral mission. The traditional dichotomized vision and mission of the church which was highly influenced by the western world view of the 'secular and sacred' divide, resulting in the tension between 'evangelism and social action', poses some challenges on the holistic ministry of the church.

Thomas Yaccino,<sup>167</sup> gives three biblical warrants for holistic mission and why churches or religious institution should be involved integral mission. First, there is the character of God. The God of the biblical revelation, being both Creator and Redeemer, is a God who cares about the total well-being (spiritual and material) of all the human beings he has made. As we have noted above in the findings of the religious health institutions contribution to health, they as agents of God contribute to the total well being of peoples' lives. The second ground for holism is the ministry and teaching of Jesus. Words and works went together in his public ministry. He preached the coming of the Kingdom of God and he demonstrated its arrival by his works of compassion, love and power. His words explained his works and his works demonstrated his words. Jesus' healing ministry was the visible manifestation of part of his mission in the world. This is well articulated in what is commonly believed to be His missions manifesto in Luke 4: 18.<sup>168</sup> Where Jesus works made his words visible and his words made his works intelligible.

The third biblical argument he gives for holism concerns the communication of the gospel- the good news. The good news was preached through word and deed. God's word became flesh. We cannot announce God's love with credibility unless we also exhibit it in action. Therefore, the church cannot stand aloof from those to whom we speak the good news, or ignore their situation, their context. Yaccino says we are compelled by the love of Christ to enter into their social reality and share in their sufferings and their struggles. At that point our actions themselves become preaching.

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<sup>167</sup> Thomas G.Yaccino, Supporting Information for the Presentation on holistic Ministry: Extension Ministries Cluster Leaders- paper presented at Red Del Camino. May 2<sup>nd</sup>, 2000.

<sup>168</sup> Luke 4: 18 ' The Spirit of the Lord is upon me.. He has anointed me to preach the good news to the poor, to proclaim freedom for the prisoners, recovery of sight for the blind and to release the oppressed'

Steve de Gruchy states that the task of the church in the world is to participate in the *missio Dei*.<sup>169</sup> The *missio Dei* encompasses everything that enhances the welfare of human beings and it is to this end that the church is called to in her integral mission. Issues of health and well being affect the general health of communities and the church has a biblical mandate or warrant to engage in holistic or integral mission in order to address any vices that dehumanize people. Rene Padilla makes a strong statement on the integral mission of the church. He says that,

Biblically, the agent of holistic mission is not a Para-church organization, but a community empowered by the spirit of God<sup>170</sup>

Padilla affirms that the church or community of the redeemed people is the right agent in the world to continue the work Jesus Christ began as God incarnate to transform individuals, political, economic and cultural contexts in which they live to the fullness of life. Health is at the center of human productivity and therefore remains a vital key in human existence and enjoyment of abundant life. The religious institutions involvement in health services is a clear demonstration of the holistic mission of the church.

Bishop John V. Taylor describes this work of the church with a three stand approach that ‘the Christian are called to articulate the gospel through what they say (proclaim) what they are (witness) and what they do (service).<sup>171</sup> This is what integral mission is all about.

The church is God’s instrument that is called to be a community with a mission and that mission is to proclaim the good news of hope in Christ in its holistic or integral ministry. The fact that the church finds itself in a specific social context, placed by God to display the purposes of God in the restoration of humanity, serves as a necessary asset and resource to engage and respond to the needs of community with love, care and healing ministry.

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<sup>169</sup> Steve Degruhy, “Ten theological Theses on mission and development,” plenary address: Micah Africa regional conference, Johannesburg, September 20-23, 2004. p3

<sup>170</sup> Rene Padilla, Mission magazine, editorial volume 62, 2005.

<sup>171</sup> Bishop John V. Taylor. *For All the World*, Holder and Stoughton, Chicago.19966. p40.

#### 6.4 Theological reflection on health, healing, well being and Gods' kingdom.

According to the World Health Organization, health is a fundamental human right. We have noticed in the study that health contributes to well being, which is far beyond the physical aspect of human life. Good health gives human beings a sense of worthiness and acceptance. The direct and indirect health outcomes, which are a result of the activities and services provided by religious health institutions, contribute to the well being of not just the people but also the communities. Anso Kellerman makes this observation on health and human dignity;

If people are well, they will be able to do more, on the productive side as well as socially in their communities. This will increase the level of human dignity and people will feel that they are indeed able to care better for themselves and their families. Because good health enables people to do more, they will be able to use their resources optimally... and their whole standard of living will improve.<sup>172</sup>

It is clear that the enjoyment of human life strongly hinges on the good health of a person. Good health gives an individual the capacity and ability to function productively; it serves as a principal asset that is necessary for good livelihood outcomes associated to human capital. Human capital with all its other aspects has health at the center; good health enhances the greater use of human capital. The absence of good health in human capital leads to poverty and poverty consequently dehumanizes people and cast a dark shadow on the presence of the kingdom of God.

The question is what has theology to do with healing, health and well bring? A theology that is abstract and divorced from the realities of everyday life fails to represent the mission of God in the world. A redeemed community engages in the welfare of everyday life. The message of the kingdom of God is about the things now and here creating a people, a community and nations that are healthy and which live to maximize their potential. This is the message, which Jesus Christ taught and demonstrated in practical terms, it encompassed everything that affects human life- health included.<sup>173</sup>

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<sup>172</sup> Anso Kellerman, 'Health and development' in *Introduction to Development Studies 2<sup>nd</sup> Ed.* (Johannesburg: Oxford University Press, 2000) p186-187.

<sup>173</sup> Luke 4: 18-19. 'the Spirit of the lord is upon me, Because He has anointed me, to preach the good news to the poor, to heal the broken hearted, to proclaim liberty to the captives, and recovery of give sight to the blind, to set at liberty those who are oppressed' [NKJV]



The church is the agent of this message and has a theological basis and mandate to be involved in health, healing and well being of people and communities. The religious health institutions engagement in health, healing and well being is a manifestation of their theological interpretation of the message of Jesus Christ is about the good news to the whole person, which message goes far beyond the narrow 'spiritual salvation' but engages with realities of life and living. Sarah White makes the following comment on doing theology, that theology is more than just an academic exercise but

‘a faith which seeks practical understanding of itself as participation in the reality of God cannot spare itself the trouble of rational grappling with the conditions for a worthwhile human life<sup>174</sup>

It is this understanding of theology that engages the social realities of human life in the context of health and the kingdom of God. The interactive relationship that exist between religion and health as highlighted in the research findings clearly shows that religious institutions' involvement in health, healing and is a demonstration of God's love, care and compassion for the good welfare of people. God's kingdom is present today and therefore warrants the church to engage in things or activities that enhance and demonstrate the presence of this kingdom.

De Gruchy alludes to the concept of the Kingdom of God and the mission of the church in the world that,

‘the church has always lived lived in this time between the resurrection of Jesus and His second coming and the relationship between the ultimate kingdom and the penultimate concerns of this life’.<sup>175</sup>

This is what is referred to as the tension between the 'penultimate' and the 'ultimate', in the ministry of the church in the world.

Dietrich Bonhoeffer in his book on ethics presents the existing tension the church faces her missions in the world, he says that while the church focuses and waits on the future 'ultimate'

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<sup>174</sup> White, Sarah and Tiongco, Romy. "What has theology to do with Development, Peace and Reconstruction?" in Phiri I. A, Ross K.A and Cox J.L, (eds) *The Role of Christianity in Development, Peace and Reconstruction: Southern Perspectives* (Nairobi: All African conference of churches, 1996) p11.

<sup>175</sup> Steve de Gruchy, "Ten theological Theses on mission and development," plenary address: Micah Africa regional conference, Johannesburg, September 20-23, 2004. P4

perspective; it still must face the ‘penultimate’ issues <sup>176</sup>of the here and now. The church has to respond to practical issues affecting the people in the now such as suffering and pain. This is a theological motivation, which serves as a motivation and challenge to the religious health institutions as they work at making the kingdom of God visible in the world through their involvement in enhancing peoples’ health and well being.

## **6.5 Health and well being an expression of the concept of God’s shalom**

Well being is a term that describes the biblical concept of shalom. The meaning of shalom is an inclusive concept that is more than just the absence of conflict or hostility. Nicholas Walterstoff argues that ‘shalom is the human being dwelling at peace in all his or her relationships: with God, with self, with fellows, with nature.’<sup>177</sup> Shalom therefore means dwelling at peace in all our relationships at four levels with God, with environment, with people and with ourselves.

Another theological reflection that emerges from the study is the relationship between direct and indirect health outcomes. We have noticed the broader concept and understanding of well being, that it encompasses everything that makes human life meaningful and productive at all human relationships.

God’s work in the world – the *missio Dei* – is about the work of shalom. Shalom a Hebrew concept is an all-encompassing word. Philip J. Nel<sup>178</sup> says that shalom is about having sound bodily health which results in a restored relationship of human to the rest of all things, such as having social and communal peace between neighbors, parties or nations, and in relation to creation. This is about having restored conditions and relationships with the rest of all creation. In relation to God it is about having people experience renewed relationships with God – commonly known as salvation, which leads to restored righteousness.

The holistic contribution of religious health assets in their intangible and tangible aspects to health and well being of people is what enhances shalom at all levels of human relationships. For

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<sup>176</sup> Eberhard Bethg, ed. Dietrich Bonhoefer-on *Ethics*, New York: Macmillan Co., 1972

<sup>177</sup> Walterstoff, Nicolas. *Until justice and Peace Embrace* ( Grand Rapids: Eerdermans,1983) p69.

