

The Impact of Faith-healing Pentecostal Churches on health and
well-being among health-seekers in Ndola, Zambia

By

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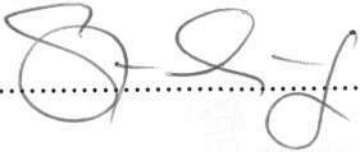
Declaration

I, Audrey Matimelo, 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.

Signature.....

Date.....11/10/07

As Supervisor, I agree to submission of this dissertation
Professor Steve de Gruchy

Signature.....

Date.....11/10/07

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Dedication

This dissertation is dedicated to my late parents, my father Trevor Mukwavi and my mother Margaret Mukwavi. They devoted their lives and resources to nurture my academic abilities. Thank you mum and dad for believing in me and being very proud of every achievement I made in life.

Abstract

This study, which lies within the ARHAP ongoing research on the interface between religion and public health, examined the impact of Faith-Healing Pentecostal Churches on health and well-being among health-seekers in Ndola, Zambia. The study involved a self-administered questionnaire answered by 100 Faith-Healing Pentecostal Church worshippers in Ndola over a period of 4 weeks.

Based on the data analysis and interpretation it was found that these churches have grown rapidly in Zambia and that many people are turning to them for their healing and well-being. There are several factors that are contributing to the rapid growth of Faith-Healing Pentecostal Churches and these range from socio-economic problems to the impact of diseases like HIV/AIDS, malaria and tuberculosis on households, due to the poor health provision in most government health centres in Ndola.

The study notes that people attend Faith-Healing Pentecostal Churches because these churches provide a home for people in need of social networks which enable them to have a sense of identity, belonging and purpose amidst their day-to-day socio-economic challenges. It was therefore evident from the research that Faith-Healing Pentecostal Churches are addressing huge socio-economic needs in people's lives within a context of poverty, unemployment and the burden of sicknesses and diseases, and can rightly be understood as a Religious Health Asset. These findings also provide the context for four important insights into a contemporary and contextual theology of health and healing.

Based on the findings of this study, this dissertation offers a number of challenges to public health policy makers and church leaders to take serious the interface between religion and public health, and to also take seriously the contribution that Faith-Healing Pentecostal Churches are making to health and well-being in Ndola, Zambia. When these two issues are taken seriously, it would help to address issues of health and well-being in communities, based on people's religious convictions and understanding of health, healing and well-being.

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Abbreviations

ARHAP	African Religious Health Assets Programme
FHPCs	Faith-Healing Pentecostal Churches
RE	Religious Entities
RHA	Religious Health Assets
SAP	Structural Adjustment Programme
SPSS	Statistical Programs for the Social Sciences
WHO	World Health Organization

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Introduction

This chapter is an introduction to the dissertation and it provides a summary of the study which focuses on the health-seeking behaviour of some Christians living in Ndola, a city on the Copperbelt Province of Zambia. The study surveys people who attend the church services of Faith-Healing Pentecostal Churches (hereafter FHPCs), to seek healing, and enables us to evaluate the contribution FHPCs are making to health and well-being in Ndola, Zambia. In this dissertation, Faith-Healing Pentecostal Churches are defined as Charismatic Pentecostals that engage in faith-healing almost every Sunday and are fully dependent on hearing from the Holy Spirit and less on systematic doctrines.

1.2 Background to the study

FHPCs have grown rapidly in Zambia and many health-seekers are turning to these churches for their healing and well-being. These health-seekers are people who are either committed members of FHPCs or people from mainline churches. It is important to also point out that even non-churched people in Zambia visit FHPCs for their healing.

There are about one hundred and eighty six (186) registered FHPCs in Ndola alone.¹ One of the largest FHPCs in Ndola is called Bethel City Church International² with about three thousand (3,000) people in membership. Based on statistics from the Church's records, three thousand seven hundred and fifteen (3,715) people visited the Church for healing between January and September 2005 as noted in the table below.³

¹ Martine Kapenda, Executive Secretary of the Pastors Fellowship in Ndola, Zambia, Informal conversation, 2005.

² Bethel City Church International is one of the biggest Faith Healing Pentecostal Churches in Ndola and runs a prayer healing and counselling clinic at the church premises.

³ Albert Bwalya, Bethel City Church International, counselling and deliverance ministry records, unpublished (2005).

Figure 1: Statistics of health-seekers at Bethel City Church

Month	Number of clients
January	333
February	465
March	631
April	560
June and July	887
August	505
September	334
Total for 9 months	3715

This figure illustrates that many people are visiting FHPCs in Ndola to seek healing and well-being. Although faith-healing is not a new phenomenon in Ndola and Zambia as a whole, there are several factors that are contributing to the increase in the number of people visiting FHPCs.

The first reason that could be cited for the increase in the number of people visiting FHPCs is the declaration of Zambia as a Christian Nation⁴ by the former Republican President, Dr. Fredrick Chiluba in December 1991. The declaration brought about an increase in the number of FHPCs who preach the prosperity gospel coupled with promises of divine healing and the “heaven on earth” kind of life.⁵ The declaration also gave an opening to American television evangelists who stormed the country either by television, the print media or personal visits to Zambia to preach at national gatherings which were mostly sponsored by Dr. Chiluba himself.⁶ Therefore, many FHPCs Pastors

⁴ The words of the former president of Zambia, Dr. Fredrick Chiluba when he declared Zambia as a Christian Nation, “I declare that I submit myself as President to the Lordship of Jesus Christ. I likewise submit the government and the entire nation of Zambia to the Lordship of Jesus Christ. I further declare Zambia as a Christian nation that will seek to be governed by the righteous principles of the word of God. Righteousness and Justice must prevail at all levels of authority and then we shall see the righteousness of God exalting Zambia.”

⁵ Austin Cheyeka, “The concept of Zambia as a Christian Nation,” *Africa Ecclesial Review*, special edition, Volume 47, Number 4 (2006) p.18

⁶ Drew Smith, “American Evangelists, Social Self-Interests, and Political Misalignments in Africa,” accessed 2 January 2007. <http://www.samford.edu/lillyhumanrights/papers/Smith_American.pdf>

and their followers continue to be influenced with western Pentecostal messages on prosperity and divine healing.

Growing poverty in Zambia is another key factor that has led many people to seek healing from FHPCs. The country has experienced much economic collapse, which has led to poverty and misery for many people. Statistics from 2004 show that 73% of Zambians live below the poverty line and that 71% of Zambians today live in abject poverty,⁷ and there has been little change since then. The breakdown of the national health provision system as a result of the economic collapse, including the introduction of user fees in the public health services (which the government has since removed in rural health centres), has made many Zambians lose faith in government hospitals. Those that are poor cannot manage to go to private hospitals. The introduction of user fees has therefore led to the reduced number of people who go to hospitals and clinics for medical attention, and such people have come up with other health-seeking strategies.⁸

The third factor that has led to an increase in people going to FHPCs for healing and well-being is the impact of the HIV/AIDS pandemic, tuberculosis and malaria on many households in Ndola. It is evident that western medicine and government health policies and programmes are having little impact on these diseases and thus many people are resorting to visiting FHPCs.

It is within the context explained above that this research, under the African Religious Health Assets Programme (ARHAP) has been done, with the aim to investigate an aspect of the contribution that religion is making to public health in Ndola, Zambia.

ARHAP is a collaborative programme that involves the University of Cape Town, University of the Witwatersrand and the University of KwaZulu-Natal in South Africa, in partnership with the Rollins School of Public Health at Emory University, and the Centres for Disease Control in Atlanta, USA. The main objective of ARHAP is to

⁷ Besinati Mpepo Phiri, 'The path away from poverty: an easy look at Zambia's poverty reduction strategy paper 2004' (Lusaka: Civil Society for poverty reduction), p.9.

⁸ Alick Duncan, et al. *Drivers for pro-poor change: an overview* (Oxford: Department for International Development, 2003), p.24.

identify, assess and map religious assets in Africa and make such information accessible to faith and health leaders, organizations such as the World Health Organization (WHO), government and private policy makers, so as to make a difference to people's lives in Africa.⁹

1.3 Research problems and objectives: broader issues to be investigated

It is important to note here that this research lay squarely within the broader concerns of the ARHAP project, and specifically in the work being undertaken to develop an understanding of the way in which religion contributes to public health in Africa. The research has also been done in the context of the struggle for health and healing in a time of AIDS and Structural Adjustment Programme in Zambia.

Until this point, the research that has been happening within ARHAP has focused on 'formal' churches and formal health programmes. The research for this dissertation however sought to focus on FHPCs as a 'religious asset' in the search for health. Furthermore, it sought to understand the perspectives of health-seekers about what health and well-being means to them and how FHPCs impact on their health-seeking behaviours. This research also sought to ask a specific research question stated below. Therefore, I see this research to be a contribution to the ongoing research work on the interface between religion and health.

The main question that this research sought to answer was,

What impact do FHPCs have on health-seekers and to what extent can they be understood as a Religious Health Asset?

In answering the above research question, the following key questions were also asked and answered during the research and the writing of the dissertation.

⁹ Steve de Gruchy, et al. *Participatory Inquiry into religious health assets, networks and agencies*, Version 4 (Cape Town: ARHAP, 2006) p.13. (To read more on ARHAP please refer to chapter 3 of this dissertation or visit <<http://www.Arhap.uct.ac.za>.>)

- Why are many people in Ndola attracted to seeking healing and well-being from FHPCs?
- What do health-seekers receive from FHPCs?
- Is there a relationship between socio-economic pressures and the emergence of FHPCs?
- In what ways do these FHPCs have an impact upon the health and well-being among health-seekers in Ndola?
- How does the healing of FHPCs relate to health provision by other agencies?
- What does this research help us understand about Religious Health Assets in general?
- What theological issues emerge from this research, and how do we engage with them?

In answering the above questions in the study, it was evident, based on the findings and interpretation of the data collected from the field work, that health-seekers are agents of their own health-seeking strategies, and that they make use of local knowledge and wisdom to seek healing from FHPCs. FHPCs, in turn, make a contribution to the health and well-being of health-seekers in both “tangible and intangible”¹⁰ ways, and can rightly be called Religious Health Assets.¹¹ It is therefore important that policy makers in both the Church and public health sectors draw on these assets in implementing effective public health policies.

1.4 Research methodology

This empirical study involved questionnaire interviews that were undertaken with 100 worshippers who attend FHPCs in Ndola. The data that was collected from the research, as presented in chapter 4, was analysed using the Statistical Programs for the Social Sciences (hereafter SPSS).¹² The findings that emerged from the data analysis were then

¹⁰ 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.

¹¹ James Cochrane, “Deliberations on religion and religious health assets,” *Africa Religious Health Assets Programme Annual International Colloquium: case study focus* (Cape Town: ARHAP, 2005). p.21.

¹² The SPSS is a comprehensive set of programmes designed for use by social scientists which has easy-to-use pull-down menus which make data analysis easy (see chapter 4, 4.2.4).

interpreted, as presented in Chapter 5 to help provide a coherent picture of the way in which FHPCs may be considered a Religious Health Asset.

1.5 Geographic focus of the study

This research was conducted in the city of Ndola, on the Copperbelt Province of Zambia. Ndola lies 321 kilometres north of the national capital city of Zambia, Lusaka. It is the second largest city in Zambia and it is the headquarters for the Copperbelt Province. This city was once economically vibrant as a result of the many industries in it.

Figure 2: Map of Zambia showing the geographical position of Ndola



Mapping Specialists, Ltd.

The figure above is the Map of Zambia. The position of Ndola indicated on the map above.

However, the introduction of the Structural Adjustment Programme (SAP), resulted in privatization, retrenchments and the closure of many manufacturing companies. The other effects of SAP are the decline in “public health provision, education and

community services.”¹³ Therefore, many people in Ndola today are affected by unemployment, poverty and the increase of diseases. The people of Ndola have been victims of the burden of the country’s debt and poor economic decisions. As rightly pointed out by Eade and Williams, “the burden of debt, economic recession and structural adjustment policies have led to reduced health budgets, decline in health services, and deterioration of health in poor countries.”¹⁴ This statement is true of Zambia as a country. It is therefore from such a background that I write this dissertation.

Within Ndola, the research was limited to the following townships: Lubuto, Kabushi, Chifubu, Twapia, Mushili, Ndeke, Masala, Chipulukusu, and in the city center of Ndola. The research was conducted over a period of 4 weeks.

1.6 Summary of research findings

Based on the data analysis and interpretation of the research conducted among FHPCs’ attendants in the townships in Ndola, as presented in Chapter 4 and 5, below is a short summary of the eight key research findings (presented in chapter 5) and the four theological challenges that are identified in Chapter 6.

First, FHPCs provide a home for people in need of social networks.¹⁵ These networks enable the people faced with much poverty, sicknesses and diseases and the impact of the Structural Adjustment Programme, to have a sense of identity, belonging and purpose. This in turn helps to support and provide life skills which promote health and well-being.

Second, people are attracted to attending FHPCs in Ndola because of the need for wholistic healing. The preaching of God’s word, spiritual songs and prayers for physical healing that the people receive are perceived to be a source of wholistic healing.

¹³ 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), p.62.

¹⁴ Deborah Eade and Suzanne Williams, *The Oxfam Handbook of Development and Relief Volume 2* (Oxford: Oxfarm publication, 1995), p.627.

¹⁵ A social network is here used in the same context as social capital. This refers to social memberships and relationships that people develop as a survival strategy.

Third, the emergence of FHPCs is related to poverty in Zambia. It is evident from the research that FHPCs are addressing huge socio-economic needs in people's lives within a context of poverty, unemployment and the burden of sicknesses and diseases.

Fourth, FHPCs are contributing to health and well-being alongside other health providing entities in Ndola. It can be observed from the research that FHPCs encourage people to visit other health service providers such as hospitals and clinics.

Fifth, people who go to seek healing from FHPCs, receive healing through prayers, anointing with oil, the preaching from God's word and through spiritual songs. Based on the research, it is clear that the people who go to seek healing from FHPCs perceive that they do get healed. This healing is either instant or progressive.

Sixth, notable differences of FHPCs' healing process as compared to other health providing entities are personal care, free service and the absence of side effects. When the administration of healing provided by FHPCs is compared to that of other health providing services, it is interesting to note that most respondents feel that the administration of healing offered by FHPCs is better than that which is offered by other health providing services.

Seventh, worshippers at FHPCs display a strong sense of agency in their search for health. It is evident from the study that amidst the many socio-economic challenges that people are faced with in Ndola, they show great determination and persistence in their health-seeking strategies, making use of local knowledge and wisdom to meet their health and well-being needs.

Eighth, the contribution that this study makes to the ARHAP's ongoing research is identifying the FHPCs as a religious health asset. FHPCs are assets located within the communities' own religious framework. They contribute to the development of public health and people have identified them as health assets from which they can draw support and hope in times of socio-economic difficulties and health problems.

1.7 Summary of theological insights

The eight research findings in 1.6 above and the context of the study in Chapters 2 and 3 provide the basis upon which the four key theological insights in Chapter 6 are developed. These theological insights help to contribute to the need for a contextual theology on health, healing and well-being in Zambia and are summarized below.

First, the work of God (*missio Dei*) as healing is a challenge to the Church's work (*missiones ecclesiae*). It is observed from the research that many people in Ndola live in dehumanizing conditions that have led to comprising their God-given dignity and integrity as people created in the image of God. This does however not mean that God is absent in their suffering. God has been at work since the dawn of the creation of the world to promote health and well-being. God has been promoting life through the giving of laws that enable people to live godly lifestyles, through the life and ministry of Jesus Christ and through the Church. This work of God in the work of healing is a challenge for the Church today.

Second, we note the importance of the gathered community of faith, in terms of its inclusivity and its worship, for healing and well-being. The study reveals that FHPCs are inclusive and are committed to vibrant healing-focused worship during their services. The importance of inclusivity among FHPCs is seen as contributing hugely to healing and well-being in that people from various work, age, creed and educational backgrounds meet together as one family in the body of Christ to pray and worship God. Also, the mode of worship, (which comprises the preaching, liturgy, songs and rituals) among FHPCs enables worshippers to go to church with much anticipation and enthusiasm, and this is a challenge to other churches in the way they order their own church services.