<sup>178</sup> Nel j. Philip. ‘shalom’ in W.A. van Generen (ed) *The New International Dictionary of Old Testament Theology and Exegesis* ( Grand Rapids: Zondervan,1997) 130-132.

instance the ‘compassionate and care’ at a spiritual level, the ‘material support’ meeting the physical and social needs and ‘curative interventions’ addressing illnesses and health matters leads to the sum total of what God’s shalom is all about. The engagement of religious health institutions in matters of health and well being is a direct participation in the vision of God and mission of God. Shalom as God’s vision endeavors to see human beings enjoying good life at all levels of relationships and thereby having life in its fullness. The church is called to share and promote the ultimate vision of God for humanity, which is shalom – the enjoyment of one’s relationships with God, with self, with fellows and with nature resulting in wholeness to life.

## **6.6 Aligning of religious health assets’ contribution to public health system for holistic health**

A theological and practical question which arises from the study is what value does the religious health assets add to the general health system. In addition, if there is any value how should we align the religious and health systems in order to have total health outcomes, which represent the concept of shalom?

Health as defined by the WHO ‘is a state of complete physical, mental and social well being and not merely the absence of diseases or infirmity.’ The study has shown that health is more than just the physical health of an individual but includes the whole person, whole community, whole life world, - social, emotional, *spiritual* and cultural of the community. Health as demonstrated in study presents a holistic view of life. Biemba, makes the following observation on the definition of health by the WHO he says that, there has been criticism about the WHO definition, by the inclusion of the word ‘complete’ and omission of the ‘spiritual’ or ‘divine’ element in its definition of health.

This means that it is very difficult to appreciate the value of religious health assets and consequently to align them with public health provision. Biemba argues that “we must however realize that the spiritual realm is ‘invisible’ even if its effects are both visible and invisible.”<sup>179</sup> The study shows that these religious health institutions are contributing to the

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<sup>179</sup> Biemba Godfrey, ‘value added and invisibility of religious health assets’ ARHAP international Colloquium, Cape Town, 2007. p 23

health systems in general and specific terms and yet there is not much leverage into the public health system.

The fact is that religious health institutions bring a unique aspect to healthcare and there is need to acknowledge its contribution in public health policy and systems as a key partner. For example CHAZ has summarized its approach to health care in a holistic approach under five ‘Cs’ namely – *Christian love, care, commitment, cure, and coping*. This is a holistic or total healthcare, to cure where possible, where there is no cure - committed to care and help the client to cope with illness, and consequently share the love of Christ in acts of compassion.<sup>180</sup>

The main argument in this theological reflection is that the church must be an integral part in the culture of healing and health provision in the public healthcare systems. As seen above, most of the Christian health programs in Zambia have institutional connections to the church structures but the participation from the local churches in activities of healing is unfortunately very minimal. Merredith Long argues that since the congregations or churches provide linkages to the community for health education and community health programs, they should be considered as key partners in health provision.<sup>181</sup>

The fact that local churches like Bethel City church *deliverance ministry* has by virtue of its ministry received recognition from the public health services through faith healing,<sup>182</sup> there is need for the public healthcare system to acknowledge and work together in the provision of holistic health. As noted also in the findings that the church provides a wider base of volunteers in health programs and contributes to the of communities, the need to align these activities in the public health institutions remains an issue of advocacy by religious entities for their wider recognition. The unique contribution which religious health entities bring to health and well being necessitates establishing and extending linkages between public health systems and religious health entities. The finding from this research agrees with the ARHAP research in

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<sup>180</sup> Biemba Godfrey, ‘value added and invisibility of religious health assets’ ARHAP international Colloquium, Cape Town, 2007

<sup>181</sup> Long, Merredith. *Health, healing and God's Kingdom*, (Harrisonburg, R.R. Donnelly, 2000). p239-240.

<sup>182</sup> The senior pastor alluded to the fact that some patients have been referred to their church for prayers over specific illness by doctors from Ndola central hospital. This shows the place and role of religious institution in the provision of health.

Zambia.<sup>183</sup> One significant finding is the need to leverage Religious Health Assets and align them with public health systems, for greater health outcomes. This is even more urgent in the prevailing situation of the HIV and AIDS pandemic with its related challenges and diseases.

## 6.7 Conclusion

This chapter has provided a theological reflection on the key issues that have emerged from the research. We have shown in the first place that the *imago Dei* is a theological ground that should inform the Christian religious institutions' involvement in matters of health, and any social services that enhance human dignity. This chapter has also shown that the *missio Dei* serves as the motif for the churches' involvement in health and well being. The mission of God in the world is holistic in nature- working at the transformation of all things. We have also seen how the mission of the church in the world includes an aspect of integral or holistic mission in the promotion of the kingdom of God wherever and whatever it is involved in. This chapter has also shown how religious health assets present among churches' contribute to holistic health outcomes and how these RHAs can be aligned and leveraged to public health systems. The next chapter presents some recommendations and a conclusion of the dissertation.

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<sup>183</sup> African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa", Report for the World Health Organization, (Cape Town: ARHAP, October 2006). See Chapter five- Engaging Religious Health Assets –conclusions/ recommendations. p128

## CHAPTER SEVEN

### RECOMMENDATIONS AND CONCLUSION

#### 7.1 Introduction

This study has examined the contribution local churches and Christian religious entities make toward health. The study has highlighted the relationship that exists between religion and health and the value religious assets contribute to the well being of people.

This chapter concludes the study with recommendations and general conclusion on the role of the church and religious institutions in health with specific reflections on the research objectives and findings on religion as an asset to health. Some recommendations on the challenge of the churches involvement in health arising from the general and specific issues from the research study are highlighted and general conclusions on the study are drawn.

#### 7.2 Recommendations emerging from the study

The recommendations below emerge from the issues identified in the study, which also serve as practical implications of the study.

##### 7.2.1 Partnership between religious health/church and public health systems

Looking at the contribution and value added to health out comes from religious health entities; it would be a wise and beneficial decision for the government to officially partner with the Christian religious institutions in the provision of health. It is a known fact that religious entities render a type of service which is unique and very important, Alick Nyirenda makes a very important observation when he acknowledge that:

Religious groups and their services remain an important source of support and care to several needy communities. After extensive health seeking across different providers, people still find the

much needed shelter, care, and treatment in homes, clinics, provided by religious groups who have the ‘heart’ to serve many bodies, souls and spirits.<sup>184</sup>

The fact that the religious entities render health services to the community and at times in places where government facilities are not even present necessitates the recommendation for formal partnership between religious health/church and public health systems.

### **7.2.2 Prepare Church workers [pastors and priest] and Christian health workers in holistic healing**

There is a great need to prepare Christian health workers and minister of Gods’ word in the holistic healing ministry to embrace a healing that takes into consideration every aspect of human life and not just the physical aspect. Bible schools, seminaries and universities should take into consideration the context in which these ministers go to serve by preparing them in healing ministry that encompasses everything that enhances the well being of the whole person.

Similarly the Christian health workers offering healing services in either clinics or health centers need to embrace a holistic ministry to their clients and refrain from seeing the patients from a simplistic physical bio - medical approach to human life.

### **7.2.3 Develop and adopt new appropriate vocabulary – in health, healing and religion in the Zambian context.**

ARHAP research in Lesotho uncovered the importance of the concept of *bophelo*.<sup>185</sup> In a similar way, this research has pointed to the concept of *ubumi* in Bemba. This calls for developing and adopting concepts about the well being of people that fits or meets the understanding of health and religion. Bophelo [sotho] ubumi [bemba] - is an all encompassing concept which refers to quality of life, sense of coherence and sense of - in other words ubumi refers to- biological life, full human life and social life. This concept fundamentally challenges the western understanding

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<sup>184</sup> Nyirenda Alick. *Interface with Public Health: Plural health systems-the CHEP view* ARHAP international Colloquium, Cape Town, 2007. p 114

<sup>185</sup> Bophelo- the meaning in its broadest sense means life, just like the term *ubumi*-bemba meaning life.

of ‘religion’ and ‘health,’ which is often looked at in a compartmentalized way. According to Germond, the findings on the bophelo research show that:

In Sesotho it is not possible to make a clear distinction between health and religion. Religion and health are key constituent elements of bophelo. There is no bophelo without the full expression of both health and religion.<sup>186</sup>

The complexity of trying to understand health, healing and religion in the Zambia context presents a challenge to the health providers. In order to address this matter, ARHAP has developed a term they call ‘healthworld’ this embraces the total or holistic meaning of *ubumi*-life, which is all encompassing. It is therefore necessary for the health givers to approach matters of healing and well being from this understanding and this will consequently affect the nature and methods of health services that will address health matters appropriately.

#### **7.2.4 Religious entities to focus on an assets based approach to health giving rather than the need driven approach for liberating and transformational health.**

A look at the institutions in this study, namely, Isubilo RCC, Dawn CC and to some extent Bethel City church, there is an element of creating a dependency syndrome on these institutions in the health seekers. The focus is more on the needs, namely the illness and deficiencies in the clients and on how to have these needs met by the health institutions or churches. This is so clear especially among the HIV and AIDS patients who are made to be dependent on these institutions for their survival – reducing the institutions as ‘life support’ systems. The need or deficit driven approach to health services fails to see the capacities and abilities the sick and disempowered people still have to cope, with their situations. It is important for the health institutions to acknowledge these capacities/assets and build on them in their health provision.

The asset based approach to health giving by religious health institutions should work at enhancing the agency of their clients by allowing their voice to be heard even in the provision of health services. Sick persons always bring with them something to improve on their health. This ‘something’ is the ‘asset’ the health providers must be aware of and build on for improved

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<sup>186</sup> Germond, Paul. *Bophelo: Toward a working definition, finding alternatives to the words ‘religion and ‘health’* Draft document paper-ARHAP Lesotho. 2005.p7.



health. This approach to health provision, promotes the dignity of human beings and respects the agency and assets present in the life of a sick person when they are considered as partners rather than just objects needing help. The ultimate goal in health provisions should lead to liberating and transformational health in the seekers lives.

### **7.2.5 Need to create organs within CCZ, EFZ, ZEC to monitor religious health institutions engaging in faith healing.**

As observed above there are some unhealthy contribution which religion and religious health activities contribute to peoples' well being especially among faith healers. It is therefore needful to establish watchdog organs in the mother body religious institutions. These would help to monitor activities among churches and religious health institutions engaged in faith healing. This would create a platform for checks and balances to help avoid unhealthy practices that may be in conflict with the generally acceptable medical health standards and procedures.

### **7.2.6 Integral mission a challenge to the churches today**

The calling of the church in the world is to work at improving the quality of human life and all that God has created. Gunderson in his book "Deeply Woven Roots" makes a bold statement that the congregations are there to help shape communities; he says that:

The church does not choose its own future. Rather, it is formed in the creative tension between the actuality and intentions of God. God intends the renewal of the whole world. Congregations are the tool for that greater purpose, not themselves the point.<sup>187</sup>

The challenge of the church today is to respond to the needs of the whole person with the whole gospel. This response demands that the church, in particular the evangelicals, commit themselves to integral mission and be able to communicate the good news through everything it is, does and preaches. Furthermore, it is also important for the churches to engage in advocacy work for the sick on those matters, which contribute to poor health such as lack of good access to water, sanitation, the non-availability of ARVs in some of the dispensing hospitals and high user fees for the poor.

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<sup>187</sup> Gunderson, *Deeply Woven Roots*, p1.

The purpose of the church is to incarnate the values of the kingdom of God and witness to the love and justice as Christ revealed it in order to transform human life in all its dimensions, at a personal and community level. The current health issues in Zambia demand that the church revisits its understanding of mission and contextualizes it to meet the challenges of the day including the issues of health.

### **7.3 Conclusion of the study.**

The study has shown that Christian religious entities and faith healing local churches contribute positively to health outcomes and therefore play a vital role in the well being of communities. The purpose of the research was to investigate the churches' direct contribution toward health and to establish how religion functions as an asset to well being of the people.

The study has analyzed these factors and shown that there is a strong relationship that exists between religion and health and that the consequent results work at enhancing peoples' well being. We have also established the invisibility of some of the religious assets, which produce visible results in health outcomes. In addition, we have established the need for the public sector to align and leverage these Christian religious assets in public health systems for holistic healing. The study has also shown the wealth of resources found among religious health institutions, most of it operating from a different premise to health care and service namely a response to the call of God as an expression of His love, care and compassion to the sick and dying.

The findings from the study leave a challenge to the health policy makers and to the public health service in Zambia in the area of partnership in order to complement each other for improved holistic health outcomes.

The study has also established that the ARHAP theory matrix is a workable framework to engage in the establishing and locating of religious health assets in churches and religious institutions in the context of health provision.

Finally, future research and investigations can be done on how to incorporate religious health assets into the public health institutions as an integral component in health provision. The study has shown that Christian religious institutions have essential intangible assets that contribute to health outcome. Some of these assets are absent in public health sector. Therefore, the call is to create accepted synergies between the bio medical and religious assets to health provision, because human beings are more than just biology when it comes to matters of health and well being.

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## APPENDIX A

## Interview Questions used in Data collection

Two sets of questions were used one for health providers and another for the health seekers. These were used to gather data on the churches' contribution to health on the Copperbelt as case studies to explore the understanding and relationship that exists between religion and health.

**A. For the church leaders and/ or religious health institutional leaders.**

1. Personal introduction, name [only if it is okay with the interviewee], institution, position held, and responsibilities.
2. What is your understanding of health?
3. Is well-being and health the same thing? Explain your answer?
4. What does religion mean to you?
5. How would you explain the relationship between religion and health?
6. Can religion be at the center of health? Why, How?
7. Can you identify what you perceive as religious assets in your health activities?
8. What would you describe as your institutions' direct contribution to the health and well being of people on the Copperbelt?

**B. For the health seekers.**

1. For how long have you related with this health institution or church?
2. Why do you consult this institution? Does it make a difference that it is religious? Why?
3. How would you define health?
4. What is your understanding of well-being?
5. Is well-being and health the same thing? Explain your answer?
6. Does your faith serve as a motivation in your health seeking?
7. Do you see any relationship between religion and health?

**APPENDIX B****Consent form for Health seekers and health providers****‘INFORMED CONSENT’****Introduction**

My name is Kabwe Maybin. I am undertaking research towards my Masters Degree at the University of Kwazulu-Natal in South Africa.

This informed consent is a voluntary agreement to participate in a research study in the field of ‘Religion and Health.’ This particular research seeks to examine and explore how Churches’ and Religious Health Institutions function as assets in their contribution to the health and wellbeing of the people on the Copperbelt.

The duration of your participation in this research exercise goes only as far as the time you offer in answering to the interview schedule question related the subject under research.

I/we \_\_\_\_\_ [*name(s) and surname(s) of the interviewee(s)*]

have been approached by \_\_\_\_\_ [*name(s), surname(s) and affiliation of the interviewee(s)*] for an interview and state what follows:

1. I/we have been fully informed of the reason for the interview to be conducted. Yes / No
2. I/we have been informed of my/our right to withdraw from the interview at all times. Yes / No
3. I/we have been informed of the use to be made of the tapes, transcript or notes of this interview. Yes / No
4. I/we have been informed of my/our right to receive a copy of the tapes, transcripts or any other account of this interview once the research has been completed. Yes / No
5. I acknowledge that the interview material is to have the following status:
  - a) Accessible to all without restriction Yes / No

b) Accessible to all after a period of \_\_\_\_\_ years Yes / No

c) Accessible only with written permission from \_\_\_\_\_ Yes / No

d) Only accessible to the interviewer(s) for the purpose stated to the interviewee(s) Yes / No

I acknowledge that the interview material may be catalogued and stored at \_\_\_\_\_  
\_\_\_\_\_ [name and address of the repository ] for release to the public,

under the conditions of the status that I have stipulated [optional] Yes / No

I/we have been informed that should the interviewer(s) use the interview material for  
publication, I am/we are not entitled to any financial gain from the proceeds of publication. Yes / No

I acknowledge that should the interviewer(s) wish to use the interview material for any  
reason other than that of cataloguing, release and publication that the interviewer(s) is/are to  
secure my/our written permission to do so. Yes / No

Contact details of the interviewee(s)

Name(s) and surnames (s):

\_\_\_\_\_

Address:

\_\_\_\_\_

Phone: \_\_\_\_\_ E-mail:

\_\_\_\_\_

[please write in capital letters]

I/we hereby agree to the above stipulations of this release agreement in conjunction with the  
interviewer(s)

Interviewee(s)

Date: \_\_\_\_\_ Signature(s): \_\_\_\_\_

Interviewer(s)

Date: \_\_\_\_\_ Signature(s): \_\_\_\_\_

## APPENDIX C

Detailed narrative report from the interviews:

### **Question 1. WHAT IS YOUR UNDERSTANDING OF HEALTH?**

#### **Responses from: Bethel City church- Pastor**

From my own understanding, health has to do with both the spiritual and physical aspect of life; it encompasses a lot of elements, the well being of a person, physical condition of a person such as fitness can be termed as health- which is the whole being of a person's physical and spiritual life.

#### **Bethel City church- Pastor [counselor/ minister]**

Health is a very difficult thing to define I am saying so because of the various cases I have encountered in my work in the area of deliverance. Health is best described as an issue that affects human life in the total well being of a person in relation first to his/her body fitness including the mind, body and second to the state of soul and spirit. This fitness is understood in relation to the immediate environment of one's sphere of influence and operation.

#### **Bethel City church –pastor**

I understand health as a minister of the word as something, which is holistic, the total well being of a person this includes cultural and environmental aspects as well as the spiritual life.

#### **Bethel city church – health seeker**

For me, health means being well in my physical, emotional and mental life. You see right now I am not working I am on sick leave because of poor health. It's my body which is sick but my mind is okay so health includes everything that makes a person to function properly. You cannot separate these issues. Health for me means life and being well or okay in body.

#### **Bethel City church- health seeker**

Health for me is *umweo* [life]; it means being fit in my body, having no problems in my relationship with people and enjoying life with no or less stumbling blocks.

#### **Bethel City Church- [Health seeker]**

Health is a state of having no diseases and having good food and sound mind. You see my perception of life as someone who has not been well for some time has really changed. Just having a life is more than health it includes everything that makes life to 'tick' to have a meaning and profitable purpose.

#### **Dawn Trust Community Care- [Center Coordinator health provider]**

As a Christian or religious organization, we offer a holistic approach to our clients, what we mean by holistic is that which includes the well being of an individual namely the physical, mental and spiritual. We engage not only the physical and material problems but also the spiritual problems of a person. We understand that a person is not made

up of independent segments but seen as a whole; therefore our approach is holistic in nature. When a person is healthy we say that his/her body is functioning well without any disturbance or pain or physical dysfunction.

**Dawn Trust Community Care- [Chaplin –health counselor/ provider]**

The word health is a wide word but in my understanding it involves all situations of life and living such as conditions, environment or state in which there is at least a good human health, at physical, mental and spiritual, and soundness of economic living in a community. Health is more than just absence of illness but it includes the capacity and availability of people whereby they are able to meet their needs in every area of their livelihood.

**Dawn Trust Community Care – [Health seeker]**

Health has to do with the physical fitness of a person, in Bemba it is what we may call *ubumi* [healthy] that's the general outlook of a person were there are no sicknesses in the body.

**Dawn Trust Community Care- [health seeker]**

Health for me is *ubumi* it means someone's life where there are no risks and complication in ones life is at all levels of life. If someone has no *ubumi* then the well being is not okay and the life is being threatened.