Third, the Church is one partner amongst others in the work of healing, and in its unique contribution it challenges others to think of health more holistically. The worshippers at FHPCs see God as not limited to healing people through their churches only but that God is committed to healing people through hospitals or clinics. This makes clear the fact that all healing is God's healing. The Church is therefore a partner amongst others in the work

of healing and its uniqueness is the way it sees healing as holistic which is a challenge to other health agencies that see healing from a physical perspective only.

Fourth, health cannot be divorced from a wider framework of God's Shalom, which provides a socio-political challenge to the Church. God's framework of Shalom for the world is broad and encases issues of health, the socio-economic and political aspects of life. This then is a challenge for the FHPCs and the Church at large, not only to engage in healing within their buildings, but to also prophetically challenge community, political and civil society leaders to commitment towards service delivery to God's people in poor communities such as Ndola townships.

1.8 Structure of the dissertation

As explained above, this dissertation is a study of the impact of FHPCs on health-seekers and the extent to which these churches could be understood as a religious health asset. The dissertation proceeds as follows.

This chapter has provided the background to the study, the motivation of the research, the research problem and the research objectives, and it has pointed to the eight key research findings and four theological insights on issues raised in the dissertation.

Chapter two focuses on the causes and impact of the collapse of health provision in Zambia. It draws from literature, the researcher's own experiences as a Zambian and her own observations during the field research in Ndola, to analyse the current state of health and well-being in Zambia as a whole. It also identifies the causes and the impact of poor health provision in Zambia, with a specific focus on the city of Ndola, on the Copperbelt Province.

Drawing from the literature and the researcher's own faith experiences within the Zambian context, chapter three seeks to understand religion as a health asset. It deals with the contributions that religious institutions/organizations/people make to public health in

both tangible and intangible ways. The chapter also provides the ARHAP's theoretical framework which is used in this research to analyse the data.

Chapter four gives the research methodology applied to the study. It presents the process applied to data collection and analysis.

Chapter five is an interpretation of the research findings presented in chapter four. This chapter gives an interpretive discussion of the findings, and also explores both the strengths and the weakness of FHPCs. It concludes with an analysis of what the research findings imply to public health policy makers and ARHAP.

Chapter six presents four key theological insights that emerged from issues raised in this dissertation. It discusses challenges that these insights present to the Church in Ndola and Zambia.

Chapter seven is the conclusion of this dissertation.

1.9 Conclusion

This chapter presented the introduction, the background to the study, the research problems and objectives, and the research methodology. The chapter also provided a summary of the research findings on the impact of FHPCs in the area of health and well-being amidst much poverty and disease in Ndola. It further highlighted four key theological insights raised on issues emerging in the dissertation. Finally, the chapter provided the structure of the dissertation.

The next chapter will analyse the poor health provision in Zambia. It will further look at the causes and impact that such poor health provision has on the people in Zambia, especially the poor. The chapter will also discuss the impact that HIV/AIDS, malaria and tuberculosis have on health provision in Zambia, with a specific focus on Ndola.

CHAPTER 2

ANALYSIS OF THE CURRENT STATE OF HEALTH AND WELL-BEING IN ZAMBIA: THE CAUSES AND IMPACT OF POOR HEALTH PROVISION AMONG ZAMBIANS

2.1 Introduction

The previous chapter provided a summary of this dissertation. This chapter will analyse the current state of health and well-being in Zambia. It will discuss the causes and impact of poor health provision in Zambia with specific attention given to Ndola.

Zambia has three health system components where people go to seek health and well-being. These are hospitals and clinics run by (i) the government, (ii) religious entities and (iii) private health providers.

The government has been the main health service provider, with clinics in almost all the districts and a general hospital in each province. Biemba states that, "in Zambia, the key players in healthcare are: Government through the Ministry of Health, the Church through the Churches Health Association of Zambia and directly through the church congregational activities, the non-governmental organizations and community-based organizations, the private for-profit sector, and last but certainly not the least are the traditional health practitioners and faith healers."¹⁶ However, it must be pointed that although the government is the main health provider in Zambia, the government health system has been unable to provide quality health services due to the economic decline and the impact of poor health policies.¹⁷

There has been a policy of user fees affected in the government health system due to the Structural Adjustment Programme. However, in the recent years, the government has

¹⁶ Godfrey Biemba, "Value-Added and Invisibility of Religious Health Assets," Churches Association of Zambia, accessed 2/5/2007. <<http://www.arhap.uct.ac.za/conceptps/biemba.doc>>

¹⁷ Evaristo Mambwe, *The Challenge of Poverty for the Church in Zambia: A response to the effects of the Structural Adjustment Programme* (Masters Thesis University of Natal, 2002), p.34.

realized the impact that user fees have had on the poor people in Zambia, and they have instituted a regulation that exempts some people from paying these fees. The people exempted (most of such people do not even know about this exemption) are patients under the age of 5 years or over 65 years old, patients needing immunization, antenatal, pregnancy, birth or postnatal care and family planning services.¹⁸ The other category of people who are exempted from paying user fees are those who have tuberculosis, HIV/AIDS, sexually transmitted diseases, cholera, high blood pressure and diabetes.¹⁹

Apart from the government health institutions, there are several religious health institutions run by Christian and Muslim groups. These health institutions are mainly operating in rural areas.²⁰ Biemba observes that, "the church provides 30% of overall healthcare and approximately 60% of rural health services."²¹ A number of these Christian health institutions have good medical facilities and qualified staff because of the substantial financial and material support they receive from medical mission boards overseas.²²

Other than the government and religious health institutions, Zambia has a growing number of private health providers. These health providers exist outside the government sector, with the aim of providing medical treatment of various diseases for profit. It must be stated that;

During the 1970s private for-profit hospitals were banned in Zambia. Although this ban was lifted in 1991, by 1994 there were only two private hospitals, both of which were in urban areas. Private clinics were always allowed and by 1994 there were 150 such clinics, all in urban areas. The distribution of private facilities reflects demand factors such as higher cash incomes. It also reflects the distribution of government doctors, as many private institutions are staffed by doctors who also hold full-time government jobs.²³

¹⁸ Erik Blas and Me Limbambala, "User-payment, decentralization and health service utilization in Zambia," *Health policy and planning* (Oxford: Oxford University Press, 2001), p.21.

¹⁹ Besinati Mpepo Phiri, *The path away from poverty*: p. 9.

²⁰ Rural areas in this dissertation refers to countryside settlement where there is not much government infrastructure and are further away from the city/town with municipality services. Urban areas are places serviced by the municipalities. These are settlements in the inner city or towns.

²¹ Godfrey Biemba, "Value-Added and Invisibility of Religious Health Assets," accessed 2/5/2007.

²² Godfrey Biemba, "Value-Added and Invisibility of Religious Health Assets," accessed 2/5/2007.

²³ Julia Moorman, *The Public Private Mix and Reproductive Health in Africa: Women's Health Project* (Johannesburg: University of the Witwatersrand, 2003), unpublished, p.16.

This situation makes clear that most of the private health providers in Zambia are concentrated in the urban area where people can pay for the medical services they provide; and because they are usually profit driven, not all of them provide quality health care and treatment.²⁴

In the last two decades, Zambia has experienced much decline in health provision. The burden of both communicable and non-communicable diseases in the nation and in households has continued to grow. Many people are either sick or nursing a sick family member or relative.²⁵ The death rate has also risen as a result of HIV/AIDS, malaria and tuberculosis to an extent that life expectancy in Zambia has dropped from about 50 years in the years between 1980 to 43 years in 1998,²⁶ to an alarming 37 years in 2005.²⁷ The three diseases, HIV/AIDS, malaria and tuberculosis have continued to negatively impact the country's national economy and people's livelihood strategies in both urban and rural areas. In response to the high death rate in Zambia, the government, non-government organizations and faith-based organizations have been implementing several programmes to reduce the causes and impact of these diseases, but there has been very little positive change achieved. Most programmes initiated by the government have yielded little impact because of minimal funding for health programmes, poor management and corruption in the award of contracts to pharmaceutical companies and other government development and maintenance partners.²⁸

In 1992, the Zambian government initiated the health reform programme and diversified the running of the health system through the Central Board of Health.²⁹ This was started with the aim to reduce bureaucracy, speed up decision-making processes with regard to health service provision and improving the management and smooth running of public

²⁴ Julia Moorman, *The Public Private Mix and Reproductive Health in Africa*, p.16.

²⁵ Lori Bollinger and John Stover, *The Economic Impact of AIDS in Zambia: Policy project report* (Lusaka: Group International, 1999), p.4.

²⁶ Alick Dunken, "Drivers for pro-poor change: an overview," p.24.

²⁷ Jesuit Centre for Theological Reflection, *Parallel Report economic, social and cultural rights in Zambia* (Lusaka: Catholic Secretariat, Zambia, March 2005), p.14.

²⁸ Besinati Mpepo Phiri. *The path away from poverty*: p.3

²⁹ Erik Blas and Me Limbambala, "User-payment, decentralization and health service utilization..." p.21

hospitals and clinics.³⁰ Following this, the government also initiated the District Health Management Boards in 1995 with the aim to decentralize the health sector and promote autonomy at district level, unlike having the central administration done at the Ministry of Health in Lusaka.³¹ It must be pointed out that the formulation of policies with regard to health and monitoring remained with the Ministry of Health headquarters in Lusaka. In these health reforms a lot of money from the donor community, such as the International Monetary Fund, was budgeted for and spent in setting up administrative offices and personnel.³² Unfortunately, despite the money that was spent in setting up the District Health Management Boards, this system failed to deliver quality health to the people of Zambia and the government reverted to the old central system of administration.³³ This is a clear indicator of how government programmes to provide quality health to the people have failed and the result of this problem has been that “there is more sickness in Zambia than there is health.”³⁴

There are other initiatives the government has embarked on in trying to improve health provision and health services in both rural and urban Zambia. One of such initiatives has been through the Poverty Reduction Strategic Plan, (PRSP). In this programme of action, the following priorities have been put in place,

- combating malaria through mosquito control, preventive programmes, treatment,
- combating the HIV/AIDS pandemic, tuberculosis, and all other sexually transmitted diseases through treatment and creating awareness,
- having an integrated approach to reproductive health which includes family planning, antenatal, postnatal and other areas that have to do with women and pregnancy.³⁵

Despite the funding from donor agencies and the many workshops that are being held to plan and put up strategies for addressing the poor health provision and control of diseases in Zambia, very little is being achieved on the ground. Cynical observers suggest that much of the money has been spent on holding workshops and purchasing expensive vehicles for people involved in the Poverty Reduction Strategic Planning. The sad thing

³⁰ Erik Blas and Me Limbambala, “User-payment, decentralization and health service utilization...,”p.21

³¹ Evaristo Mambwe, *The Challenge of Poverty for the Church in Zambia*, p.34

³² Evaristo Mambwe, *The Challenge of Poverty for the Church in Zambia*, p.34

³³ Evaristo Mambwe, *The Challenge of Poverty for the Church in Zambia*, p.35

³⁴ Besinati Mpepo Phiri, *The path away from poverty*: p. 9.

³⁵ Besinati Mpepo Phiri, *The path away from poverty*: p.10.

is that people in both rural and urban areas continue to be deprived of their human rights to good health provision; and as noted above HIV/AIDS, malaria and tuberculosis continue to account for a large percentage of deaths in both rural and urban areas. Therefore, HIV/AIDS, malaria and tuberculosis have been identified in this dissertation as the major causes of death in Zambia. These three diseases have also impacted negatively on the city of Ndola. People in Ndola die everyday from HIV/AIDS, malaria and tuberculosis as will be explained in detail below.

2.2 HIV/AIDS, malaria and tuberculosis in Zambia

HIV/AIDS, malaria and tuberculosis have been identified as three of the most important killer diseases globally, and they constitute one goal of the eight Millennium Development Goals. Goal six is: "To combat HIV/AIDS, malaria and other diseases."³⁶ This is very important in Zambia where the rate of infection with HIV/AIDS, new malaria cases and the transmission of tuberculosis from one person to other is huge and continues to impact negatively on most Zambians as noted above. Drawing on the literature, this section will therefore show how that these three diseases have negatively affected Zambia as a nation.

2.2.1 The problem of HIV/AIDS

Since the diagnosis of the first HIV/AIDS case in Zambia, in 1984,³⁷ the number of people infected and affected with HIV/AIDS has continued to increase. Government and non-government HIV/AIDS activists have come up with a slogan which states that, "there is no household in Zambia that has not been affected by the HIV/AIDS pandemic."³⁸ The impact of HIV/AIDS has been felt by most Zambians in many ways.

³⁶ United Nations, "UN Millennium Development Goals," accessed 04/05/2007.

<<http://www.un.org/millenniumgoals/>>

³⁷ Dorothy Chanda and Davina J. Gosnell, "The impact of tuberculosis on Zambia and on the Zambian Working Force," *Journal of Issues in Nursing*, Vol. 11 No. 1 (2004), p.4

³⁸ Besinati Mpepo Phiri, *The path away from poverty*: p.15.

The statistics below, provided by the Zambia National Aids Alliance,³⁹ clearly show the impact of HIV/AIDS on Zambians.

More than a million Zambians are now living with HIV and an estimated 300 more people are infected daily. In 2004 the national prevalence rate was 15.6%. Prevalence rates among young women between the ages of 15 and 24 are 3.5 to four times higher than in young men of the same age group. More than twice as many people in urban areas (23%) are infected than in rural areas (11%). An estimated 25% of pregnant women are living with HIV, and 40% of babies born to these women are also infected. Zambia has nearly 1.2 million HIV/AIDS orphan children.⁴⁰

The statistics above are an indication of how HIV/AIDS is one of the leading causes of death in Zambia. It is currently estimated that more than 50% of the beds in most hospitals in Zambia are occupied by people who are ill with HIV/AIDS related diseases.⁴¹ The sad fact is that most people who are dying of HIV/AIDS-related illnesses are bread-winners and this means that a great many households are affected.

Clearly then, many people in Ndola, like the rest of the country, have been hugely affected by HIV/AIDS. A survey conducted by the Tropical Disease Research Centre in Ndola revealed that 22.7% people in Ndola are living with HIV/AIDS.⁴² Young adults in Ndola, between the age of 15 and 29 have been the most prone to HIV/AIDS and 29% of people in this age group are living with HIV/AIDS.⁴³ HIV/AIDS has created a problem of street children, teenage prostitution and crime. A number of young people in Ndola who have lost their parents to HIV/AIDS have ended up on the streets begging. Some of them have resorted to prostitution and criminal activities.

³⁹ The Zambia National Aids Alliance is an NGO which operates as an umbrella body for smaller NGOs involved in HIV/AIDS preventive, care and treatment programmes.

⁴⁰ Zambia National Aids Alliance, National report on Zambia, accessed 15/12/2007.

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

⁴¹ Avert International, "The Epidemic and its Impact." Accessed 17/1/2007.

<<http://www.avert.org/aids-zambia.htm>>

⁴² Central Board of Health, *Antenatal Clinic Sentinel Surveillance of HIV/ Syphilis Trend in Zambia* (Lusaka: Ministry of Health, 2002) p.44.

⁴³ Central Board of Health, *Antenatal Clinic Sentinel Surveillance of HIV/ Syphilis*, p.44.

2.2.2 The problem of malaria

Malaria in Zambia is a killer disease and claims roughly 50, 000 lives each year, especially those of young children and pregnant women.⁴⁴ Many people in Zambia die as a result of malaria each day in both rural and urban areas, and especially in high malaria infested areas such as fishing camps and swamps. Statistics show that almost 50 percent of deaths in Zambia, more so in rural areas, are as a result of malaria.⁴⁵ It is sad to point out that malaria was almost eradicated in Zambia from early 1976 to 1984, but the problem of HIV/AIDS has led to much funding meant for malaria-control being diverted to the fight against HIV/AIDS.⁴⁶ There has been an evident rise in malaria cases from the time the first HIV/AIDS case was diagnosed in Zambia in 1984.⁴⁷ Malaria has therefore become one of the major causes of death in Zambia in both the rural and urban areas.

The government, in partnership with the World Health Organization and other donor agencies, has of late re-introduced programmes to reduce malaria cases in Zambia, especially in the rural areas. They have introduced new malaria drugs, chemically treated mosquito nets (which are usually given free or sold at a very low price) and an extensive malaria-testing programme on pregnant women. These programmes have to some extent helped to reduce the rates of deaths with malaria although people are still dying on a daily basis.