[What then is the difference between *ubumi* [well being] and *umweo* [life]? I think there is no difference because when there is no *ubumi* then there is no *life*. For me the two are the same, there is no difference but one and the same thing. I am speaking from personal experience, when I was sick and bedridden for three months I could not do anything though I was alive 'had life' alive but not of any good, I cannot not say I had *ubumi*, although I think *ubumi* can be more than just good health.

**Dawn Trust Community Care- [Health seeker]**

Health means having a life without or with fewer problems in terms of the body's fitness, functioning or well being. I think health of an individual has to do with having balanced good diet, clean and sufficient water and good sleep that is the way I understand good health apart from this there is no health.

**Fiwale Hill Rural Mission Health Center: [Nurse in charge -Health care provider].**

I understand health as somehow a sense of well being, whereby a person enjoys physical, spiritual, emotional and mental soundness, health for me includes the whole person in his or her totality. You know a person may look very okay and yet not experience true meaning of health. Sometimes you may find that people who are physically handicapped 'lame' may experience good health- because they have the essential things that make up good health. For me health is what makes a human being live and enjoy life able to do what he/she desires to do.

**Fiwale Hill Rural Mission Health Center: [Nurse Health care provider.]** Health means a person with no diseases, but also some one who is psychologically, spiritually and socially living in harmony with the rest of the people and the rest of all creation. Although it may be broader in medical terms but that's how I understand health, it is the condition of some ones life in the context of the rest of other lives.

**Fiwale Hill Rural Mission Health Center: [Chaplin- health care provider.]**

Health to do with the state of a person's well being, covering both the empowerment of the surrounding environment that takes into account the issues of hygiene and state of the body. The state in which, the body functions well. In my mother tongue – Tonga we say

*'kuba abumi bubotu'* the understanding of this includes everything that makes a human being function at his or her best with no or less encumbrances.

**Fiwale Hill Rural Mission Health Center: [Health seeker.]**

Health means being physically fit in body and mentally stable in mind and functioning well as a normal human being not incapacitated in any way.

**Fiwale Hill Rural Mission Health Center: [Health seeker.]**

Health to me means having a free mind free; free from anything that makes life difficult. It involves having a balanced diet, free from life threatening illnesses. I am saying threatening because none of us is free from illness, people experience illness these are part and parcel of life. Health relates to the well being of a person in terms of physical fitness and enjoying life as a human being. Health is what one would call *ubumi* in Bemba. In fact there are many people who look healthy but are not well in their inner being.

**Isubilo Community Resource Center [Health provider -Coordinator]**

My name is G....., I am the coordinator of the center and also the spokesperson. I oversee all the activities. Isubilo Community resource center (ICRC) has a number of activities which run as supporting entities to the overall running of the center. We have Home based care (HBC) this is the core activity of Isubilo, the other activities came up as a result of the HBC program we saw the needs in these homes and so we opened up the Orphans and Vulnerable Children (OVC), and in order to supplement Agricultural department to support back yard gardens and a specialized clinic for our clients was established to suit the type of client we have –who are HIV+ the clinic and we also have a grinding meal, the mill has reduced the expenditure of buying maize meal by half the prize. The meal serves the rest of the community as well.

Isubilo was born out of a passion to contribute to the welfare and well being of the people in this community, our catchments area is Chifubu, Kawama and Pamodzi we are speaking of a population of about 160 000+ people. Our passion is to see poverty reduced and the health of the people improved. A lot of people were suffering so came about to give hope-Isubilo as the name means 'hope' was born to give hope to the people to encourage the people that all was not lost we are here to care and give hope.

**What is the meaning of health –[ Coordinator]**

To me health has a lot of component around you need a good state of mind and well being that cannot be achieved if nutrition is lacking. Health is more than just being in sound state but includes a state of mind that is physically okay and this is best achieved through good nutrition and good livelihood. In short it is having a sound mind and not sick in body and in the inner being of a person.

**Isubilo Community Resource center [Community mobilization-coordinator]**

My name is I....., I am in charge of community mobilization, coordinate the OVC, in charge of Stores as supervisor, I am a social worker and I am also a psychosocial counselor. I also go into the community and teach some mothers on how to run their homes in the area of hygiene, nutrition and also in anything that will bring development in the livelihood of people. I also participate in the development of backyard gardens so that people become self reliant and not dependent on Isubilo.

**What is your understanding of health?**

Health I think has to do with the mind it does not just end up with the physical but there is a psychological, component to health, health is more than physical, but social and spiritual- as well in Bemba it is *Ubumi bwamuntu*- other needs-somebody to say I am in good health it means they are in good mind is clear comfortable they are able to eat well they are not sick general all is well.

**Isubilo health seeker [female Positive living]**

For me health means one who is not sick but enjoys good health, being fit, fat, eating well, good water system, having good shelter and a nice place to sleep on all this makes up good health.

**Isubilo health seeker [female Positive living]**

For me health means one who is not sick but enjoys good health, being fit, fat, eating well, good water system, having good shelter and a nice place to sleep on all this makes up good health.

**Isubilo health seeker [male Positive living]**

Health is *ubumi ubusuma* whereby a person has no sickness and is fit to do all that he or she wishes to do with fewer limitations. Basically not sickly. For me I look healthy but there are certain things I cannot do, I have lost my job because of being sickly so I am not healthy

**2 Understanding of the concept of well being and health**

The following question intends to explore the understanding of the concept of well being and health whether these are the same or not. This question also intends to investigate the unnoticed relationship and conceptual frame work that exist in the power of concepts such as the holistic meaning of term health.



**Question 2. IS WELL BEING AND HEALTH THE SAME THING? EXPLAIN YOUR ANSWER?****Health provider: Bethel City Church**

To me, I would say, yes and no. Yes, they are one and the same thing, when we talk of health we are dealing with a human being as a whole; we cannot separate the two that is physical and spiritual. So when we talk of health we are dealing with the physical fitness of a person, which is directly related to a person's well being. Health will deal with the aspects of having sickness in the body, from the way I look at it, that person is not health, in the sense of physical fitness.

When we talk of well being, we are referring to such things as are more than just the physical fitness, we talk of the financial well being, the moral aspect, the emotional the economic welfare in general – in Bemba it is what we call '*Ubumi*' Like I said, there is a very thin line between the two, in terms of physical fitness one may be okay but in moral aspect they may be in a crises and this directly affect their well being.

**Health seeker: Bethel City Church**

I understand well being as incorporating everything that makes a person exists in a normal way; apart from a sound good health we also need other things for our livelihood to make life complete and manageable, that is what well being means. It also includes the economic and spiritual aspects of life. Right now I am on long sick leave and my company pays me only half of my pay. This is also affecting my well being and health because lack of sufficient money means limited access to good health services. You know it is a complicated matter when you talk about well being of an individual it is not that easy, especially when one is sick like me. When someone is not sick in body it is easy to talk about health but not when you sick I am.

**Health seeker: Bethel City Church**

Well being is more than just being fit or being health it includes everything that makes my life and health survive in a more relaxed and rewarding manner. Health goes far beyond myself but touches the welfare of other people.

**Health provider- Dawn Trust community Care**

As a Christian I understand that well being does not necessarily depend on health, a person can be at peace in the heart and experience well being even in times of sickness, I am saying this because the most important thing in the life of a person is the inner state of a person, therefore well being and health are not the same thing, health has to do with the physical fitness or the well being of the body. On the other hand, well being is all inclusive in its understanding. It is therefore possible to experience well being even when the body may be sick. Well being is more than health though health is part and parcel of well being.

**Health provider- Dawn Trust community Care**

They are not the same, however there are some similarities; you see to be health does not mean a life absent of illness at all. You can fall sick while enjoying a healthy environment that gives you satisfaction in life.

Well being is a general term that covers a broader picture of life, in which a person has a livelihood in things such things as being a business person, politician religious minister and the like, this is where well being is found it is in what gives a person a livelihood.

The difference between health and well being comes in the fact that, in well being it is more of what gives an individual meaning and purpose of life, in such circumstances there is generally a lengthy period of no illness or /and any other that make life difficult. This kind of situation makes life affordable and enjoyable.

Health for me in my mother tongue is *kuba kabotu* [Tonga] this in a narrow sense refers to the condition of ones physical state. While well being means *bumi bubotu*, this is more than mere physical health but involves everything that gives life a meaning. The difference lies in the fact that *good* health extends to socially, economical and spiritually enjoyment of life. Well being is mainly centered on an individual or on what a person owns.

I think one can enjoy well being while she/he is sick in body, for me well being has to do with a persons' livelihood how is she surviving in life.

#### **Health seeker- Dawn Trust community Care**

Well being for me means *ubumi* [that which gives life meaning] that is when one is completely okay this includes health and other things such as food, shelter and off course money.

#### **Health seeker- Dawn Trust community Care**

Well being for me consist in the complete harmony of a person this includes things such as food, shelter, clothes, money and a good health. I think well being is more than health, though health is a part of well being. Let me just explain what I mean, one can be sick of malaria but still have *ubumi*-well being. [Is it possible to be bed ridden and still enjoy *ubumi*]. No I do not think so, [why] because *ubumi* includes sound health.

#### **Health seeker- Dawn Trust community Care**

Well being is just like *ubumi* although there is a slight difference, depending on the situation of an individual. For example when someone is sick his or her health is not well and consequently the well being is affected. This is so because a sick person cannot do certain things his/her physical outlook may be well but the inner person the body frame work may not be in a position to do certain things. However, the fact that the person is alive, we can say at a different level that the individual has *ubumi*, which may be the same as having life- in him or her.