Most townships in Ndola are hugely affected by malaria; especially the townships covered by this research; Lubuto, Kabushi, Chifubu, Twapia, Mushili, Ndeke, Masala and Chipulukusu. Sanitation in these townships has been neglected by the local municipal council and as such there are ponds full of stagnant water which serve as breeding places for mosquitoes.⁴⁸ The situation becomes worse when it is the rainy season. Many drainage channels get blocked with uncollected garbage and drains become ponds which

⁴⁴ Malama Muleba, Africa fighting malaria, "Plans to reduce Malaria in Zambia by 75 percent, accessed 21/3/2007. <<http://www.africafightingmalaria.htm>>

⁴⁵ Malama Muleba, Africa fighting malaria, accessed 21/3/2007.

⁴⁶ Malama Muleba, Africa fighting malaria, accessed 21/3/2007.

⁴⁷ Malama Muleba, Africa fighting malaria, accessed 21/3/2007.

⁴⁸ The Times Reporter, "Water Firm under Fire," in *The Times of Zambia*, (Ndola: Printpak Limited, August 27 2004), p.2.

in turn are breeding grounds for mosquitoes, as observed above. This situation leads to many mosquitoes and contributes to the growing problem of malaria in Ndola.

2.2.3 The problem of tuberculosis

Zambia is one of the countries in Africa that has a high rate of tuberculosis cases.⁴⁹ Despite the fact that this disease is curable and can be controlled, many people get infected with tuberculosis on a daily basis and some die of this disease. Chanda and Gosnell observe that there has been a drastic increase in tuberculosis cases in the last 10 years as stated in the statistics below.

In 1964, Zambia had a TB prevalence rate (number of cases present in a specific population at a specific time, or case rate) of approximately 100 cases per 100,000 persons. That figure remained constant for the next 20 years. The first case of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) in Zambia was diagnosed in 1984. Between 1984 and the present, the prevalence of tuberculosis has risen dramatically. In 2004, the case rate of TB was 450 cases per 100,000 and in 2005 is approaching 500 cases per 100,000. The mortality rate is 88.7 per 100,000 persons.⁵⁰

It is clear from the statistics above that the rates of tuberculosis infection in Zambia are very high and that many people are dying as a result of this disease. Having lived and worked in Ndola, where there is one of the largest hospitals in Zambia along with the Flying Doctors' Clinic (which now almost specializes in treating tuberculosis) and as a church pastor's wife, I have noted that there is much ignorance about tuberculosis among people in Ndola. There are many reasons that have led to the dramatic increase of tuberculosis cases. First, there has been, a lack of sensitization and education on tuberculosis, especially in Ndola rural where some people do not understand how this disease is transmitted. Many people in rural areas still believe that tuberculosis is as a result of witchcraft, and they spend time nursing tuberculosis patients without putting in place precautions to protect themselves from catching this deadly disease. Second, there has been few educational programmes offered in clinics such as the Directly Observed

⁴⁹ Dorothy Chanda and Davina J. Gosnell, *The impact of tuberculosis on Zambia*, p. 4

⁵⁰ Dorothy Chanda and Davina J. Gosnell, *The impact of tuberculosis on Zambia*, p. 4 -5.

Treatment,⁵¹ (hereafter DOTS), there has not been much work done in educating the masses. The levels of knowledge and compliance to tuberculosis treatment and knowledge through the DOTS has not proved very effective as revealed in a research statistics stated below;

A household-based survey was conducted in six randomly selected catchment areas of Ndola, where 400 out of 736 patients receiving TB treatment within the six months period...The common reason given for stopping treatment by both the compliant and the non-compliant patients was that they could not continue with the medication when they started feeling well (45.1% and 38.6%), respectively. Meanwhile, other reasons given by compliant patients were lack of knowledge on the benefits of completing TB course (25.7%), TB drugs too strong (20.1%) and lack of food in the home (11.4%). Similarly, the non-compliant patients mentioned running out of drugs at home (25.4%)...as reasons for stopping.⁵²

The statistics above clearly show a lack of knowledge on tuberculosis and a lack of understanding on the implication of non-compliance to tuberculosis treatment.

Third, there is much stigma around tuberculosis in the Church and in the community as a whole.⁵³ Many people believe that tuberculosis is a symptom of HIV/AIDS. Therefore, when one has tuberculosis, they are thought of as having HIV/AIDS even if these two diseases are clearly distinct. Based on much stigma and fear of being diagnosed with HIV/AIDS, there are very few people who go to health centres to be tested and treated for tuberculosis in Ndola. Therefore tuberculosis is a disease that threatens the well-being of many people and has had a negative impact on most households.

Three major diseases that threaten the well-being of most Zambians have been pointed out. It is important to observe that there are other diseases such as cholera, mental

⁵¹ The Directly Observation Treatment is a standardised methods for tuberculosis detection, management, monitoring and also entails that medication is taken while the care provider is observing the patient swallowing the drug at home. This initiative is a World Health Organization program aimed at combating the problem of tuberculosis, (see Fredrick Kaona, "An assessment of factors contributing to treatment adherence and knowledge of TB transmission among patients on TB treatment (Ndola: Mwengu Social and Health Research Centre, 2004) p.3.)

⁵² Fredrick Kaona, "An assessment of factors contributing to treatment adherence and knowledge of TB transmission among patients on TB treatment" (Ndola: Mwengu Social and Health Research Centre, 2004) p.1.

⁵³ Fredrick Kaona, "An assessment of factors contributing to treatment adherence and knowledge of TB transmission among patients on TB treatment," p.4.

illnesses, bilharzia and the like, that also impact on the well-being of most Zambians, but the three mentioned above are currently the major causes of death.

2.3 The causes and impact of poor health provision in Zambia

It has been made clear in the previous sections of this chapter that Zambia is a nation hugely impacted by sicknesses and diseases. It is important to note that the standards of health provision and health services have continued to go down in most government hospitals and clinics. These health institutions are now turning into centres where people go to die rather than being places where people could receive healing and well-being. There are several reasons that have led to the poor health provisions in most government hospitals and clinics, and there are also several reasons why most people in Zambia are not able to access good health provision. We now turn to examine some of these reasons that have led to poor health provision and a lack of access to good health provision in Zambia.

2.3.1 The problem of poverty⁵⁴

Despite its vast land and huge water reserves, Zambia is one of the poorest countries in Africa. Poverty in Zambia is wide-spread and traceable through the living conditions and the poor quality of health among most Zambians. As a result of the country's bad economy, there are very few clinics and hospitals that have been built in the last decade by the Zambian government, and as such the burden of disease has continued to impact on the country's economy and the well-being of most people.⁵⁵ It is important to point out that very few hospitals and clinics have been built since 1990 and that those that were built by the colonialists and during the years between 1964 to 1989, have no proper

⁵⁴ Poverty in this dissertation refers to human poverty that has to do with low life expectancy, lack of decent education, and poor access to basic needs, such as secure food supply, health care, education, water, sanitation and housing. Rural Poverty Portal, see <<http://www.ruralpovertyportal.org/english/regions/africa/zmb/index.htm>> (accessed 05/09/2007).

⁵⁵ Julius Ihonvbere, *Economic Crisis, Civil Society and democratization: The case of Zambia, Africa* (Asmara: World Press, Eritrea, 2005).

communication systems, and lack essential drugs and ambulances which the poor in rural areas could utilize to access good medical services.⁵⁶

Zambia has also been affected by the problem of unemployment.⁵⁷ This problem has been at its highest since 1991. The problem of unemployment has to a large extent been caused by poor economic policies that were implemented through the World Bank and the International Monetary Fund. These policies, commonly known as the Structural Adjustment Programme, (SAP) led to the privatization of a number of companies in Zambia leading to a number of people being retrenched by the new owners of the companies which were privatized. Therefore, the impact of poverty among most Zambians is huge and affects many people as stated by Phiri in the quotation below.

It is estimated that 73% of Zambians live below the poverty line and that 71% of Zambians today live in abject poverty. Because of the much poverty in Zambia, many people are prone to sicknesses and disease. Most women are involved in prostitution as a survival strategy.⁵⁸

To add to Phiri's observations it is important to state that findings based on the research conducted by various organs of civil society in Zambia revealed that the life expectancy has dropped to an average of 37 years, while the infant mortality rate is currently as high as 112 per 1000 children born and that, of all the children that survive death at birth, 23% of these children living in towns and cities are undernourished.⁵⁹

The Zambia Enrolled Nurses in the rural part of the North Western Province of Zambia also conducted research to determine the extent and impact of poverty in the area. It was revealed in their research that 47% of all the children in Mwinilunga and the surrounding villages are stunted because of poor diet and unhygienic conditions, and that 43% of these children are underweight due to undernourishment and poor living conditions.⁶⁰

⁵⁶ International Monetary Fund Report on Zambia, "Enhanced Structural Adjustment Facility, Policy Framework Paper, (Lusaka: 1999-2001), p.21.

⁵⁷ Evaristo Mambwe, *The Challenge of Poverty for the Church in Zambia*, p.21.

⁵⁸ Besinati Mpepo Phiri, *The path away from poverty*: p.3.

⁵⁹ Jesuit Centre for Theological Reflection, *Parallel Report economic, social and cultural rights in Zambia*, p. 14.

⁶⁰ Julius Ihonvbere, *Economic Crisis, Civil Society and Democratization*: p.194.

The city of Ndola, where I have lived all my life, has also been affected by high levels of poverty like the rest of Zambia. This has led to a situation where people are turning to crime, prostitution and street trading as a means of survival. Ndola used to be one of the cleanest cities in Zambia, but because of street trading it has become littered all over. Many people in Ndola survive on buying and selling of food on the main streets of the city.

Based on the above facts, it can be observed that the problem of poverty in Zambia is huge and accounts for many untimely deaths and the bad health situation which most people are currently experiencing.

2.3.2 Expensive medical services

There are many people in Zambia who would want to seek good medical attention from privately-run hospitals and clinics, but cannot do so because it is very expensive. It is only a few people who are able to pay for such health services provided by private practitioners. The introduction of user fees in government hospitals and clinics (which have recently been abolished in government rural health centres) has also contributed to much sickness and disease because people living in abject poverty cannot afford to pay these user fees and they stay away from seeking professional help whenever they are sick.⁶¹

It is important to also point out that those people who manage to pay user fees to attend government clinics and hospitals do not receive essential drugs because they usually are not available and they are given prescriptions so that they could buy medicines from private drug stores.⁶² During my visit to some clinics and the hospitals in Ndola and through my day-to-day life experiences with the people in townships, I observed that many people who get prescriptions are not well informed about medicines, and they go to

⁶¹ Alick Dunken et al. *Drivers for pro-poor change: an overview*, p.25.

⁶² International Monetary Fund Report, Zambia, "Enhanced Structural Adjustment Facility," p.14.

buy prescribed drugs from illegal drug stores which are usually operated by untrained pharmacists who often sell either expired drugs or advise patients wrong dosages.⁶³

The impact of expensive medical services is evident in Ndola, especially in townships where most people live in abject poverty. Ndola, once a vibrant city economically is one of the cities with the highest rate of HIV/AIDS infections, high cases of malaria and tuberculosis in Zambia.⁶⁴

Clearly then, expensive medical services have had a huge impact on most Zambians who are unable to pay for health services. It is evident that only people with money are able to pay for good health services and this has led to a situation where only the rich have access to good health services.

2.3.3 Dilapidated infrastructure and poor community services by government

Much infrastructure such as roads, public buildings and recreation centres are dilapidated in Zambia. The road network is poor in many towns and rural areas in Zambia. In some rural and urban areas roads are impassable as a result of huge potholes, and this makes it difficult for medical services such as ambulances, mobile clinics and professional medical people to travel to rural or peri-urban areas and provide medical services.⁶⁵ In peri-urban⁶⁶ areas and some urban areas, potholes on some national roads make it difficult for people from rural areas to travel and have access to good health institutions such as hospitals and clinics.⁶⁷

⁶³ Gerry Nkombo Muuka, *Zambia's SAP— A response to Sam Okoroafo's Paper: "Managerial Perceptions of the Impact of Economic Reform Measures on the Economic Reforms and Firm Performance in Restructuring Economies: A Comparative Assessment*, accessed 23/2/2007.

<<http://www.ewp.rpi.edu/jbdn/lbdnv101.htm>

⁶⁴ Central Board of Health, *Antenatal Clinic Sentinel Surveillance of HIV/ Syphilis*, p.44.

⁶⁵ Department for International development. *Zambia: Country Assistance Plan* (Department for International Development, London, 2004), p.4 -5.

⁶⁶ Peri-urban areas in this dissertation refer to location where there are less government infrastructures, less municipality services and near to a city/town. See Andreas Schmidt, BORDA Cooperation Office SADC, Lesotho, accessed 05/09/2007 < <http://www.borda-sadc.org/modules/news/article.php?storyid=6> >

⁶⁷ Department for International development. *Zambia: Country Assistance Plan*, p.5

Other than poor roads, there is also a problem of poor sanitation in most towns in Zambia with many people living in very unhygienic environments. The municipal councils no longer provide quality services and this has led to many people being deprived of safe drinking water. Research conducted by the Jesuit Centre of Theological Reflection revealed that about 49.1% people in Zambia have no access to safe water and that up to 50.9% of Zambians in rural areas have no access to safe drinking water.⁶⁸

The problem of good drinking water is huge in Ndola, especially in the townships where this research was conducted. As a resident of Ndola, I observed that in Mushili Township, people drink water that comes from a dam and is not properly treated. There are times when one is able to trace dead insects in water coming from the tap. The lack of good sanitation and safe drinking water has led to the problem of constant cases of diarrhoea, typhoid and cholera in Ndola and other parts of Zambia.⁶⁹ As a result, many people die of cholera during the rain season. Such unhygienic conditions, in which most Zambians find themselves in, have led to the problem of poor quality of health due to much disease-causing germs.

2.3.4 The problem of the brain-drain in the health sector

Zambia has in the past 20 years experienced a great brain-drain, especially in the medical field. A large number of experienced, qualified and professional medical people and those in other fields such as engineering, education and accountancy, have left the country and gone to seek better work conditions in other countries such as South Africa, Botswana or the United Kingdom. The medical field has been the most affected by such migration.⁷⁰ A survey conducted by a *Mail and Guardian* Journalist from South Africa revealed that there are some clinics in the rural areas of Zambia where they only have one nurse who works as a pharmacist, a doctor and a midwife.⁷¹ Another survey conducted by the Catholic Secretariat in Lusaka found that the problem of brain-drain in the medical

⁶⁸ Jesuit Centre for theological reflection, parallel report economic, social and cultural rights, p. 14.

⁶⁹ Times Reporter, "Blocked Ndola sewer pipes raise concern," in *Times of Zambia Newspaper* (Ndola: Printpak Limited, January 2005), p.3.

⁷⁰ Jesuit Centre for theological reflection, parallel report economic, social and cultural rights, p.23.

⁷¹ Caroline, Hooper-Box. "African brain drain," *Mail and Guardian Newspaper*, 05 September, (South Africa, 2006). See also Nomusa, Maunga, . "Shortage of Health Staff Worries Chituwo," *The Post* (January 27, 2005), p.3.

field has immensely contributed to the poor health provision in Zambia.⁷² It was revealed in the findings of this research that most health centres have a problem of low staffing.⁷³

The problem of low staffing also affects hospitals and clinics in Ndola. I observed that in some clinics in Ndola, there were only two to three nurses with one clinical officer at the clinic attending to over a 100 (one hundred) patients. These nurses have to spread themselves out to attend to patients suffering from various diseases, right from bandaging people with wounds to delivering babies.

Given all this, it is concluded that the problem of brain-drain in the medical field has hugely affected the quality of health provision in Zambia. The few doctors and nurses in most government hospitals and clinics are over-burdened with the load of work they have to do each day. This does not only frustrate them but also causes them to compromise the quality of health they have to provide to the people.

2.4 Conclusion

This chapter has provided a clear picture of the problem of health and well-being in Zambia with specific attention given to the city of Ndola. The chapter has identified poverty, expensive medical provision, dilapidated infrastructure and the brain-drain in the health sector as some of the key factors that have led to such a situation of poor health provision in Zambia.