#### **Health provider – Fiwale Hill Mission health center**

I do not think so, although some how they can be the same thing, if we include all the things I have mentioned above. In my mother tongue that is Tumbuka from Eastern province well being means '*tilimakola*' it is more than just being well in body. When we speak of health, the focus is on the condition of the physical function of the body, while well being includes the whole person, this deal with how I am fairing in my life in general and specific terms related to my clinical fitness. Just to give an example I might not have any illness in my body but if at home there is

fighting and no harmony, the absence of this peace is a threat to well being – sometimes life is not enjoyable, because of some emotional disturbances. In terms of physical fitness things may be okay but in terms of well being, I may lack the essential ingredients that make life meaningful.

**Health provider – Fiwale Hill Mission health center**

I think health includes well being, we can say a person is enjoying well being when there are no encumbrances related to psychological, physiological and spiritual. It is the out come of a good health plus other things that make well being and life to be nice and enjoyable, having very little worries or concerns things such as food, shelter, sound mind etc.

**Health seeker – Fiwale Hill Mission health center**

Well being involves the complete person, whose body is in good condition and is functioning well, whereby the body, soul, spirit and mind are in harmony. Well being includes also on how a person relates to the rest of society and God's creation. I think it is more than just what an individual enjoys but more on how the individual relates to the rest of the things and people that make life meaningful.

**Health seeker – Fiwale Hill Mission health center**

Well being is different from health let me explain where I see the difference, well being has to do with me meeting all my material and social necessities of life. Health has to do with my physical well being restricted to a life that is not sick or sickly. Well being includes good health.

**Isubilo CRC – health provider**

A person can say I am health, but not have what one would say a good well being. Well being is more than just having a good health. When a person is said to be enjoying a good well being, that person has a free mind, no worry having no complaints. Well being is more than just yourself being okay, but it also affects those around you and everything about you – it is related top other issues, in fact none of us can say we have or can completely enjoy perfect well being because it is relational.

**Isubilo CRC – health provider**

It depends on what one is looking at. The benefit of being health brings the enjoyment of well being. I think health precede well being, well being includes everything that makes a human being live well, the physical, mental, spiritual economical social and environmental soundness make up well being. Its what in Bemba we would call *ubumi ubusuma* - complete welfare of life with no worrying concerns.

**Isubilo CRC – health seeker**

Yes they are although they differ in terms of degrees of enjoyment health may be limited to physical well being, whilst well being may include health plus other things which make life become more meaningful and enjoyable.

**Isubilo CRC – health seeker**

For me health is a prerequisite to well being, when one is in good health he can try to have some well being depending of what he is able to do, so these two are different but related. For example when you are constantly sick you lose the job and your well being is affected.

**Isubilo CRC – health seeker**

No they are not, look at me I am on ARVs I have to live on these medicines I may look health but I do not think my well being is okay because it is more that just enjoying good health but also involves my mind, spiritual life and all surrounding things that make life enjoyable I do not have those these though my health looks okay outwardly the two are not the same.

**3. Understanding of religion**

The purpose of this question is to investigate and establish the understanding of what religion in its generic sense is perceived by the health providers and health seekers, and the role it plays in their service provision as health providers and health seeking as for the patients.

**Question 3. WHAT DOES RELIGION MEAN TO YOU?****Health provider- Bethel City Church**

As a Christian, I understand it as the spiritual aspect of any human being. There is a spiritual aspect in every human being regardless of his or her religious belief and affiliations; it is this spiritual aspect that constitutes religion. For me, religion means life as a Christian

**Health provider- Dawn Trust community Care**

Religion for me can be anything- it relates to having a belief in some greater being. But as a Christian, religion means having a relationship with God through faith in Jesus Christ as savior and Lord of my life. I think that when a person has a relationship with God, this gives a person an added perspective on the well being. This relationship is the most important component of life because it gives someone a special peace, which in fact helps one to endure times of afflictions. Religion then means having a relationship with God in Christ Jesus.

**Health provider- Dawn Trust community Care**

Religion simply means what one believes in and that object of belief has influence in and over that persons' life.

**Health provider: Fiwale Hill Mission health center**

Religion means a lot, depending on the understanding and experience of an individual; it is a general word often related to any form of belief or relationship with God some higher being or some deity, depending on a person's beliefs and religious experiences. For me the way I look at religion is different, as a Christian, religion has to do with a person having a conscious relationship with God and living by faith based on that relationship everyday. This

involves having a personal encounter with Christ Jesus, whereby a spiritual change occurs and affects a person's perspective, beliefs and practice on life in general and specific terms.

In specific terms being religious involve having some form of 'faith' in God.

**Health provider: Fiwale Hill Mission health center**

Religion means a set of acceptable beliefs which influence human behavior and thinking. For example as a Christian, I believe religion has to do with accepting Jesus Christ as personal savior and join oneself to a community of people who support and pray for each other and follow certain commands which rule life and relationships

**Health provider: Fiwale Hill Mission health center**

Religion means having a belief in some higher being which you choose voluntarily to pay homage or respect. This is done when a person expresses some kind belief, in a divine being and that being is venerated or worshipped.

**Health provider: Isubilo Community Resource center**

Religion is like an ideology whereby someone puts his or her belief in something or some one which affects his or her perceptions and practice in life. This is why we have so many religions

As a Christian my understanding of faith in God means believing in the eternal existence of the God of the Bible and exercising faith in the unseen but hoped for.

**Health provider: Isubilo Community Resource center**

Religion is something one believes in and stands on it in life and practice. As a Christian, religion to me means having a relationship with God through Jesus Christ.

**4. Understanding the relationship that exist between religion and health**

The question on the relationship between religion and health intends to establish the knowledge which the health providers and the health seekers have on the direct and indirect outcome of health contributed by religion.

**Question 4. HOW WOULD YOU EXPLAIN THE RELATIONSHIP BETWEEN RELIGION AND HEALTH?**

**Health provider: Bethel city church**

I believe there is a strong relationship, the two cannot be separated, a person maybe healthy but his or her spiritual life may not be up-to-date that person may not function well maximizing his/her potential because life is both spiritual and physical.

Take for example the ministry of Jesus Christ; His ministry combined the two, the spiritual that I call religion and the physical. For example in Matthew 9:30-35 – Jesus attended to both the health, healing people of their sickness, diseases and the other afflictions. In terms of religion, he felt compassion thereby communicating one of the

attributes of God which is love. Another example is when he fed the 5000 people, eating is part and parcel of health so he gave them physical food to eat, this is about health aspect of life, after giving them the spiritual food. There is a very strong link between the two.

**Health seeker: Bethel city church**

Yes I do, in fact during this time I have been sick that's when I have noticed that ones faith or relationship with God matters a lot, life becomes meaningless when one is bed ridden most of the time I am in the bedroom just thinking about my life and what will happen when I die, there are so many fears, you see, questions such as who will keep my children when I die, my wife does not work. The kids are still young in primary school. So somehow God becomes the only last and dependable hope. For me religion and health are a reality and there is definitely a relationship.

**Health seeker: Bethel city church**

My faith relates to my health just like my life cannot survive without food, faith or religion to me is like food to my body. The relationship I see between religion and health is that the two always coexist- and are important to a normal existence of any human life.

**Health provider- Dawn Trust community Care**

I think that a person who is a believer and living a life that is in a sound personal relationship with his/her maker will experience sickness in a different way, this relationship or faith in God gives such a one the abilities to endure and stand firm amidst illness or crisis. There is hope and resilience in such a person and it creates a good condition for quick improvement.

So there is a relationship of some kind between faith and health. *[Can you explain further]?*

You know when a Christian is sick, he/she can pray to God for healing and if it is the will of God, a person can receive healing. Personal faith also helps an individual not to get depressed easily when some one is ill, the person will have hope and exercise patience to go through the times of sickness and weakness in the body. I believe that in order to restore the body to its proper health and sound state, relationship with God is necessary.

*[What about those who are not Christians, don't they have other alternatives?]*

Someone who is not a Christian will struggle a lot when sick; usually such a person has no enduring hope. They usually lack strength and confidence to go through sicknesses and suffering, they are easily depressed. Very often their alternatives are in the negative way. For some they would want to know not just what has caused the illness, but who has caused it and so they resort to consult witch doctors and some traditional healers. This is common among the non Christians. The process of illness is often full of despair and troubles, which result in the absence of hope and resilience.

But those with faith or religion are convinced of course with good counseling and support that the Lord is with them even in sickness and also have brothers and sister to support and encourage them during sickness. They also have a church behind them to pray for their healing.

**Health provider- Dawn Trust community Care**

Definitely there is a relationship, in the sense that religion in the first place is a basis on which one exercises some faith to believe in something. There is faith that reaches out in religion, it times of sickness a person has some faith in whatever he or she is doing for the purpose of getting well there is some kind of reaching out to some outside help. For me this is a relationship that I see that exists. Many people in my community would resort to some religious activity.

**Health seeker- Dawn Trust community Care**

Yes there is a relationship, religion or having faith in God has a direct effect on some ones health for example in my case I was not a Christian not until I came to DAWN before that my health or my sickness was solely dependent upon the doctors and nurses. But after I become a Christian all things changed, I had hope that things will change. Prayer has become an important component in my illness and the assurance that God would make everything well. I think the issues of hope and faith in God are related to health. I would say the two are closely linked together. There is no way I can divorce health from religion, for me the true meaning of *ubumi* - well being incorporates religion, health and everything that gives life meaning.

**Health seeker- Dawn Trust community Care**

Religion plays a very important role for some one to experience holistic healing it is a known fact that every person has a deep rooted spiritual component seated within the inner person. This aspect of a person is very important to the well being of a person.

Religion also helps one to manage his or her life especially when one is HIV positive living like me. Religion plays a very important role, it gives or creates a basis for hope and resilience and patience to endure during sickness. I see a very strong relationship between religion and health the two go together, when someone is sick, they often resort to God for healing or some high being for help. Especially here in Zambia people are so religious that anything that happens to an individuals health is connected to some spirit or spiritual powers- you see this is normal no wonder many people especially those who are not Christian resort to witchdoctors and witch finders for deeper understanding of the cause of illness.

**Health seeker- Dawn Trust community Care**

For me these two go together I am speaking this from a point of view of some one who believes in God and have experienced how my religion has strengthened and kept me in times of sickness. Religion and health go hand in hand. Human beings are made up of body and spirit, the spiritual aspect is what relates to religion in times of sickness or trouble, the body is the part and parcel of the whole person, which directly responds to health or physical matters. Religion for me is at the center of all human activities.

**Health provider- Fiwale Hill Mission Rural Health Center**

There is a very clear relationship; the relationship that is there is often seen in the circumstances when some one is very ill. On thing I have observed in my over 18 years of practicing as a health worker and as Christian working at a Religious health institution is that whenever a patient receives some medical attention they also resort to religion for help, this could be either trusting in some traditional/ ancestral spirits or even in some form of religious beliefs, people would ask for prayers from us as nurses because they know that this is a religious health institution praying for them should be part of the healing therapy.

This for me is a very clear indicator that there is a relationship between the two things. In fact true healing involves the spiritual component of a human being. I am saying this because on several occasions we have some patients who come to the health center with all sorts of unexplainable illnesses, however, with specialized counseling we have often discovered that some of the people only needed specialized spiritual counseling and prayers and no physical or clinical treatment. So often, the burdens which manifest in physical illness are dealt with from a spiritual point of view. This is why I would say that religion and health are somehow related I mean religion in the sense of ‘spiritual’ aspect of a human being.

**Health provider- Fiwale Hill Mission Rural Health Center**

When we speak of religion as a Christian, the relationship that exists between religion and health is very clear. As a Christian, when the health or well being of a person is affected, religion or the Christian faith engages certain values or tools, such as prayer, the word of God for comfort, hope for healing, care from other Christians I mean love in exhibited in practical terms to the sick. I think all these are things needed when someone is not well.

I would say that the values or activities involved in Christianity helps one to pull through in times of sickness, stress or when going through other problems in life that threaten the persons well being. What I can say is that religion lightens up health issues from every angle and religion for me sits at the centre of every human problem.

**Health provider- Fiwale Hill Mission Rural Health Center**

In religion, there is a central focus that makes it to be a reality that is the object of worship. Similarly in health there is something that is at the core of human existence that responds either positive or negative to religion depending on the circumstances. In a time of a crisis especially if it has to do with health, religion or faith some how resurrects and becomes very active. So I think faith cannot be divorced from health. You also know that health has to do with my whole being, and the whole being is where faith rests and operates, there is definitely a clear relationship.

**Health seeker- Fiwale Hill Mission Rural Health Center**

There is such a strong relationship, in fact let me make a bold statement here, for me human existence is equal to health and health is life. Yes the levels of soundness of health may vary from person to person but as long as some one is alive there is some kind of health present. Similarly religion and health are inseparable in my understanding,



God is the one who ultimately provides health, yes human beings may play some role in the well being of their health, but God blows the final whistle when it comes to human life. So religion and health are closely related in their operations. Human life is made up of body and spirit these respond differently to matters of health and are equally important if sound health is to be maintained and enjoyed.

From my personal experience as a Christian who has struggled with illnesses for the past 7 years I can from my heart confidently say that my faith has greatly helped me in my health matters. I have many times pulled through many sicknesses because of my faith in God, some hope and inner strength within helps me pull through in times of sickness.

**Fiwale Hill Mission clinic [health seeker]**

The relationship that exists is that religion and health both help people in maintain a health life. You see sin can cause healthy people to do certain evil things which would affect their health. Religion plays a very important role in promoting good health. There is what is often known as spiritual healing this is kinds of healing that happens at a spiritual level and yet ultimately affect the physical life of people. For me faith is an indispensable asset to the well being of people, it is a protective tool, which helps people to live and enjoy life in it totality.

**Isubilo CRC- Health provider**

Yes in fact there is a very strong relationship, when a person is very health they start appreciating the religion if at all they have a correct religion with which they can relate to as in Christianity –There is a very good relationship when people are health they start appreciating God. God is health for me.

**Isubilo Community Resource Center [Health seeker P+ Female]**

There is a relationship, as a Christian I believe in pray, when my health is not okay my faith is affected. When I have a need as someone such as health, I pray, prayer is done in the spiritual realm it is something intangible but the results or effects are seen in the physical or tangible things. So there is a relationship.

**Isubilo CRC- Health seeker**

Yes I do just as I mentioned above these two are closely related and affect each other, when my faith in God is weak I may indulge in all sorts of things which can affect my health. And when my health is weak it also affects my faith because as a human being I am one and not made up of segments independent of each other.

**Isubilo Community Resource Center [Health seeker P+ living male]**

Yes there is a strong relationship Isubilo is a Christian organization, the way they view health ids different in approach to the non Christian clinics and HBC organization. Religion is blended in their service just see the way they provide for the sick and the orphans, old people and the street kids, it all because of their faith and concern for the health of the community. What Isubilo are doing is what true religion is all about taking care of the needy.

They visit me at home read the bible with me, pray, with me and simply spend some time with me. Isubilo helps people to have a meaningful livelihood.

**Isubilo Community Resource Center [Health seeker P+ Female]**

I want to say yes there is, this is demonstrated in what Isubilo is doing they are a religious or Christian organization. All that they are doing in terms of uplifting the health and well being of people is motivated by their faith in God or religion as you put it. I subilo has helped me see religion from my health problems that life is holistic,

They educate my children, take care of me when I am sick, buy me soap, food, medicines and basically everything I need.

I thank God for Isubilo I have come to know more about God through their deeds, come to know myself much better.

**5 Understanding the invisibility of religion as an asset to health**

The primary purpose of the question on the whether religion can be at the center of health intends to establish the invisibility of religion as a vital asset to health and general well being of communities.

**Question 5. CAN RELIGION BE AT THE CENTER OF HEALTH? WHY AND HOW?**

**Health provider- Bethel city church**

I would say a big yes, if any thing, all healthy issues should revolve around religion.

*Why do I say so?, You see people can adequately understand healthy issues when combined with religion, because when it comes to aspects of addressing health matters compassion, is at the centre of any compassionate work done in the work of Christ toward the sick and dying this is a Christian virtue, the underling factor to any sound health is ones religious standing and compassion.*

Religion is the primary basis of human existence whether Christian or not the spiritual inner being determines ones physical well being-what ever one may call it- for me I call religion life revolves around this matter.

**Health provider- Dawn Trust Community Center**

I think religion in my understanding the ‘Christian faith’ should be at the center of health, let me explain what I mean, sometimes some of the illness that come upon people are caused by the persons’ lifestyle. Like for example the current HIV and AIDS pandemic, it is known that the highest factor contributing to the transmission of the disease is through sex, and most of it through unwholesome sexual behaviors. Also the abuse of alcohol and other things can cause illness that can be avoided. You see as a Christian, certain things in a normal circumstance would be avoided or shunned or better say abstain from such vices and practices, which could cause healthy problems.

I believe being a Christian is something, which serves as a restrainer to such things, not only that, a human being is made up of a spiritual component as well which generally is religious in nature whatever the type of religion one has.

**Health provider- Dawn Trust Community Care**

That's how it should be, but that is not the case most of the time. They are people who have good health and do not have any kind of religion, so I cannot say that it should be at the center for one to enjoy good health otherwise all those without religion will be miserable but we do not see that all in reality.

However, religion has to do with a choice one makes in life one can have no religion but still enjoy good health. Naturally, religion should influence a person's general life in both public and private. So it is a bit difficult to say it should be at the center of health what of those who do not subscribe to any form of religion?

**Health provider- Fiwale Hill Mission Rural Health Center**

Yes it is, in fact it is the very thing that gives true meaning to health.[*why?*] I say so because for people to truly enjoy good health they need Christ Jesus in their hearts. [*so you mean that all those who are not Christians are not enjoying any meaningful health?*] I think so, for me they are like living dead, you see many people have problems which they do not know. For example, some people come here as patients to the clinic thinking they are physically sick and when you interact with them, by asking personal questions, we often discover on several occasion that the problems they have is not physical but spiritual.

So I really think Christianity or as you are calling it religion is at the center of all health matters, once we remove religion out of health we remain without true meaning of health.

**Health provider- Fiwale Hill Mission Rural Health Center**

Yes it is in fact as I was saying it is at the root human existence, as a health provider I know that each time I dispense medicine and give some treatment, ultimately God is the healer, because he is the one who has created us so he knows our bodies and has power over all illnesses. Even as staff members at times we have experienced occasions when we have lost hope over certain cases but to our surprise healing has come through miraculously[ we attribute this to some higher being]. That's why we always pray every morning as members of staff and also pray for the patients for quick recovery because we believe that religion seats at the heart of human life.

**Health provider- Fiwale Hill Mission Rural Health Center**

Precisely, you see within the African tradition, beliefs or religion is part and parcel of an African person everything we do is influenced by our beliefs, in fact unknowingly it is infused into our culture. You know when our grand parent in their time even today when some one is sick they would consult ancestors for guidance in the area of finding appropriate medicine. Everything related to religion of some kind. Similarly even as Christians we know that

health and faith are related. If I were to draw a circle, representing human life, health would be part of that circle together with religion 'some kind of belief' in some greater being.

You know in our culture we have *Ngangas* [traditional diviners] who relate the physical to the spiritual well being of human life. From a religious and African point of view I would say Yes religion is at the center of health

**Isubilo Community Resource Center [Health provider -Coordinator]**

Yes there also I look at it this way when a person believes in God, what ever God says it will come to pass if leaders understand the meaning of health they would teach proper massages about human well being that religion or better say God is at the center of good health, religion plays a very important role I n the well being of people.