Based on the facts that the chapter has provided, it could be concluded that health in Zambia has become a right for people who are able to pay for it.⁷⁴ Those who are poor and cannot afford to pay for good health services have mostly ended up providing medical help to members of their families in their houses or go to traditional healers, who are now raising their fees because of the growing demand for their services. There are others who have turned to FHPCs to seek prayers for healing.⁷⁵

⁷² Jesuit Centre for theological reflection, parallel report economic, social and cultural rights, p.23.

⁷³ Jesuit Centre for theological reflection, parallel report economic, social and cultural rights, p.23.

⁷⁴ The World Council of Churches, "Breaking the silence," *Contact Magazine* 169 (2000), p.23.

⁷⁵ Besinati Mpepo Phiri, *The path away from poverty*: p.9.

The next chapter will give the *Zambian* context of religion, health and healing. It will also seek to examine the interface between religion and health. Based on some of the research and theory-building that has been undertaken within ARHAP, this chapter will be answering the question as to whether religion could be considered as a health asset.

CHAPTER 3

UNDERSTANDING RELIGION AS A HEALTH ASSET

3.1 Introduction

The last chapter drew our attention to the current situation with regards to health provision in Zambia. It also noted that most public hospitals lack essential drugs, have few medical personnel and also lack proper facilities to provide good medical services. Infrastructure such as roads from rural communities to some health centres are poor and people in these areas cannot easily access medical services. As a result of this poor health situation, many people are now turning to alternative health providers, many of which are religious in nature, to seek health and well-being. This chapter will therefore seek to understand religion as a health asset.

When one observes day-to-day life in Africa, it is no hidden fact that religion plays a huge role in public life and in households.⁷⁶ Generally, people in Africa are religious and religion is part of their way of life. This leads to a situation where the decisions they make on a day-to-day basis are based on their religious beliefs and convictions.⁷⁷ It could therefore be surmised that religion has a direct impact on people's career choices, livelihood and health-seeking strategies. The impact that religion has on most people in countries like Zambia is also evident on the days of worship, such as Saturday or Sunday. People take time to go to a place of worship like a church, a mosque or a traditional shrine to seek spiritual, emotional and physical health and well-being. In these places, they receive the eucharist, prayers and listen to spiritual songs which mould their moral and social lives in such a way that religion becomes a benchmark in what ever they do or act upon.

⁷⁶ African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa", p.123-124.

⁷⁷ African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa,"p.124

Given this, it is clear that religious convictions hugely influence people's health-seeking strategies in Africa. Cochrane et al, correctly observes that, "...particular religious orientations or world views or convictions enter into the choices made by people seeking health."⁷⁸ If then religion has such a huge impact on people's way of life in Africa, it is important that it is established how religion contributes to health and well-being.

This chapter will first seek to provide an understanding of religion, health and well-being in the Zambian context. Second, it will seek to suggest what it is that religion and religious entities contribute to people's quest for health and well-being. Finally, the chapter will discuss concepts, research and theoretical frameworks developed by the African Religious Health Assets Programme, (ARHAP)⁷⁹ as they continue to seek to make visible to policy makers, religious leaders and organizations like the World Health Organization the religious health assets which people in African communities value and seek healing and wellbeing from.

3. 2 Religion, health and well-being in the Zambian context

Zambia is predominantly a religious nation. It has Christianity as the major religion, with about 85% of Zambians identifying themselves as Christians.⁸⁰ The FHPCs are the fastest growing churches in Zambia and have the highest number of members, followed by the Catholic Church and the evangelical churches which are affiliated to the Evangelical Church in Zambia. About 5% of the population in Zambia is Muslim and about 5% of the population belongs to other faiths such as Buddhism, Hinduism or Baha'i, while Atheists account for 5%.⁸¹ Given the prevalence of religious affiliation, it is important to reflect on the way in which religion influences people's understanding of health and well-being.

By way of illustrating the situation in Zambia, we turn to the interesting story of the Catholic Archbishop of Lusaka, Bishop Emmanuel Milingo. From 1975 he emerged as a

⁷⁸ James Cochrane, et al. ARHAP tools workshop report, accessed 22/12/2006. <<http://www.arhap.uct.ac.za/resources>>

⁷⁹ See the ARHAP website for more details of this research programme. <www.arhap.uct.ac.za>

⁸⁰ African Religious Health Assets Programme, *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*, p.62.

⁸¹ African Religious Health Assets Programme, *Appreciating Assets: The Contribution of Religion to Universal Access in Africa* p.62.

Roman Catholic Faith Healer.⁸² His ministry of healing received much support and following among most Zambians, but was in direct conflict with the Vatican in Rome. The irony to the whole of Milingo's support and opposition was that it was the mainline churches that were mostly influenced by missionaries and the Catholic Church in Rome that stood against his healing ministry. The local people in Zambia, however, especially the poor, saw Milingo as a prophet sent from God. The reason for the condemnation of Milingo by the Catholic Church in Rome, even though he was himself an Archbishop, was simply that his miracle services were different to the understanding of health and well-being in the western context. On the other hand, Milingo's healing ministry received acceptance among most Zambians because it was contextual and addressed the correct understanding of healing and well-being within the Zambian context.

This story alerts us to the fact that while there are a number of different ways of understanding health in Zambia, nevertheless for the majority of Africans, health and well-being is understood in a different way to the way it is understood in western countries and by western medical scientists. In the western medical context, it is usually said that when a person is medically examined and found to be without any diseases, then that person is healthy and well. To western medical scientists, someone living without diseases in the body is said to be healthy. Furthermore, most societies and organizations in the western context define health as "the capacity for work and for enjoyment."⁸³ And if somebody's capacity for work is diminishing, then such a person's capacity for pleasure is slowed down and that individual is considered not healthy.⁸⁴ When these capacities have been restored through medical treatment, the individual is then considered healthy.⁸⁵ Contrary to this, Perera observes that, "Wholeness is an old English word that means health. It connotes a state of well-being. The person is integrated in body, mind and spirit as an individual - an undivided person in a right relationship with God and

⁸² For the full story of archbishop Milingo's healing ministry in Zambia see, Gerrie Ter Haar, *The spirit of Africa: The healing ministry of Archbishop Milingo of Zambia* (London: Hurst and Company, 1992).

⁸³ Jurgen Moltmann, *God in Creation: An ecological doctrine of creation*, The Gifford Lectures (London: SCM Press limited, 1984-1985), p. 271.

⁸⁴ Jurgen Moltmann, *God in Creation: An ecological doctrine of creation*, p. 271.

⁸⁵ Jurgen Moltmann, *God in Creation: An ecological doctrine of creation*, p. 271.

fellow beings. When wholeness is broken, the person is ill.”⁸⁶ This is similar to the Zambian context where health is seen holistically and not just in terms of physical well-being.

To further explain the understanding of religion, health and well-being in the Zambian context, I now want to turn to two research projects that were undertaken through ARHAP, beginning with the research that was conducted for the World Health Organization.⁸⁷ The research was done in a workshop context and the participants provided information in a participatory manner, where they debated issues with regard to religion and health within the Zambian context. In all the towns in which the research was conducted, religion and religious entities ranked high with regard to contributing to health and well-being. The first two findings noted in the research report are as follows:

1. Since the mid 1990's there has been a dramatic proliferation of the number of religious entities (REs) involved in promoting health and wellbeing in a variety of ways, many of which are directly responding to HIV/AIDS. This is altering the nature of the religious contribution to health in Zambia.⁸⁸
2. Religion and religious entities (REs) are perceived to play an important role in the struggle for health and wellbeing in Zambia, with REs ranking higher than other “general” health facilities.⁸⁹

The two findings above show that religion and religious entities play a key role in contributing to health and well-being within the Zambian context. Furthermore, the research informants perceive religion to contribute to well-being in a holistic manner, in the form of food security, education factors, emotional factors and the like.⁹⁰

A second research project undertaken by ARHAP that is of importance for us to note, is that undertaken by Germond and Molapo in Lesotho. In an article, “In search of Bophelo

⁸⁶ Theodore H Perera, “Therapeutic Conversational and prayer: Making persons whole,” Ram, Eric. *Transforming Healing: approaches to healing and Wholeness* (California: World Vision International Publishing House, 1995), p.273.

⁸⁷ This research can be accessed at <<http://www.arhap.uct.ac.za/publications>>

⁸⁸ African Religious Health Assets, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa,” p.72.

⁸⁹ African Religious Health Assets, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa,” p.67

⁹⁰ African Religious Health Assets, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa” p. 73

in the time of HIV/AIDS: seeking a coherence of Economies of Health and Economies of Salvation” they present the understanding of health and well-being in Lesotho that is similar to the understanding of health and well-being in the Zambian context.⁹¹ Germond and Molapo found that the Basotho people of Lesotho refer to health as “*bophelo*.”⁹² The word *bophelo* is explained as follows,

...*bophelo* is full human life in its complex of expressions and social relationships...thus a family can have *bophelo*. So can a village or a nation. In this sense, *bophelo* refers to the quality of life, the total wellbeing of society in all its elements and relationships.⁹³

For our purposes it is significant to note that Germond and Molapo noted that they found a similar perception to that of *bophelo* amongst the Bemba in Ndola in Zambia, concerning the word for health, *ubumi*. They state that, “...the Sesotho concept of *bophelo* correlates almost precisely to the Bemba concept of *ubumi*...the socio-spatial configurations which constitute *bophelo* are also present in *ubumi* in very much the same way as they work in the *bophelo* world.”⁹⁴

I agree with Germond and Sepetla that the concept of *ubumi* in Ndola, where this research was conducted, refers to soundness in the body, soul, spirit, sound relationships with the neighbours and the environment. A person within the Bemba context is said to have *ubumi*, good health and well-being when they are at peace spiritually, physically, emotionally and at peace with their neighbours and the environment. Health and wholeness within the Zambian context is a state of holistic well-being just as it is in the Basotho vocabulary.

This then makes it clear that as health and well-being are discussed in this dissertation, there is need to view it from a holistic point of view and not just in segments. Following what has been discussed above; I present the diagram below to illustrate the interpretation of the understanding of health and well-being.

⁹¹ Paul Germond and Sepetla Molapo, “In search of Bophelo in the time of HIV/AIDS: seeking a coherence of Economies of Health and Economies of Salvation,” *Journal of Theology for Southern Africa*, 126, (2006), p.30.

⁹² Paul Germond and Sepetla Molapo, In search of Bophelo in the time of AIDS, p.30.

⁹³ Paul Germond and Sepetla Molapo, In search of Bophelo in the time of AIDS, p.30.

⁹⁴ Paul Germond and Sepetla Molapo, In search of Bophelo in the time of AIDS, p.39.

Figure 3: The religious understanding of health and wellbeing in the Zambian context

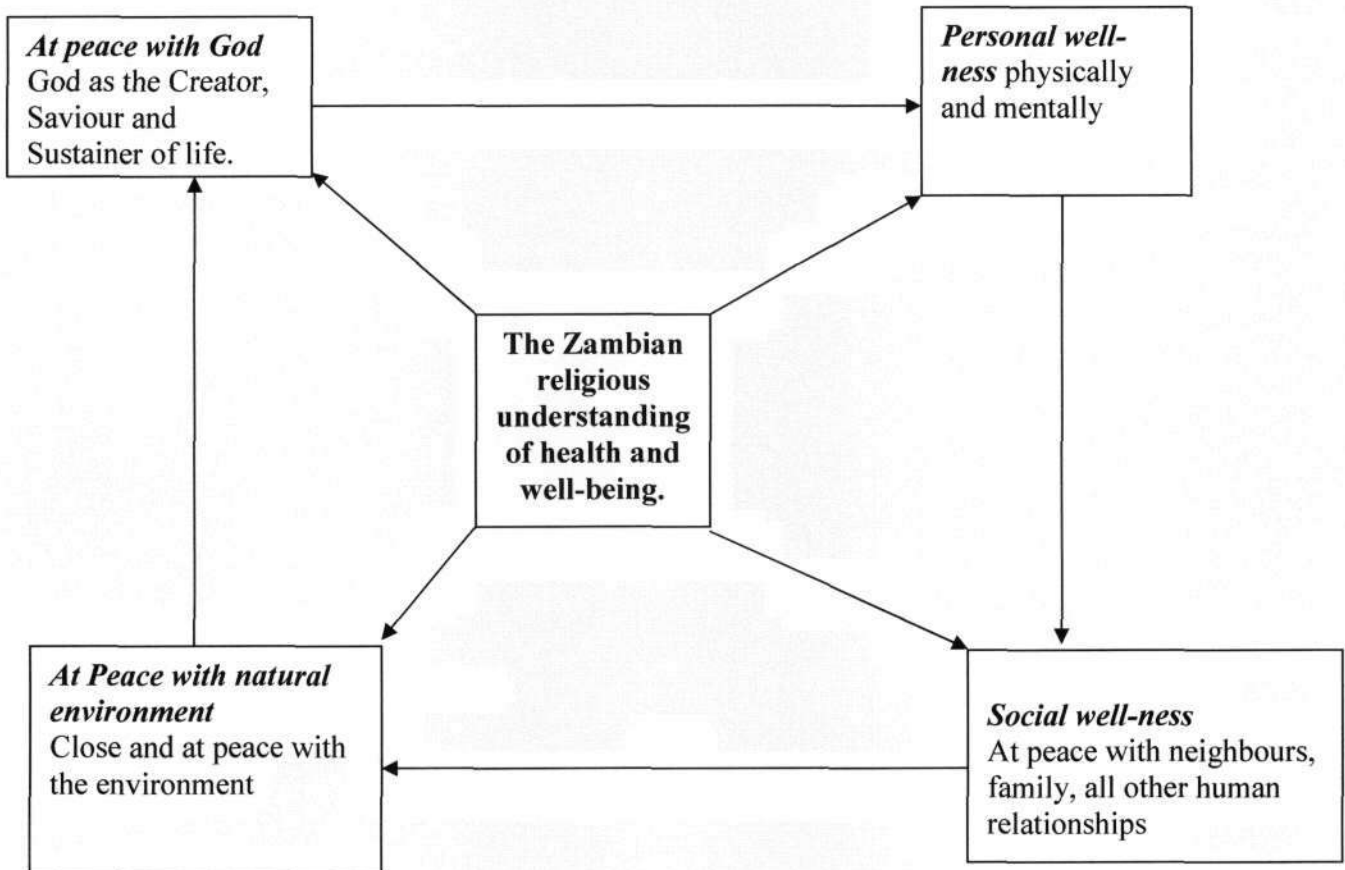


Figure 2 above shows the understanding of health and well-being in the Zambian context. The arrows connecting all the segments, one to the other, indicate that the understanding of health in Zambia is holistic and that all the components represented in the five segments above are interconnected and interrelated. They need to be true of an individual before they could be considered healthy as explained above.

This understanding of health and well-being illustrated above has a direct impact on the practice of African traditional and faith-healing in Zambia. Chavunduka correctly observes that people who go to traditional healers do receive healing which is totally different from the western approach to healing.⁹⁵ The difference is that traditional healing

⁹⁵ G.L Chavunduka, "Traditional Medicine in Africa," in Ram, Eric. *Transforming healing: approaches to healing and wholeness*, (California: World Vision International Publishing House, 1995), p.293

does not just deal with the actual disease in a patient, like in the case of most western approaches to healing, but rather seeks to deal with the disease, the emotional and the psychological effects of the disease.⁹⁶ At the end of the day, one discovers that traditional healers administer a full healing process in that they help minister healing in the physical, spiritual, social and emotional realms, unlike the western scientific medical approach which only addresses the physical realm.

This dissertation focuses on Faith-Healing Pentecostal Churches, who are currently expanding at a fast rate in Zambia, but we must remember that because of the African understanding of health and well-being that we have noted in this section, faith healing has always existed in Zambia. There have been African Independent Churches such as the Zion Churches and the Mutumwa Churches which are among the oldest churches in the country.

Having explained the understanding and perceptions of health and well-being within the Zambian context, the next section will further examine in detail the contribution that religion and religious entities⁹⁷ make to health and well-being.

3.3 The contribution of religious health assets to health and well-being

It has been observed that religion is significant in Zambia and plays a major role in the understanding and seeking strategies of health and well-being. This section will now discuss the contribution of religious health assets to health and well-being. In this dissertation religious health assets will mean the things that religious groups have and offer as they seek to respond in tangible and intangible ways to health problems in communities.