**Isubilo Community Resource center [Community mobilization-coordinator]**

Yes I think so, if I believe that whatever I pray for or believe in the two are part and parcel of me as an individual these two are inseparable you see when you talk about religion you are talking about something that gives a person meaning and purpose similarly health is what gives a person some foe of and believe for God hears so

**6 Understanding of religious health assets**

The following question endeavors to establish whether the health providers are conscious of the religious health assets in their activities and to what extent they engage the same assets in their health activities.

**Question 6. CAN YOU IDENTIFY WHAT YOU PERCEIVE AS RELIGIOUS ASSETS IN YOUR HEALTH ACTIVITIES?**

**Health provider: Bethel city church**

Our main activities in the health programs at our church, consist of deliverance, by deliverance I mean praying for people who have all sorts of health problems for spiritual divine intervention.

The things I would call as our faith or religious assets are –

- prayer which is the main asset,
- counseling,
- exorcism through prayer,
- prophetic utterances in the lives or situations of peoples' health problems,
- care and support
- meeting the physical needs such as material
- deliverance, setting people free from spiritual bondages through the word of God

**Actually we deal with the physical at the spiritual level; we address the healthy problems physical in nature using the spiritual weapons which I can say are our spiritual assets.**

The ministry is a faith ministry therefore all that we do is faith healings. Prayer and counseling are the main asset in deliverance.

**Health provider: Dawn Trust Community Care**

As a Christian health organization, we offer

- Counseling in the context of HIV and AIDS, we do testing as well.
- Spiritual or Christian counseling related to issues of life and living, we receive clients who have spiritual problems.
- We do have specialized Bible studies at the center called ‘firm foundations’ for the community, we deal with subjects that are related to life and health these studies are attended by people who would normally be un-churched and not exposed to Christianity or the gospel.
- We also have a bible correspondence course for the children and young people
- We have fun time were we spend time together playing games
- We pray with our clients
- We have health talks
- We have health support groups in the communities, which creates an environment to share life experiences especially among the people living with HIV and AIDS (PLWHA).
- Also as a Christian organization we do assist in material things to those who are needy, things such as food, clothes and the like. We are conscience that Christ during his ministry addressed both the spiritual and the material needs of the people.
- We also teach our clients in the support groups on food and herbal production. We are encouraging alternative herbal medicines such as ‘artenezier’ we try to remind people that herbs are provided by our creator.

**Health provider: Dawn Trust Community Care**

As a center, being a Christian organization, everything we do is informed by the Christian principles. Every activity is measured by our faith we are simply putting into practice what we believe.

Some of the physical assets we have are the building where we operate from it is within the community people find it easier to come here than to the hospital, there is privacy and personal relationship developed in such an environment. We provide Christian literature produced to meet the kind of clients we receive.

Also all members of staff are Christians we believe this is an asset to health giving because of the hope, encouragement and accompaniment that health providers should walk along with the health seekers.

We offer spiritual counseling, we have noticed that many health institutions give counseling but it lacks the spiritual component.

We pray for our clients. We also have regular bible studies.

We also have an independent office for specialized spiritual counseling independent from the clinical counseling we give at the center.

We also offer what I would call social therapy on socially disturbed individual in the communities

**Health provider: Fiwale Hills Mission Rural Health Center**

I think as a church health institution placed at a mission center, the institution operates differently from some of the government health providers. The way we manage our patients is different from what generally practiced, we have a personal interest in our clients with a spiritual bias.

As Christians we are conscious that these are more than just patients or clients but people created in the image of God and should be treated with dignity.

We pray for our patients and interact with them freely at a personal level than what normally happens in a government or non religious health institutions.

We have a hospital chaplain who talks with our patients, counsels and prays with them giving them assurance, comfort, support and hope in their sickness. We also offer spiritual counseling. I see these as some of the religious assets we have at the center.

Sometimes we do have patients who are demon possessed or have illnesses related to demonic influences the chaplain prays for them and some are delivered, this does not happen in non religious health centers. Every morning we have prayers and preaching at a personal level done by the Students from the mission Bible College.

I would say we offer a holistic therapy to our patients in all dimensions spiritually, emotionally and physically. So we are talking about being healed in totality. I think that is a great asset to the well being of people in our health services.

But the non religious health providers may offer good health services to the patients but fall short of this component, which offers a person holistic healing.

**Health provider: Fiwale Hills Mission Rural Health Center**

I think they are a number of them, what I can immediately identify as religious or Christian assets are thing such as:

Prayer we offer to patients and staff, counseling, word of encouragement from the bible from the chaplain. Sermons delivered by the student pastors from the mission Bible College.

We also give material support to our patients in areas of providing transport to those who are in a crisis once they are referred to the bigger hospital.

Also our sense of commitment to serve the lives of people by sharing our love and personal relationship with the patients is a religious asset, which is not found in some of the non religious health institutions.

You see here at the clinic we have agreed as staff that we work for God, we are only 6 instead of having 22 members of staff, so working long hours is not an issue we are not paid for overtime, again if we say we will not work it is people lives at stake. So because of our Christian faith, whenever we work beyond our normal shifts, every hour thereafter we say we are working for God. You will be surprised to learn that our salaries are so low, honestly it is not money that motivates us to work such extra hours but love for God and to save lives of people.

#### **Health provider: Fiwale Hills Mission Rural Health Center**

Some the religious assets I can think of in our institution, are the presence of chaplain, who offers prayers, counsel, share the word of God, exhortations, giving guidance to people in their lives. The assets which we have are intangible in nature but issue into tangible, you see peoples lives changed or have courage to move on in life with a strong spirit in spite of their circumstances. When one sees the changed or transformed lives it serves as a motivation to engage such religious assets we have as an institution.

#### **Isubilo CRC Health Provider**

The religious assets we have is the passion of Jesus Christ we have even the people who work here see themselves as serving God, the money or salary seen as secondary. Our passion as a Christian organization is motivated by the love we have for the people and the community we are working in. We would want to show Christ and his word in deeds as well and not just in words. You see the pastors in this community have even chosen this place to be their meeting place for their weekly meetings. People see this as their place. The life of Christ we are sending in the community is making the community to open up to the center, we are now receiving cases which initially were not among our objectives for example homes are reporting to use about wife battering, child defilement, rape cases, sexual abuse, we are serving as a link to the community church and community development committees. These are the issues we are receiving people are coming for counseling we have put Christ at the center. The community is identifying us as an asset to the well being not just with the orphans or sick people but for the good and well being of their lives. They are now identifying us with Christ.

We also offer spiritual counseling; we are picking up pieces from the clinic, for example at the clinic, the pharmacist simply prescribes without having any meaningful relationship except that of patient and health provider, but with us we develop a relationship, we talk, pray together, visit them in their homes, feed them and provide even transport when they are unable to go to the hospital and clinic.

For example when the patients are given ARVs they come here for explanation, especially with adherence.

### **Isubilo CRC Health Provider**

Religious assets, we have pastoral department deal with religious matters, we have a clinic and a spiritual/ psychosocial counselors, we have a team of intercessors their work is to pray and also those who are involved in deliverance. We often receive clients who come with what is perceived to be a physical problem and after spiritual counseling we have experienced some of them having problems deeper than physical, but spiritual so we engage the spiritual assets we have that of prayer, bible sharing, encouraging and giving them hope.

This institution upholds prayer and the biblical application of total healing. Those who are not Christian we try to share the good news and encourage them to look at health from a holistic aspect of life.

### **7 Understanding the role of ‘religion’ or personal faith in God as a motif in health seeking**

The question investigates the extent to which religion or personal faith in God plays or serves in health seeking. This question also intends to establish the role religion serves as a motivation to seek health service and why they prefer visiting a religious health institution. Does the religious component by religious health institution also service as a motivation by the clients to seek health services from such institutions?

#### **Question 7. DOES YOUR FAITH, SERVE AS A MOTIVATION IN YOUR HEALTH SEEKING?**

##### **Health seeker: Bethel City church**

What do you mean my faith? [I mean your relationship with God through Christ Jesus] I do not understand what you mean if you mean baptism yes I was baptized a long time ago and I join in the Mass during the Holy Communion.

Yes I believe that God is able to heal me from my illness, I know things have not improved even after having received so many prayers, as you can see now I have even lost my sight I was told my liver is not functioning well.

We stopped going for prayers last month in August. [Why] The people who were praying for us said we should stop going at Bethel for prayers instead they will start coming home to pray especially when my illness is severe we should simply phone them they will pray for me on the phone. In fact I do not understand why they stopped us from going because this is the time I need their prayers more than ever before. [So why do you think they stopped you to go for prayers] I do not know, maybe they saw that there was no improvement because as I said now I have even lost my sight. But I still believe God for a miracle. What ever the meaning of ‘faith’ is, I believe that the trust I have in God helps me to hang on even when things look unpromising.

##### **Health seeker: Bethel City church**

Yes it does, when I am sick I pray to God and on several occasions God has answered my prayers. Faith for me plays a very important role in my health seeking. Like I told you I went to Bethel City deliverance centre because of some of the problems which I perceive to be spiritual in nature and I needed special prayers to be delivered, this calls for faith. I believe in spiritual deliverance which ultimately affects my health positively.

##### **Health seeker- Dawn Trust community Care**



I would say my faith in God has really contributed to my health. What I mean is that because of my trust in God I am able to believe and endure my sickness with the hope that God is with me and one day I will recover. So there is hope, confidence that keeps me on even when things are tough.

I see that there is a great difference between when one who has faith falls sick compared to without. The one with faith believes in something beyond him/herself for healing, safe keeping, hope, prayers and even the strength to endure sickness for a long time without despairing. But the opposite is often true with those without faith in God, they easily resign to fear and death, there is no inner peace, hope and assurance. Some resort to self condemnation and pity instead of hoping for the better. So for me, my faith helps me in my health matters.