There are several ways religious people and entities contribute to health and well-being. However, before some of the research and theoretical work that ARHAP has done to show how religion contributes to health is discussed in detail, we will examine four ways

⁹⁶ G.L. Chavunduka, "Traditional Medicine in Africa," p.293.

⁹⁷ All churches, mosques, shrines, religious organizations, etc, will be considered as religious entities in this paper.

that Benn has pointed to as being the contribution that religion makes to health and well-being.

He first observes that membership in communities and social networks contribute to the promotion of health and well-being among people in a community.⁹⁸ Benn states that people are social beings and want identity, belonging and a sense of purpose derived from community membership and networks as usually demonstrated in most African nations. The social networks in a given community help to promote, support and provide life skills which at the end of the day help to promote healthy living. It is in these social networks that care for the sick is also promoted. Social networks such as women's fellowships, youth fellowships and men's fellowships help to promote a sense of accountability which usually leads to moral agency. Benn states that it has been proved through research that patients who have a strong social network support are highly likely to recover from chronic illnesses compared to those without social networks of support.⁹⁹

I agree with Benn on the fact that membership in communities and social networks contributes to health and well-being. When support is rendered to a patient by people from the same religious orientation and beliefs, it does help the patient to have the courage and hope to face the next day. Some people even recover from their illness as a result of the emotional support which they receive from their social networks. In fact, groups within religious groups such as the women's fellowship, youth fellowship and men's fellowship become a huge source of strength and support to people who are sick. They visit the home of the sick person, provide food for the patient and even bathe the patient. They also spend time praying for the patient. Such support, as pointed out by Benn helps the patient to recover. Therefore in agreement with Benn it can be said that membership in communities and social networks are one of the ways religion contributes to health and well-being.

⁹⁸ Christopher Benn and Erlinda Senturias, "Health, Healing and Wholeness: Concepts and programs in the ecumenical discussion," in *Neglected Dimension in health and healing: Concepts and explorations in an ecumenical perspective*, study document number 3 (Tübingen: German Institute for medical mission, 2005), p. 54.

⁹⁹ Christopher Benn and Erlinda Senturias, "Health, Healing and Wholeness, p. 54.

The second aspect that Benn observes as the contribution that religion makes to health and well-being is moral agency. Benn observes that the principles that are promoted by religious groups keep people from behaviour that would put them at a higher risk of contracting sicknesses and diseases. Disease such as HIV/AIDS which infect some people as a result of bad lifestyles may be prevented by people who seek to live by the moral standards promoted by their religious moral traditions.

I agree with Benn that moral agency is yet another way in which religion contributes to health and well-being. Many people within religious circles have managed to protect themselves from being infected with diseases that are as a result of being engaged in things that their religious tradition have pointed out to be sin. Cancer of the lungs is mostly common in people who smoke and smoking in most religious groups is seen as sinful and this keeps most religious people from having lung cancer. HIV/AIDS and other sexually transmitted diseases are mostly acquired as a result of adultery or fornication. However it must be noted that some religious people are also infected through unfaithful spouses and other forms of transmission of the viruses such as blood transfusion etc. Therefore the passion and commitment by religious people to teach their members and members of society on the importance of living a holy and righteous life before the Supreme Being to an extent, promotes moral agency which in turn promotes health and well-being.

The third aspect that Benn identifies as the way in which religion contributes to health and well-being is the contribution made by religious entities through worship and rituals.¹⁰⁰ He states that spiritual songs, prayers and the sacred scriptures have a positive impact on people as these bring about resilience and hope in life.

I served as a pastor's wife for 7 years in Ndola, Zambia, a town where this research was conducted. I found it amazing as I observed that many people received emotional, spiritual and physical healing when spiritual songs, prayers and the reading of sacred scriptures were done. In one of the FHPCs that I visited during the field research, I observed that most people who had responded to the altar call for prayer later gave a

¹⁰⁰ Christopher Benn and Erlinda Senturias, "Health, Healing and Wholeness, p. 54.

testimony before the congregation, that God had given them a scripture to assure them that they would live and not die. I therefore agree with Benn that spiritual songs, prayers and the reading of the sacred scriptures contribute to health and well-being.

The fourth aspect observed by Benn as to how religion contributes to health and well-being is the value and respect of life.¹⁰¹ Benn states that people who have found meaning in life seek to live a fruitful life and develop resilience and motivation when they are sick. Most religions promote life and see it as a gift from the Supreme Being. When people live to respect life as a gift from the Supreme Being, they are committed to its sanctity. They live each day to protect themselves from things that could destroy life because they consider themselves as stewards of the life they have received from the Supreme Being. Such people are most likely to live lifestyles that will promote health and well-being.

It can therefore be observed that religion, though viewed with much skepticism by some people, can contribute to health and well-being as stated above. The next section will further explain specific tangible and intangible ways that religion contributes to health and well-being as noted through the ongoing research work and the conceptual theoretical framework that has been developed by the African Religious Health Assets Programme.

3.4 African Religious Health Assets Programme (hereafter ARHAP)¹⁰²

This research, and other ongoing research work within ARHAP, is seeking to establish a clear understanding of the value that religion and religious entities add to the provision and promotion of health and well-being in Africa. At this point it is important to now explain what ARHAP is and the objectives it is working within.

ARHAP, as noted in Chapter 1, is a research programme that involves scholars from a range of disciplines and institutions of learning such as Emory University in the U.S.A., and the University of Cape Town, University of KwaZulu-Natal, and University of the

¹⁰¹ Christopher Benn and Erlinda Senturias, "Health, Healing and Wholeness, p.54.

¹⁰² To learn more about Africa Religious Health Programme, visit <<http://www.arhap.uct.ac.za>>

Witwatersrand in South Africa, and many other leading institutions and organizations that are involved in health and religion.

ARHAP was started in the year 2002 and has since grown to be an important research programme in the area of religion and health in Africa. "It was predicated upon a conviction that faith-based organizations, groups and movements, though playing a significant role in the delivery and promotion of health, are generally not well understood or sufficiently visible to public health systems in most societies."¹⁰³ Based on such convictions, ARHAP has sought to unveil the role that religious health assets are playing in most societies in Africa and beyond. It must also be said that ARHAP views the health of a society, especially the health of women and children as a clear indicator of a community's well-being and not necessarily the general gross production of a society or a nation.¹⁰⁴ To further comprehend the ethos of ARHAP on matters of health and well-being, we can reflect on the meaning of the letters ARHAP.¹⁰⁵

African: The first letter A stands for the continent of Africa. A continent affected with diseases, environmental degradation and poverty. Therefore, Africa is the context in which ARHAP is seeking to research into the contribution of religion to health and well-being. However, there is need to point out that though ARHAP's research work has been happening in Africa, it has a global focus as well and its research work is applicable in other continents.

Religion: ARHAP is an Inter-religious group which seeks to address issues of health among all religious groups in Africa. The focus is mainly on ways in which various religions in Africa view health and well-being. ARHAP also seeks to investigate the assets that religious groups have and how such assets contribute to health and well-being. It would therefore be stated that the goal of ARHAP is to identify, assess and map religious health assets in Africa and make the information they get accessible to religious leaders, and private health policy formulators, organizations such as the World Health

¹⁰³ James R. Cochrane et al. et al. ARHAP tools workshop report, accessed 12/1/2007.

¹⁰⁴ African Religious Health Assets programme. <<http://www.arhap.uct.ac.za/homepage>>

¹⁰⁵ The explanations on the letters A.R.H.A.P are taken from their website. Accessed 12/11/2006. <<http://www.arhap.uct.ac.za>>

Organization (WHO) and national governments' policy makers in Africa. ARHAP research work is not only limited to the Christian faith but engages all other religions. The fact that these religious groups are involved in public health activities and provide between 30 – 70 % of all health providing institutions in Africa, suggests that there is need to make visible this enormous contributions all religious groups are making in Africa, especially at such a time when HIV/AIDS, malaria and tuberculosis are the leading cause of death in Africa.

Health: ARHAP is interested in what contributes to health and healing in an African context. ARHAP takes seriously the fact that the understanding of health in the western scientific context is different from the understanding of health in the African context. As earlier mentioned, in the western context, a person is said to be healthy when he/she is not ill. When someone has been examined and proved to be without any diseases in his/her body, such a person is said to be healthy. In the African context, health is seen to be wholistic. A person is said to be healthy when he/she is at peace with God, the neighbours, environment and themselves. Therefore, it has so far been understood that health in Africa is seen as the interior, the exterior and the social body.¹⁰⁶

Assets: Most research and development organizations approach their research work based on the needs and deficiencies of the people in a given community. They research problems and the way outside organizations could bring in experts to come and help solve the problem of the people in a society. ARHAP's approach is different. Their research work is based on the assets that the community has and how such assets could be mapped, understood and then leveraged and aligned for the promotion of the health and well-being of people in Africa.

Programme: ARHAP is not a company or a faith-based organization. It is a programme that draws together academics from various disciplines which are mainly in public health and religious studies. As a programme, ARHAP seeks to draw together information through its research, and use such information to influence policy formulation with regard to health and well-being.

¹⁰⁶ Paul Germond and Sepetla Molapo, "In search of Bophelo in the time of AIDS..."p.36-37.

As a programme, ARHAP operates within set objectives and these objectives are stated below.

3.4.1 ARHAP's objectives

The following objectives of ARHAP are as stated on their website.¹⁰⁷

- To assess existing baseline information sources and conduct an inventory (“mapping”) of religious health institutions and networks in Africa.
- To articulate conceptual frameworks, analytical tools, and measures that will adequately define and capture religious health assets from African perspectives, across geographic regions and different religions, in order to align and enhance the work of religious health leaders and public policy decision-makers in their collaborative efforts.
- To develop a network that will include nodes of scholars and religious as well as public health leaders in sub-Saharan Africa; plus scholars from outside Africa, religious leaders and representatives of key funding, development and policy-making organizations.
- To train future leaders of both public health and religious institutions in religious health asset assessment skills (capacity building).
- To provide evidence to influence health policy and health resource allocation decisions made by governments, religious leadership, inter-governmental agencies and development agencies.
- To disseminate and communicate results and learnings widely and regularly.

The above objectives are the boundaries within which ARHAP seeks to operate.

3.4.2 ARHAP in Zambia

There are two levels of research happening in Zambia under the support and initiative of ARHAP. The first level of research is being done by MTh students from the University of KwaZulu-Natal, namely Mary Mwiche, Roy Hamalyango'mbe and Maybin Kabwe and myself. Mwiche has been interviewing Church leaders and her research seeks to explore

¹⁰⁷ Please note that the objectives of ARHAP presented below are as stated on their website: <<http://www.arhap.uct.ac.za/home>>

the extent to which local churches in Ndola are recognizing and making use of religious health assets. Hamalyango'mbe has interviewed 13 national leaders within the medical and religious circles involved in policy making. His research seeks to find out the extent to which policy makers see the connection between religion and health. Kabwe has been interviewing five Church leaders running provincial health programmes and his research will seek to investigate the contribution local churches are making towards direct health outcomes on the Copperbelt in Zambia.

The second level of research, which has already been concluded, was done by ARHAP for the World Health Organization. This research sought to assess and map Religious Health Assets (tangible and intangible) in Zambia and make available the information to religious and national policy makers, World Health Organization and other leaders so as to help in the ongoing struggle against HIV and AIDS.¹⁰⁸

This research lies squarely within the broader concerns of the ARHAP project, and specifically in the work being undertaken to develop an understanding of the way in which religion contributes to public health in Africa. And this is done in the context of the struggle for health and healing in a time of AIDS and Structural Adjustment Programme.

3.4.3 ARHAP theory matrix

In trying to understand the interface between religion and health, ARHAP has developed a simple matrix to describe what is meant by a 'religious health asset' (RHA).

The matrix presents two kinds of assets, tangible assets and intangible assets, with two kinds of health outcomes. Below is the explanation on what tangible and intangible mean.

¹⁰⁸ 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.121.

Figure 4: ARHAP THEORY MATRIX¹⁰⁹

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

3.4.3.1 Tangible assets

As the discussion on the contribution that religion makes to health and well-being continues, and builds on the four aspects that Benn points out (in 3.3, above) as ways in which religion contributes to health, it is vital to explain what tangible and intangible assets mean in this dissertation. These two words will be used time and again as an understanding of the value that religion contributes to health and well-being is sought. Tangible contributions to health and well-being refer here to visible ways religion contributes to health and well-being, in ways such as hospitals, clinics or dispensaries. As tangible assets are discussed under this heading, it is important to state that between 30%

¹⁰⁹ This research and other ongoing research in Zambia, South Africa and Lesotho forms part of a wider research project which is using the above matrix to clarify the relationship between religion and health, and to describe what is meant by a 'religious health asset.' To learn more about the matrix visit <http://www.arhap.uct.ac.za>

- 70% of all health centres and infrastructure in the sub Saharan region of Africa are run by religious groups.¹¹⁰ A survey conducted by the Churches Health Association of Zambia has found that more than 30% of health provision in Zambia is provided by Christian hospitals and rural clinics which are fully run by either a church or a Christian Organization.¹¹¹

Research conducted by Oxfam, one of the longest-serving Non-Governmental Organizations in Zambia has rightly observed and has stated this about religious health assets,

The formal health-service infrastructures in many developing countries have recently experienced serious problems due to a combination of local, regional and international factors, ranging from the debt crisis and unfair trading practices, to weak infrastructures and lack of skills. Governments have had to rely on religious missions and other non-government organizations to fill gaps in the provision of services, since these are often able to obtain foreign currency and trained personnel.¹¹²

We therefore observe that religion contributes to health and well-being in Africa in tangible ways.

3.4.3.2 Intangible assets

Other than making a tangible contribution to health and well-being, religion, as seen in the matrix above, also makes intangible contributions to health and well-being. Intangible assets are assets that are not visible to the human eye and cannot be quantified physically by people and yet effectively contribute to people's health and well-being. These assets are things like prayers, spiritual songs or hope. Prayer and anointing with oil are common intangible assets in Zambia. There are people who attend, time and again, FHPCs prayer services and receive only prayer and anointing with oil. They then testify of experiencing the power of God. One of such prayer services where people used to go to in Zambia was those hosted by Emmanuel Milingo as mentioned earlier in this chapter. The people who

¹¹⁰ African Religious Health Program, accessed 23/11/2006. <<http://www.arhap.uct.ac.za>>

¹¹¹ Godfrey Biemba, "Value-Added and Invisibility of Religious Health Assets," accessed 2/5/2007.

¹¹² Deborah Eade and Suzanne Williams, *The Oxfam handbook of development*, p.633.

attended Milingo's healing services declared openly with much faith that they found these sessions, "moving, inspiring, invigorating, and captivating."¹¹³ Many Zambians felt that Milingo was God-sent and had divine power from God which was manifested through prayer and the anointing of oil.¹¹⁴ The fact is that people received healing when they attended Milingo's healing services. This suggests that while prayer and other religious activities are intangible, they nevertheless have an impact on people's health and well-being.

It must be stated that church organizations are also doing much counselling, encouragement and support for the sick and the dying in the times of HIV/AIDS in Zambia.¹¹⁵

It is therefore clear from the above explanation of tangible and intangible assets that there are a range of tangible and intangible ways in which religion can contribute to health and well-being. When the ARHAP matrix is further examined it can also be seen that there are four key quadrants and these quadrants are explained below.

3.4.3.3 Tangible religious assets and direct health outcomes

This category of assets is for those that are tangible and have a direct health outcome on the people and society. They are tangible in that they are visible to the eye. They also have a direct health outcome in that there is an obvious and direct impact that they have on people who go to seek health and healing from such entities. The examples of such entities are;

1. Faith-Healing Pentecostal Churches
2. Traditional Healers and their shrines
3. Faith-Based Care Groups
4. Faith-Based Hospitals, Clinics, Church Dispensaries

¹¹³ Ter Gerrie Haar, *Spirit of Africa: The healing Ministry of Archbishop Milingo of Zambia*, (London: Hurst and Company, 1992), p.50.

¹¹⁴ Gerrie Ter Haar, *Spirit of Africa: The healing Ministry of Archbishop Milingo of Zambia*, p.50

¹¹⁵ African Religious Health Assets Programme, "Appreciating Assets, p.76.

All the above entities are considered as tangible within the ARHAP matrix and also have a direct outcome on health and well-being in society.

3.4.3.4 Intangible religious assets and direct health outcomes

The assets that are considered to be intangible and having a direct health outcome on people and their community are those assets that one cannot quantify and are invisible to the human eyes. Though physically unquantifiable, these assets produce results on direct health outcomes when administered to people. Examples of such assets are things like,

1. Prayer and anointing – praying for the sick and anointing people with oil.
2. Advocacy/ prophetic ministry – speaking against unjust or immoral acts.
3. Motivation – ability for the sick to not give up, but persevere in life.
4. Moral responsibility – moral agency

As pointed out above, these are assets that one cannot take a photograph of, but work to produce results when they are implemented on people.

3.4.3.5 Tangible religious assets and indirect health outcomes

There are religious health assets that are tangible but have indirect health outcomes. In other words, one can physically quantify these assets but cannot quantify their direct health impact on people and their communities. Examples of such assets are:

1. Women's, men's and youth fellowships – church or community-based fellowships.
2. Choir – The singing that is done in church, for the sick and at funerals.
3. Education – formal and informal education. This incorporates education of health and well-being.
4. Sacraments/rituals – The Breaking of Bread, baptisms (spirit and water baptism).

The suggestion through the matrix is that these assets could well have a great impact upon people's health and well-being, and yet such impact cannot be immediately noted and described.

3.4.3.6 Intangible religious assets and indirect health outcomes

Finally, the assets that are considered intangible and having indirect health outcomes are those assets that one cannot physically quantify and though they have an impact on health outcomes, such impact is not direct and thus cannot be obviously gauged or quantified.

Examples of such assets are things like;

1. Individual (sense of meaning) – value for life as a gift from the Supreme Being.
2. Belonging-Human/Divine – a sense of knowing that I belong to a community and I am a child of God.
3. Trust/distrust – ability to trust the Supreme Being and also ability not to trust things they realize could cause harm to them.
4. Faith-hope-love – Ability to hope for the best from the Supreme Being and not give up in life.

The above assets work silently and yet have a huge impact on people's health and well-being.

Having analysed what intangible and tangible assets are, and the health outcomes that result from these assets, it is important here to state that the ARHAP matrix will be used in Chapter 5 to analyse how FHPCs work very strongly in the 2nd quadrant – intangible assets and direct outcomes – making use of factors such as prayer, ritual and an ongoing relationship between the 'pastor' and the congregation to impact directly upon health. Through this they also have an ongoing effect upon quadrant 4 – on the general well-being (indirect health outcomes). I must however state here that, this matrix is just an interim theoretical device to help ARHAP with their initial research work on the interface between religion and public health, and this study is testing it and contributing to it.

3.5 Conclusion

This chapter has explained the understanding of health and well-being in the Zambian context. The chapter has also explained the concepts and frameworks that ARHAP has been working with to make visible to policy makers the contribution that religion and religious entities are making to health and well-being in Africa.

The next chapter will provide the research methodology and data analysis for the research that was conducted in Ndola, Zambia among FHPCs health seekers. As pointed out above, many people in Ndola are visiting traditional healers and FHPCs to seek healing and well-being amidst poverty and the burden of diseases and unemployment that are affecting most households. Therefore, the aim of the research in Ndola was to investigate the impact of FHPCs on health-seeking behaviours among health-seekers in Ndola, Zambia.

CHAPTER 4

RESEARCH METHODOLOGY AND DATA ON FHPCs AND HEALTH-SEEKERS IN NDOLA

4.1 Introduction

The previous chapter provided insight into ways in which religion can be understood as a health asset. It also highlighted the understanding of health and healing in the Zambian context. Finally, the chapter introduced ARHAP and brought out the objectives, concepts and the framework within which this programme is working as it seeks to make visible to policy makers the impact of religion on health and well-being in Africa.

This chapter will focus on the research methodology applied in the study to answer the main research question asked in Chapter 1, "What impact do FHPCs have on health-seekers and to what extent can they be understood as a religious health asset?" The chapter gives details of how the research was conducted, showing the process followed to obtain the data. It also shows how the questionnaire was designed and administered. The chapter finally provides an analysis of the data collected.

4.2 Research design

This study used a survey method in order to secure a representative sample of the relevant population. In a survey, a sample of selected people are used but results are generalised to a larger group from which the smaller group was chosen.¹¹⁶ As stated in Chapter 1, Ndola has many church denominations and the Pentecostal movement is very broad. There are Pentecostals whose teachings and practices lean more on the evangelical doctrine and there are also those that are more charismatic and are fully dependent on hearing from the Holy Spirit and less on systematic doctrines. It is such Charismatic Pentecostals that engage in faith-healing almost every Sunday. Therefore the sample of

¹¹⁶ Lawrence Neuman, *Social Research Methods: Qualitative and Quantitative approaches*, (Boston: Ally & Bacon press, 2000) p.34.

this study was drawn from this population which is being referred to as FHPCs in this dissertation.

The sampling of the churches was at two levels. First, purposively the FHPCs were selected from the many Pentecostal Church denominations. It must be stated that in a purposive sampling the researcher selects as many cases as possible with a specific purpose in mind and one of such purposes is to identify particular types of cases for an in-depth investigation.¹¹⁷

Second, looking at the number of registered and non-registered FHPCs in Ndola, this research had no scope to cover all of them but to sample haphazardly a few in order to have a representation in all the areas of the region that the study sought to cover. Nauman observes that the goal of haphazard sampling is to select cases that are convenient.¹¹⁸ Thus, in this research, there were only 48 FHPCs which participated out of about 186 registered in Ndola as stated in Chapter I. The research did not carry the responsibility to establish whether the churches which participated were registered or not, as the focus of the study is on the church attendants and not the leaders who would be in a position to provide or confirm such information. It also appears from my observation as the researcher, that some of the churches could be sub-branches falling under the umbrella of bigger churches registered with the registrar of societies.

A self-administered questionnaire (see appendix A) was used as an instrument to collect data. This was developed to ask questions based on the research questions, and the respondents read the questions and marked their answers on it.¹¹⁹ The questionnaire was used because it was the easiest way of getting information from participants and did not require much of their time. It was also helpful for me to use a questionnaire in that a lot of information from a large number of the sampled population had to be gathered. It must be stated here that time is very significant in research and it limits data collection as it is

¹¹⁷ Lawrence Neuman, *Social Research Methods: Qualitative and Quantitative approaches*, p.198.

¹¹⁸ Lawrence Neuman, *Social Research Methods: Qualitative and Quantitative approaches*, p.196.

¹¹⁹ Lawrence Neuman, *Social Research Methods: Qualitative and Quantitative approaches*, p.250.

determined by the availability of finances and resources, and the interviewer is not the only person whose time is valuable but also people being interviewed.¹²⁰

The research involved 100 participants who were haphazardly sampled among the sampled FHPCs in Ndola. The purpose for sampling 100 participants was to draw a deeper understanding from the FHPCs worshippers on their opinion of their churches in relation to health and well-being. The participants answered most of the questionnaires in my presence and some were done in the presence of my colleagues. As it was not possible to do all the research at once, the research covered 4 weeks in which the sampled churches were visited before or after their Sunday service or weekly meetings. Others were done outside church programmes by individuals whom my colleagues and I identified as members of FHPCs. It took between 10 to 15 minutes for the participants to complete answering the questionnaires.

4.2.1 Design of the research instrument

The questionnaire was short, just 4 pages, and was self-administered (see Appendix A). Kanjee states that a questionnaire should allow the researcher to collect as much information as possible relevant to the research purposes but it should not be too long to complete.¹²¹ The questionnaire had both closed and open-ended questions. There were 28 questions altogether and 26 of them were closed. The close-ended questions had checklists provided and spaces to express another opinion. Close-ended questions do not allow respondents to answer in their own words but to choose from the list provided; this helps to have standardized responses from all the respondents therefore, making data analysis easier.¹²² The close-ended questions asked the respondent's personal details in order to know each respondent participating in the research. They asked for the respondent's age, sex, marital status, language, educational level, and occupation. They also asked for details of the church that the respondent attends. They asked for the name of the church, its location and how long it has existed.

¹²⁰ Brian Pratt and Peter Loizos, *Choosing Research Methods: Data Collection for Development Workers*, (Oxford: Oxfam, 1992), p.29.

¹²¹ Anil Kanjee, "Assessment research," *Research in Practice: Applied Methods for the Social Sciences*, (Cape Town: University of Cape Town Press, 2006), p.485.

¹²² Anil Kanje. "Assessment research," p.486.

Kanjee correctly observes that open ended questions allow respondents to communicate their experiences or opinions on issues in their own words.¹²³ In the study only 2 questions were open-ended and they asked for the respondent's opinion and view on how their church relates with other health service providers and the wider society. As reflected under the section on pre-testing, a list of possible answers to the questions could not be made. The problem which arises with open-ended questions is that they are not easy to classify into categories and analyse especially where a large sample is involved.¹²⁴

In the questionnaire that was used to collect the data for this research, there were three sections to it, each with instructions on how to complete it. The first section focused on the background information of the respondent. The second section asked for details of the FHPCs that the respondent attends. The third section asked the respondent on the healing practices of their church and their experiences with the healing sessions. It also asked for the respondent's view or opinion on their church's healing practices in relation to other health service providers and the wider society.

4.2.2 Pre-testing of instrument

After the questionnaire had been constructed, it was tested. Pre-testing a questionnaire gives the researcher an opportunity to determine the time taken to administer it, identify problems associated with it and discover questions that may arise from it.¹²⁵ In this study the instrument used was pre-tested in December 2005 to enable me as the researcher to come up with a range of possible answers to the questions so as to form a list of predetermined options for each question in the questionnaire. The other reason for pre-testing the instrument was to assess if the respondents would find it manageable in terms of time and clarity. The pre-testing was done in a focus group¹²⁶ consisting of eight people attending FHPCs in Ndola, Zambia. This group was chosen to ensure that they

¹²³ Anil Kanjee, "Assessment research," p.486.

¹²⁴ J. Schnetier, "Principles of Constructing questions and Questionnaires," *Survey Methods and Practices*, Cape Town: Opinion Survey Centre, Human Sciences Research Council, 1989), p.50.

¹²⁵ J. Schnetier, "Principles of Constructing questions and Questionnaires," p.87.

¹²⁶ Lawrence Neuman, *Social Research Methods: Qualitative and Quantitative approaches*, p.275. "In a focus group, a researcher gathers together 6 to 12 people in a room with a moderator to discuss one or more issues for one to two hours....Focus groups are useful in exploratory research or to generate new ideas for hypotheses, questionnaire items.."

would relate to the questions from their experiences with their churches. They were also seen to be adequate in considering the issues that the questionnaire was trying to find answers to. The eight participants were willing participants who had interest in the subject that I was working with when it was mentioned to them. They were willing to set aside 2 hours for a discussion on the afternoon of 17 December 2005. As is required in a focus group, a moderator introduces issues, and keeps people on the topic and encourages the discussion.¹²⁷ During this research, as the researcher, I facilitated the discussion in the focus group. First, the research and its purpose were explained, after which each question was discussed and possible answers given and agreed upon by the group. The questionnaire was then adjusted accordingly, re-worded where necessary and each question was given a possible range of answers. However, the group could not find a narrow option list for question 3.11 and 3.13 and so they remained open-ended (as noted above).

4.2.3 Data collection and response rate

The data for this research was collected by me and my colleagues in Ndola, Zambia over a period of four weeks in July 2006. There were 100 questionnaires hand-distributed, each accompanied by a covering letter (see Appendix B) explaining the purpose of the study. This letter also informed the respondents of the conditions relating to their participation in the research and sought their consent. The conditions included were that the respondents acknowledge being informed of the purpose of the study and agreed to have their responses used in the report without their names being recorded. The other conditions were that they were not going to be paid and that they could stop answering the questions at any time.

The respondents were encouraged to complete the questionnaires in my presence or that of my colleagues. All the 100 questionnaires were returned to me. The total response rate was 100%. However, there were some questions which were not answered and these are reflected later in the data analysis as missing.

¹²⁷ Lawrence Neuman, *Social Research Methods: Qualitative and Quantitative approaches*, p.275.

4.2.4 Data coding and analysis

Once the questionnaires were collected they were numbered. The checklist provided for each question was numerically assigned codes. Therefore each response had a numerical code assigned to it. This was to enable me as the researcher to capture and analyse data electronically using the Statistical Programs for the Social Sciences (hereafter SPSS) computer program.¹²⁸ The SPSS is a comprehensive set of programs designed for use by social scientists which has easy-to-use pull-down menus which make data analysis easy.¹²⁹

Question number 3.11 and 3.13 as noted above had no range of possible answers so all the answers given by each respondent were tabulated and then similar responses grouped together to come up with a narrow range of responses that could be coded and easily analysed. The presentation of the data was in the form of tables and graphics like pie charts and bar graphs.

4.3 Results of the study

This section of the study reports on the results of the survey of the population of respondents attending FHPCs in Ndola. In line with the intentions of the study the results are reported under headings. They are listed in graphic or table form and they describe the responses to the questionnaire distributed to the respondents. It is important to note here that the slices on the graphs represent percentages of a particular response for a given question of the total population sampled in the research. The slice denoted missing, represents the percentage of the population that did not answer that particular question. Under each graph presented is a key giving an interpretation of the codes represented in the graph.

As mentioned earlier under 4.2.1, the questionnaire had three parts to it and there were 28 questions altogether. In this section, though much space will be taken up, it is important that the results for all the questions be presented in the form of percentages and graphs

¹²⁸ Colin Tredoux and Mario Smith, "Evaluating research design" in *Research in Practice: Applied Methods for the Social Sciences*, (Cape Town: University of Cape Town Press, 2006), p.193.

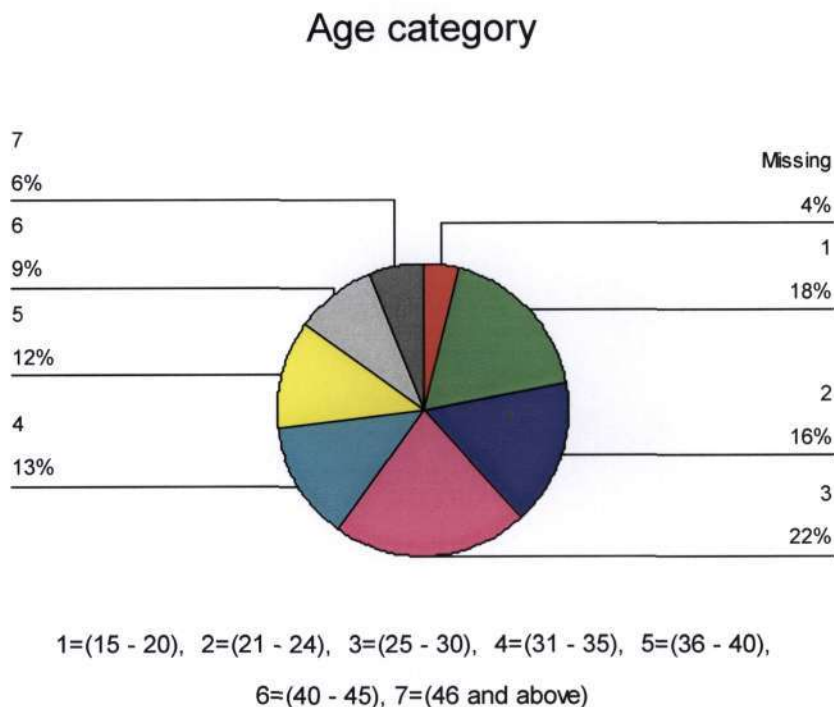
¹²⁹ Colin Tredoux and Mario Smith, "Evaluating research design," p.193.

under each part of the questionnaire as they are significant in the interpretation of the results following in Chapter 5.