#### **Health seeker- Dawn Trust community Care**

Yes it does because as a Christian when I am sick, I turn to God in prayer, I also seek for Christians to encourage and support me in my afflictions. When I am in need especially if it has to do with my health, my faith in God helps me to hold on and believe for quicker healing and improvement. It gives me hope beyond the present life. Faith or religion helps to deal with issues of fear and worry. When one is sick especially having AIDS, you know I am HIV positive, there are so many anxieties, but I trust in God always for better life. My faith also helps me to shun or avoid evil things and behaviors that may cause harm to my health.

As someone who is HIV+ my faith in God serves as a source of strength, even when I was told of my status I did not panic nor loose heart as if that was the end of life.

On the part of the center, the fact that it is Christian institution, it also has helped me get motivated in seeking for health provision especially the spiritual, emotional and psychological aspect of my life. Religion or my faith is at the center of my life I cannot divorce it from everything that I do. My faith in God has really helped in dealing with my sickness.

#### **Health seeker- Dawn Trust community Care**

Yes it does, you see when I am sick, I can pray to God. My faith in God gives me the courage, hope and conviction that there is a God who cares and will make all things well. My faith also helps me to refrain from certain evil activities [such as immoral sexual behaviors] that could have some negative effects on my health in other words my faith produces a positive fear in my life.

My faith is connected to my health, when I am not well in my body health wise, I have the belief that God will heal me and so I do not easily despair but instead believe God for healing.

#### **Health seeker- Fiwale Hill Mission Rural Health Center**

I am a stronger believer that health and well being are gifts that come from God; God wants us to enjoy good health. When my health is poor or bad, it affects my faith and my whole being. When someone is healthy in body, even their service and work is better. I remember when I was sick for a long time, I could not stand in front of my class

for over 20 minutes this affected my performance and expectations. My health was affected and consequently my spirituality was affected as well and my whole being was in a mess. I would say that faith or religion facilitates in the process of good health and recovery, hope and resilience come about due to the presence of faith or better say my relationship with God.

It is for this reason I say that there is a difference the way one that has 'faith' or is religious handles the matters of well being and health. As for me, my faith in God has really helped in my health seeking. There are times when my body is weak but my inner person is strong.

**Health seeker- Fiwale Hill Mission Rural Health Center**

Faith or religion as you are calling it serves as a great motivation in my health seeking; the fact that Fiwale Mission clinic is Christian simply gives me the motivation that the care will be different. When I am healed from any illness I always attribute it to God. I think apart from this the fact that this place is mission does not in itself make it Christian in practice, however it is the staff and the way they treat patients that would attract people to seek health matters at any mission clinic or hospital. But you see just to have the name Christian or mission hospital serves as a motivation because of the general acceptance that mission clinics/hospitals provide good services.

**8 Understanding the direct contribution of religion on health outcomes**

The question endeavors to high light what the health providers and health seekers perceive as the direct contribution to health outcomes on the communities well being. This engage especially the health providers to pin point the achievements and positive health outcomes arising from the fact that they are a religious institution employing religious assets as well in their health services.

**Question 8. RELIGIONS' DIRECT CONTRIBUTION TO HEALTH AND WELL BEING OF THE PEOPLE ON THE COPPERBELT.**

**Health provider: Bethel City Church**

When it comes to well-being and health, we are offering people with voluntary services which I believe is a positive direct contribution to the well being of people in Ndola and beyond. When people are delivered from all manner of health related problems, they are now able to become more productive in their work and community services. We have received seekers from all over the country, coming with all kinds of diseases some of the diseases we have dealt with have been labeled as incurable. We have prayed and people have been set free. For us at Bethel we believe we are contributing to the well being of the people on the Copperbelt and beyond as we restore the apparent lost human resource in the community through our deliverance ministry.

**Health provider: Dawn Trust Community Care** Dawn Trust Community Care as a private Christian organization is placed right up within the community the reason was to be identified with the community and be part of the community. I believe we are contributing to the well being of our community in a number of ways.

We offer private and user friendly VCT within the community. The spiritual counseling we offer and the post counseling to our clients has contributed to the improved well being of the people this has helped a number of them to exhibit resilience and greater hope in their illnesses. We also believe that our follow up visits to some of our clients is a direct contribution to the people and the communities they live in.

We have had experiences whereby people come for further counseling after the Bible study asking questions that are at times not even related to the subjects handled it's like the studies simply serve as a link and door to other aspects of life. We have support groups of PLWHA, we teach them life skills and offer income generating projects on how to make soap, skin lotion, candles which they sale for income. We also provide them food supplements such as Soya beans, Soya flour, and 'Moringa' leaves - herbal food supplement. We also teach and promote conservation farming; our clients grow maize and other cash crops. We had a seminar on conservation farming; those who qualified after the training were provided with farm inputs such as maize seed, fertilizer, lime and a special hoe. We offer training, supervision and monitoring, we trained 54 and only 20 qualified to receive the inputs. I think we are contributing to the well being and health of the people in this community.

#### **Health provider- Fiwale Hill Mission Rural Health Center**

I want to say that the presence of this Health Center has contributed very much to the well being and development of the community. When the people are healthy, they are able to work and produce food. You know this is a rural area people depend on farming so good health is necessary for one to survive.

In the past we had so many admissions, but ever since we introduced the community to participate in health care giving we have seen fewer admissions, the community have been empowered to be part and parcel of the Health Center.

Most of the patients who now come to the health center have a feeling and knowledge that they are going to their own institution and since this health centre belongs to the church, there is a feeling especially by those who are members of the church that the clinic is theirs. This has helped especially in mobilizing the people in community health support groups. We have a high number of community based health care volunteers whom we have trained, these come to the clinic to collect medicine for those patients who are unable to walk to the clinic, I think this is empowerment and a direct contribution to both health and development of the community.

We have also trained Traditional Birth Attendants (TBA), Community Birth Control Distributors and Community Health Care givers.

One thing we have noticed after training or incorporating the community in health matters is that the number of admissions and health care seekers has reduced. I think this is a plus on our part in terms of the clinics' direct contribution to the well being of the community.

**Health provider- Fiwale Hill Mission Rural Health Center** If I have understood your question well, I think that when people are in good health and their minds are free from disturbing concerns, they are able to be productive and

contribute to the development of their community. You see Fiwale is a rural community people depend on what they produce from their fields. So when they are sick it means their fields are not worked on and consequently this affects their livelihoods, which impacts on their well being.

Talking about the area which I coordinate Primary Healthcare, I have seen a number of children and mothers lives saved due to our health services. We receive mothers as far as 30 km coming for treatment and health care and talks.

As a result of many people experiencing good health the community which is part of the Copperbelt has contributed to the development and well being of people. This is a farming community that produces a lot of vegetables and maize often sold for cash to sustain the families and send children to school.

#### **Fiwale Hill Mission health center- Health provider**

Initially the goal of the center was to cater for a small catchments area but because of its location in the village set up and among the poor of the poorest, this health center has become the only health center that cater for such a huge area covering a distance of over 45 km. People come all the way from distant places to this place because of the services we offer. We believe that good health gives people a better life. When people are health they can work and earn a living. Through the health center we minister to people the love of God we meet the physical needs of people and thereby contribute to the well being of the people in this area. One such example is the nutrition lessons offered to mothers, lessons on HIV/AIDS and also on how to take care of the sick in the home setting. One of a success story which shows the contribution the health center has on the community is the good will we have received from the ministry of health, all the health workers except for a few are seconded to the mission center from the Government. This is so because they have seen the kind of contribution we are making for the good of the Fiwale community.

**Isubilo CRC Health provider** One of the objectives of Isubilo is to bring the community and the church together in order to identify the health and community problems affecting the people in our catchments area. We do invite different groups of people to our meetings such as the church leaders, community development leaders, police, social workers, health institution, and school teachers, this helps us to network and look at health and development from an all encompassing perspective. We bring in all the stake holders in community development. By doing this we hope to bring development in the community. Isubilo has become a peoples' center were they come and discuss issues affecting them in the community.

We have a large number of volunteers from the community who have been empowered to identify the needy in the community and encourage the same to come to Isubilo for help.

We have also bought a piece of land which we have allocated to our clients for maize growing; we provide them with seed and fertilizers. The center has a grinding meal which is open to the community at a very minimal fee. We are also encouraging them to have backyard gardens.

We also work hand in hand with schools to help us identify needy school children; we have provided school necessities to about 250 school children. The center has a clinic which also serves as a contribution to the well being of the people in this community. We have a trained matron, clinical officer, psychosocial counselors all bringing in not just the physical health but also the spiritual component.

**Any success stories:** yes we have managed to bring church, community, and civic leaders together in order to identify our community problems.

Also helped to level down the poverty levels through empowerment program and also through the food supplement we provide to our clients.

### **Isubilo CRC Health provider**

The water issue Isubilo, has sunk two Bore holes and have put up a tank for the community to draw water, we have 15000 liters of water we give this water free of charge, all the people in this area draw water from here. We also have 8 orphans we are keeping at a home and offer them everything.

We have become part and parcel of the community, we have a feeding program for OVC, old people, we have also the underweight babies come to feed here every Wednesday, and we give them food the older clients who are positive we give them food for two weeks.

**Success stories:** We are the helping of 260 children through in school paying all the costs. The other success story is that in the past we used to bury a lot of people who were dying from AIDS, but ever since the ARVs were introduced, the deaths have reduced, and people have hope-*Isubilo* that it is possible to live health with a virus in ones body. We have about 165 clients visiting us who are on ARVs.

Management structure: We a board, manages, and department leaders, we have support from well wishers donors abroad and local. My wish is to have more of Isubilo in the other community so that people do not have to walk such long distances and also if we can duplicate this work all