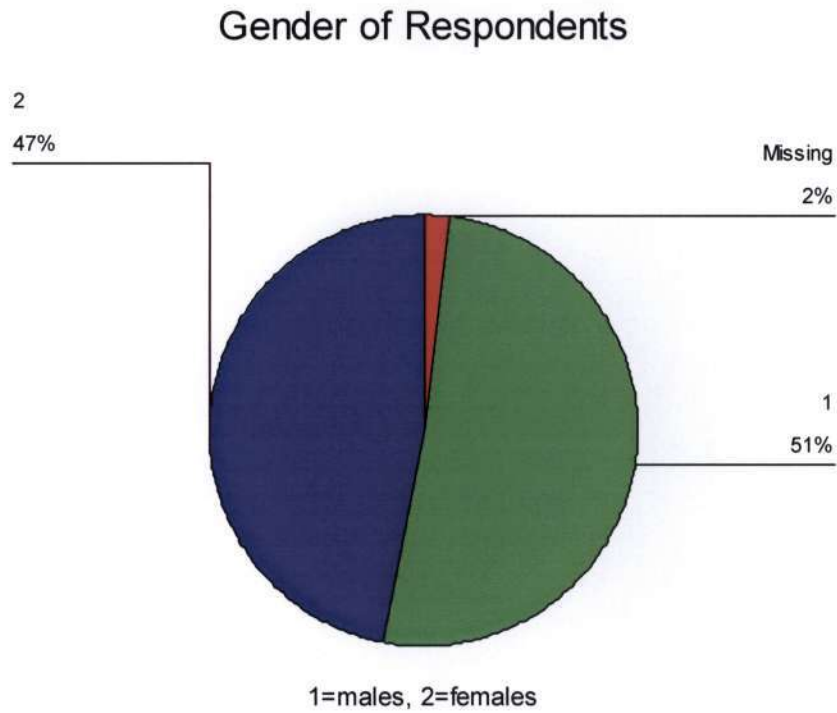
4.3.1. Background information of the respondent

Under this heading, results for the first part of the questionnaire giving the background of respondents are presented from Question 1.1 to 1.7 as follows;

Figure 5 - Question 1.1



This question sought to find out the age-range category of the respondent. The results indicate that 22% of the population of the respondents was in the age range of 25 to 30 years, 18% in 15 to 20, 13% in 31 to 35, 12% in 36 to 40, 9% in 40 to 45 and 6% in 46 years and above. The missing percentage of the population of respondents who did not answer the question was 4%. There is a significant pattern in the age population reduction as the age increases.

Figure 6 - Question 1.2

This question asked for the gender of the respondent. The results indicate that there were 51% males and 47% females in the population that participated in the research. The missing percentage of the population sampled was 2%.

Figure 7 - Question 1.3

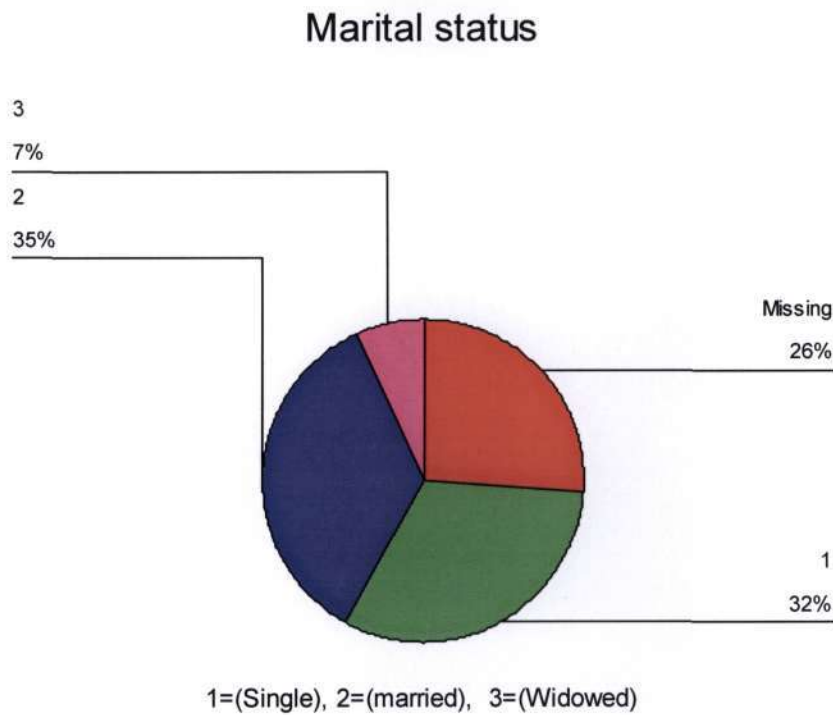
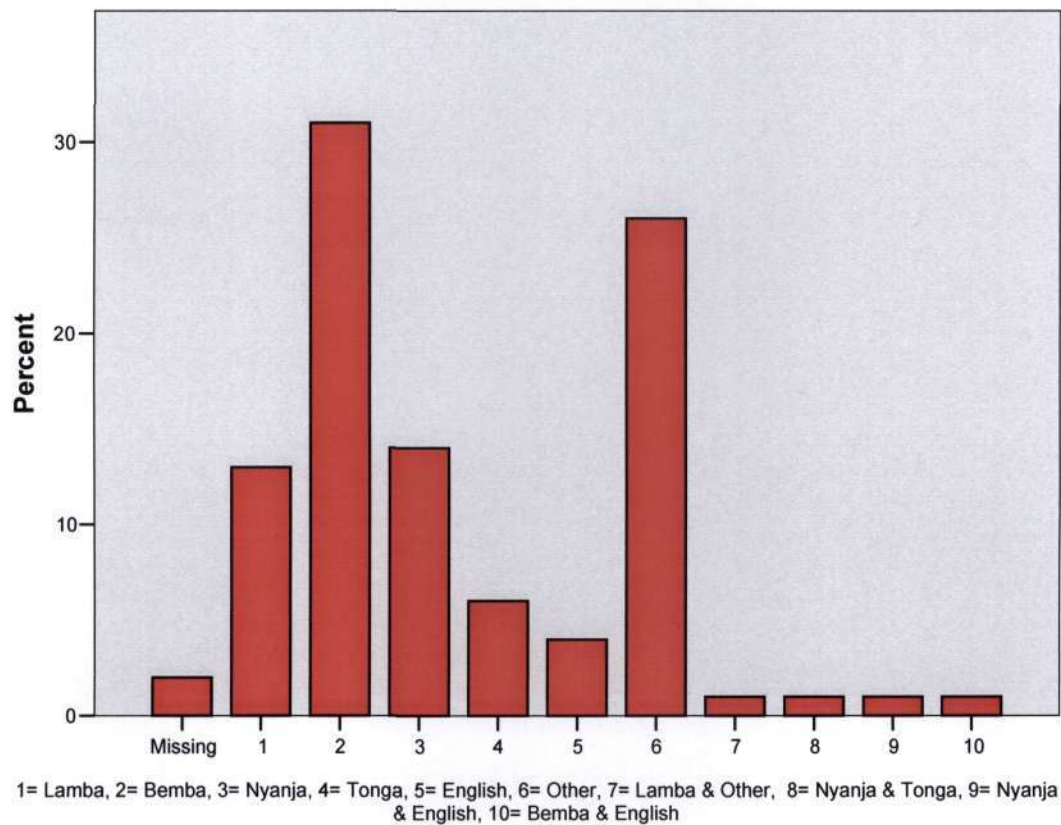


Figure 7 above illustrates the marital status of the respondents. It shows that 35% of the population of respondents was married and 32% was single. The representation of the population for the widows was 7%. The percentage of the population of respondents that did not respond to this question was 26%.

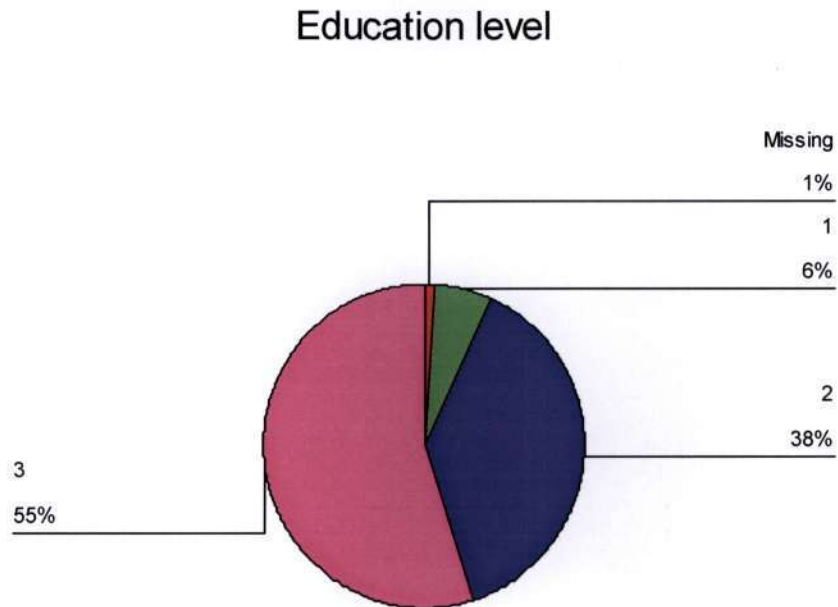
Figure 8 - Question 1.4

Home Language



This question sought to identify the home language of the respondents. The results indicate that 31% of the respondents were Bemba, 26% of them did not have their home languages reflected in the range provided in the questionnaire. Those that are Nyanja were 14%, the Lamba 13%, Tonga 6% and English 4%. There were four combinations of more than one home language each representing 1% of the population of the respondents. The population of respondents that did not answer this question was 2%.

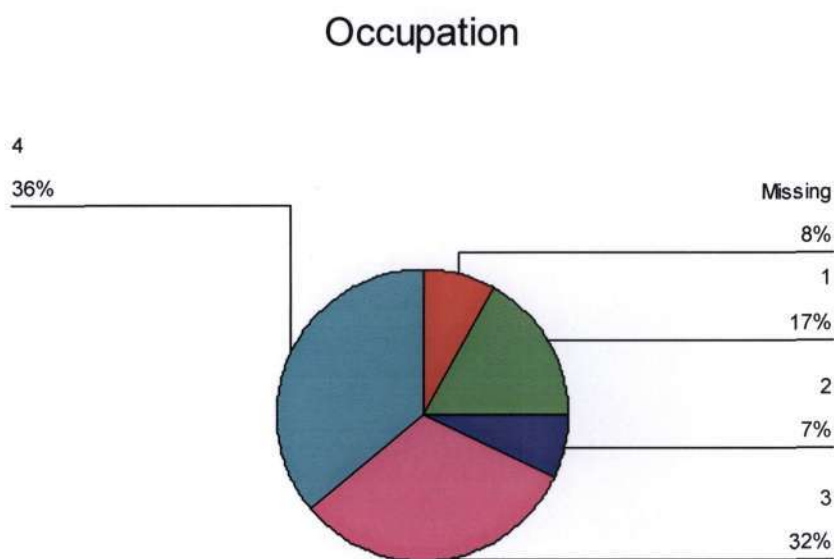
Figure 9 - Question 1.5



1=(Primary school), 2=(Secondary school), 3=(College/ University)

This question was asked to find out the education level of the respondents. The results indicate that 55% of the population of the respondents were at tertiary level, 38% at secondary school level and 6% at primary level of education. There was 1% of the population of respondents that did not respond to this question.

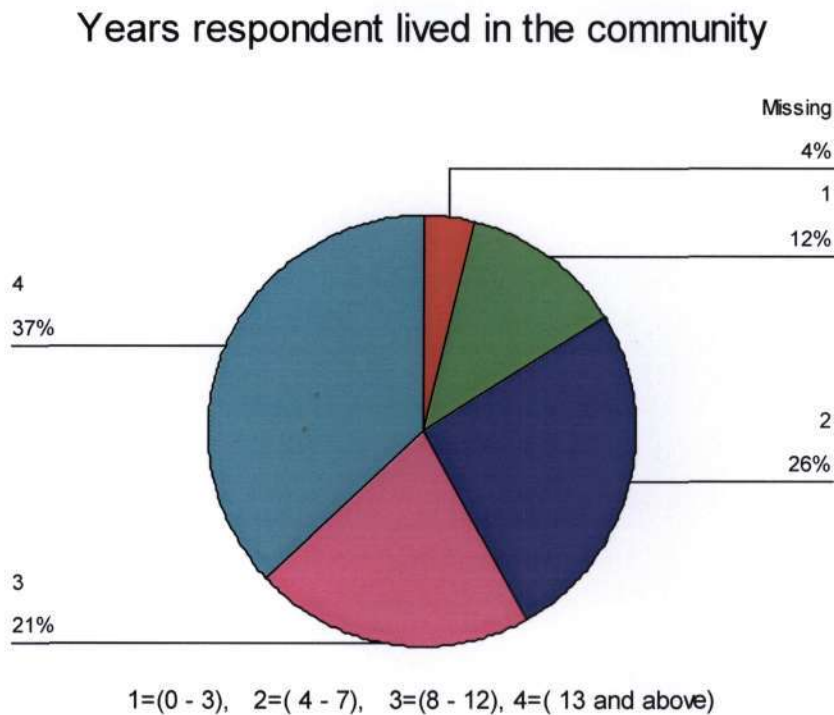
Figure 10 - Question 1.6



1=(Personal Business), 2=(House wife),
3=(Student), 4=(formal employment)

This question sought to identify the occupation of the respondents. The results show that from the total of 100 respondents 36% of them were in formal employment, 32% were students, 17% in personal business and 7% house-wives. The missing percentage of the population of respondents that did not answer this question was 8%.

Figure 11 - Question 1.7



This question asked for the period the respondent had lived in the community. The results show that 37% of the population of respondents lived in the community for 13 years and above, 26% had lived there between 4 to 7 years, 21% between 8 to 12 years and 12% for 3 years and less. The missing percentage of respondents that did not respond to this question was 4%.

4.3.2 Details of the church

This section gives the results for the second part of the questionnaire which focused on the details of the respondent's church. Questions 2.4, 2.5 and 2.6 however sought information on the respondent's personal and family church commitment. The questions covered under this section were from 2.1 to 2.8 as below;

Figure 12 - Question 2.1

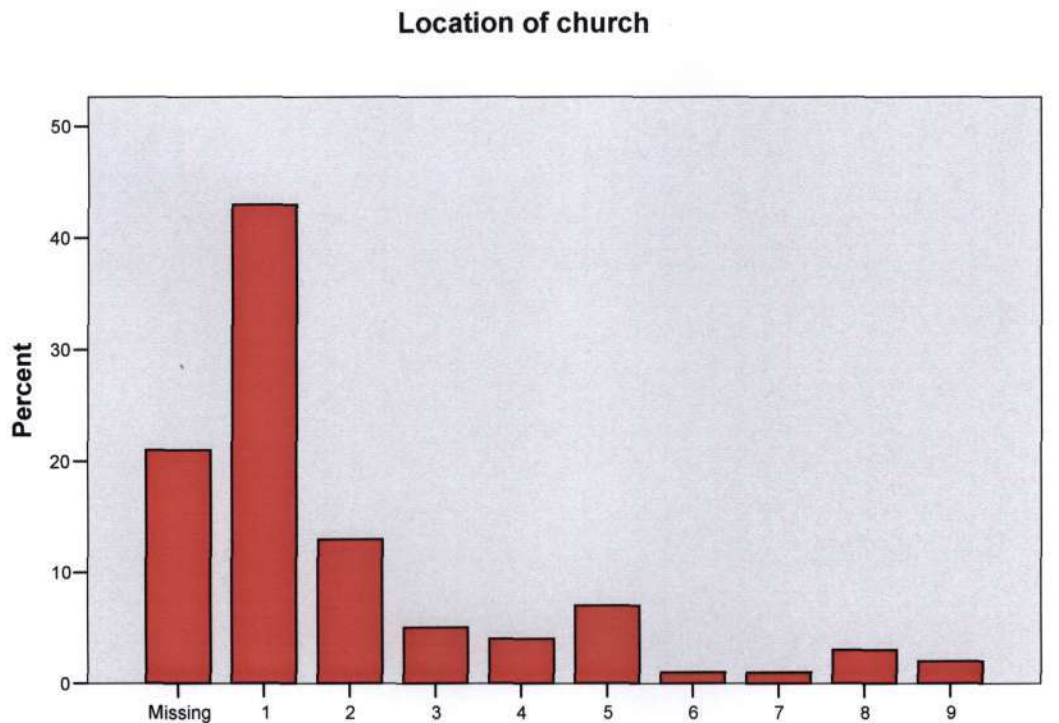
Name of church

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	3	3.0	3.0	3.0
	2	2	2.0	2.0	5.1
	3	2	2.0	2.0	7.1
	4	4	4.0	4.0	11.1
	5	1	1.0	1.0	12.1
	6	26	26.0	26.3	38.4
	7	1	1.0	1.0	39.4
	8	3	3.0	3.0	42.4
	9	3	3.0	3.0	45.5
	10	2	2.0	2.0	47.5
	11	2	2.0	2.0	49.5
	12	5	5.0	5.1	54.5
	13	1	1.0	1.0	55.6
	14	1	1.0	1.0	56.6
	15	3	3.0	3.0	59.6
	16	3	3.0	3.0	62.6
	17	2	2.0	2.0	64.6
	18	1	1.0	1.0	65.7
	19	2	2.0	2.0	67.7
	20	1	1.0	1.0	68.7
	21	2	2.0	2.0	70.7
	22	1	1.0	1.0	71.7
	23	1	1.0	1.0	72.7
	24	1	1.0	1.0	73.7
	25	1	1.0	1.0	74.7
	26	1	1.0	1.0	75.8
	27	1	1.0	1.0	76.8
	28	1	1.0	1.0	77.8
	29	1	1.0	1.0	78.8
	30	2	2.0	2.0	80.8
	31	1	1.0	1.0	81.8
	32	1	1.0	1.0	82.8
	33	1	1.0	1.0	83.8
	34	1	1.0	1.0	84.8
	35	1	1.0	1.0	85.9
	36	1	1.0	1.0	86.9
	37	1	1.0	1.0	87.9
	38	2	2.0	2.0	89.9
	39	1	1.0	1.0	90.9
	40	1	1.0	1.0	91.9

41	1	1.0	1.0	92.9
42	1	1.0	1.0	93.9
43	1	1.0	1.0	94.9
44	1	1.0	1.0	96.0
45	1	1.0	1.0	97.0
46	1	1.0	1.0	98.0
47	1	1.0	1.0	99.0
48	1	1.0	1.0	100.0
Total	99	99.0	100.0	
Missing System	1	1.0		
Total	100	100.0		

This question sought to identify the name of the FHPC that the respondent attends. Due to confidentiality the study will not use the names given but figures used in the data coding. In this question the results show that 26% of the population of the respondents were from the church named 6 in this research. The rest of the population of the respondents was thinly spread over 47 churches. The population of respondents that did not answer the question was 1%.

Figure 13 - Question 2.2

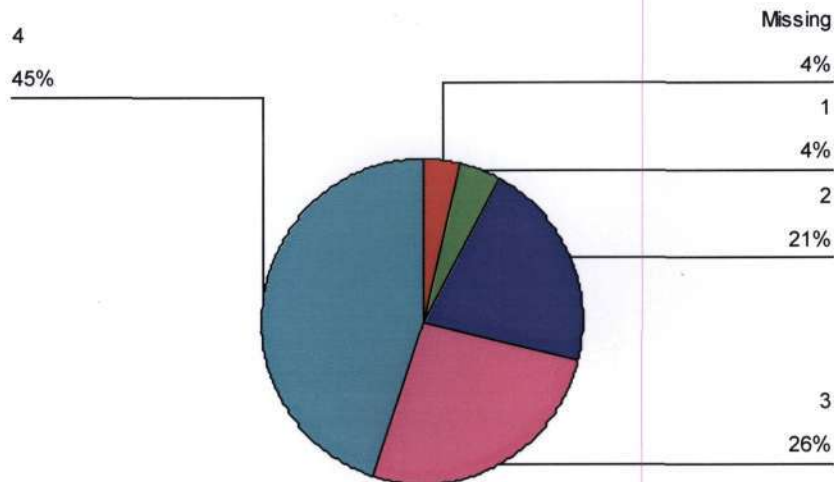


1= Town Centre, 2= Lubuto, 3= Chifubu, 4= Twapia, 5= Kabushi, 6= Masala, 7= Chipulukusu, 8= Mushili, 9= Ndeke

The question asked for the location of the respondent's church. The results show that 43% of the population of respondents' churches were located in Ndola town centre, 13% in Lubuto, 7% in Kabushi, 5% in Chifubu, 4% in Twapia, 3% in Mushili, 2% in Ndeke, 1% in Masala and 1% in Chipulukusu. The population of respondents who did not respond to the question was 21%.

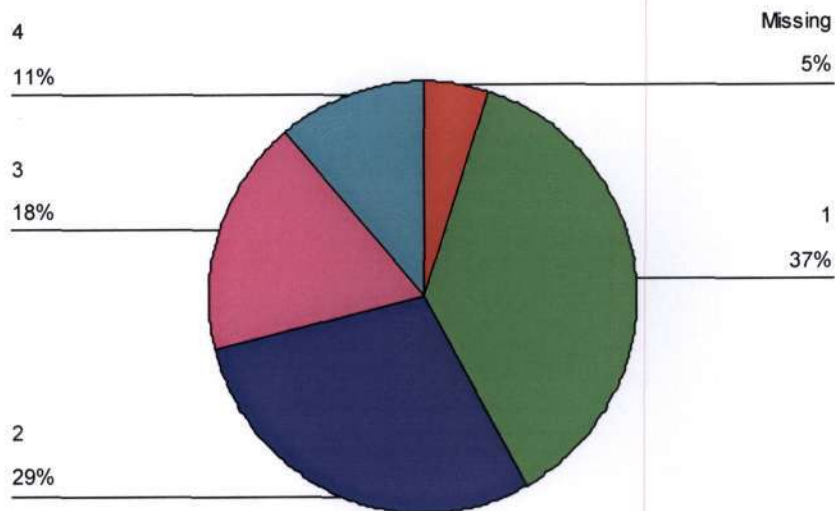
Figure 14 - Question 2.3

The period the Church has existed



1=(0 - 3), 2=(4 - 7), 3=(8 - 12), 4=(13 and above)

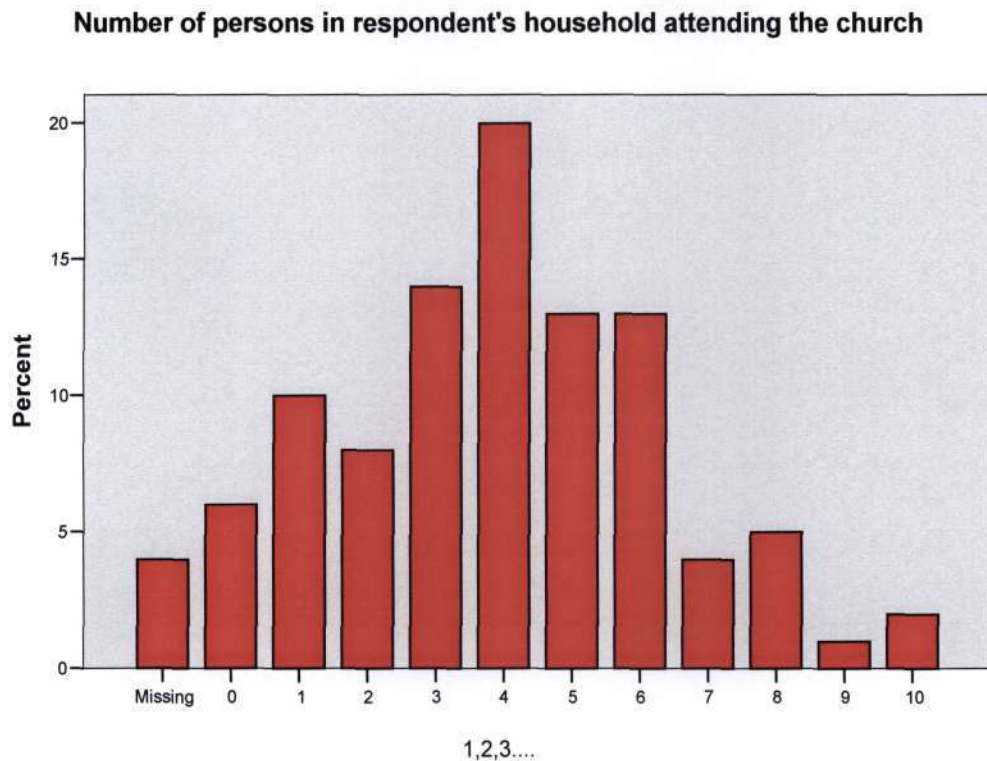
This question sought to find out how long the respondent's church had existed. The results indicate that 45% of the churches of the respondents have existed for 13 years and above, 26% were in existence between 8 to 12 years, 21% for 4 to 7 years and 4% for 3 years or less. The representation of the population of respondents who did not participate in answering the question was 4%.

Figure 15 - Question 2.4**How long the respondent has attended the Church**

1=(0 - 3), 2=(4 - 7), 3=(8 - 12), 4=(13 and above)

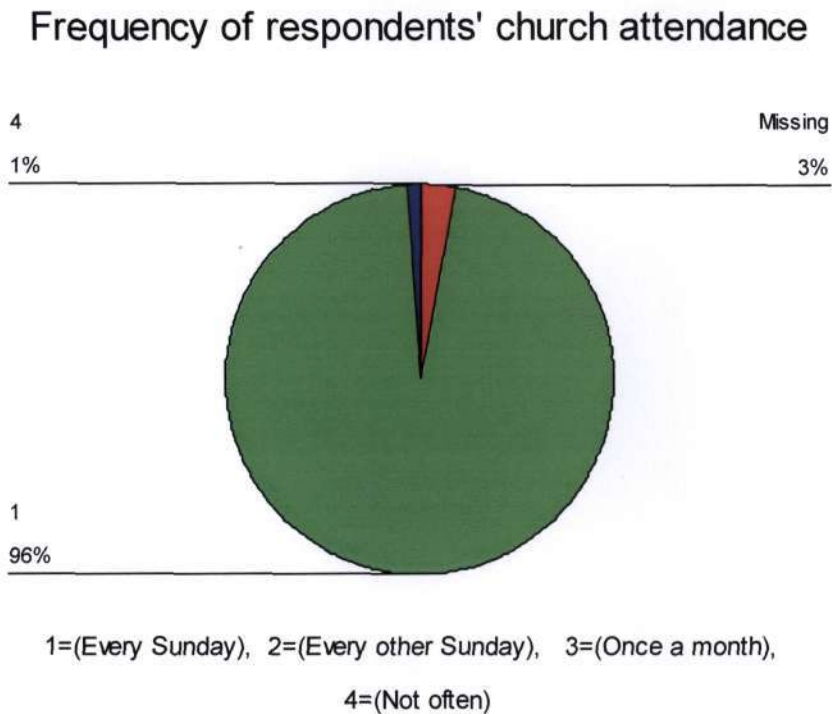
This question was asking for the length of time that the respondent had been attending the church. It can be seen from the results that 37% of the population of respondents had been attending their church for 3 years or less, 29% of them between 4 and 7 years, 18% between 8 and 12 years, and 11% for 13 years and above. The percentage of respondents who did not answer the question was 5%.

Figure 16 - Question 2.5



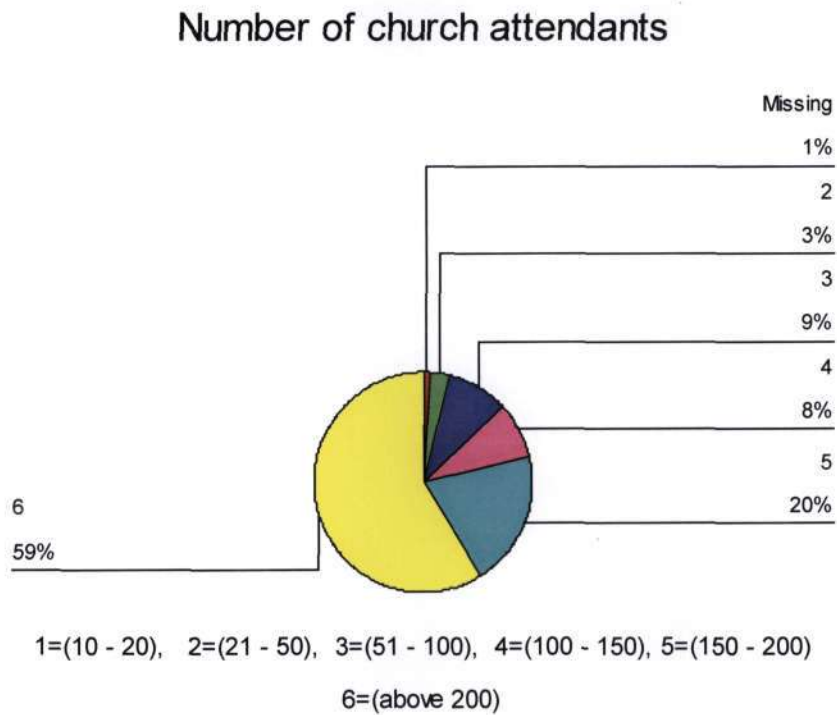
The purpose that this question served was to find out how many other persons from the respondent's house attended the church. The results show that 20% of the population of respondents had 4 members of their families attending the same church with them, 14% had 3, 13% 5, 13% 6, 10% 1, 8% 2, 6% none, 5% 8, 4% 7, 2% 10 and 1% 9. The percentage of respondents who did not respond to the question was 4%.

Figure 17 - Question 2.6



This question sought to find out how often the respondent attended his/her church services. The results indicate that 96% of the respondents attended their church services every Sunday, 3% did not attend church often. There was 1% of respondents who did not answer the question.

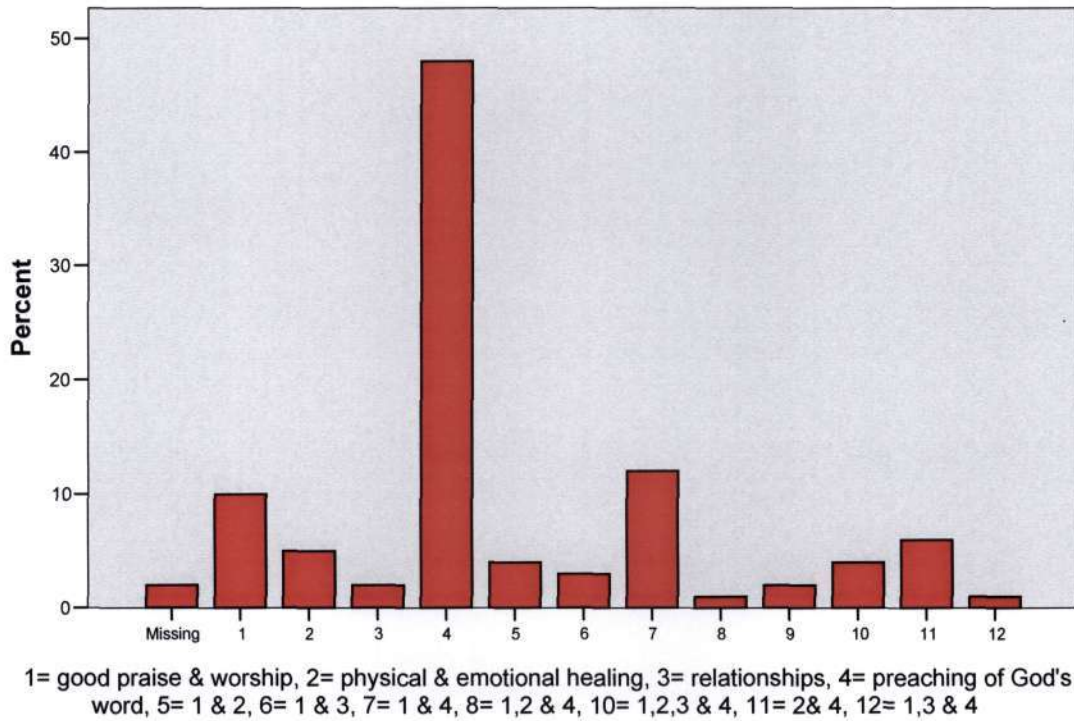
Figure 18 - Question 2.7



The question was finding out how many people attended the respondent's church. What the results show is that 59% of the respondents' churches had 200 and above attendants in their churches, 20% had attendants in the range between 150 and 200, 9% between 51 and 100, 8% between 100 and 150, and 3% between 21 and 50. The population of respondents who did not answer the question was 1%.

Figure 19 - Question 2.8

The respondent's view of why people attend the church

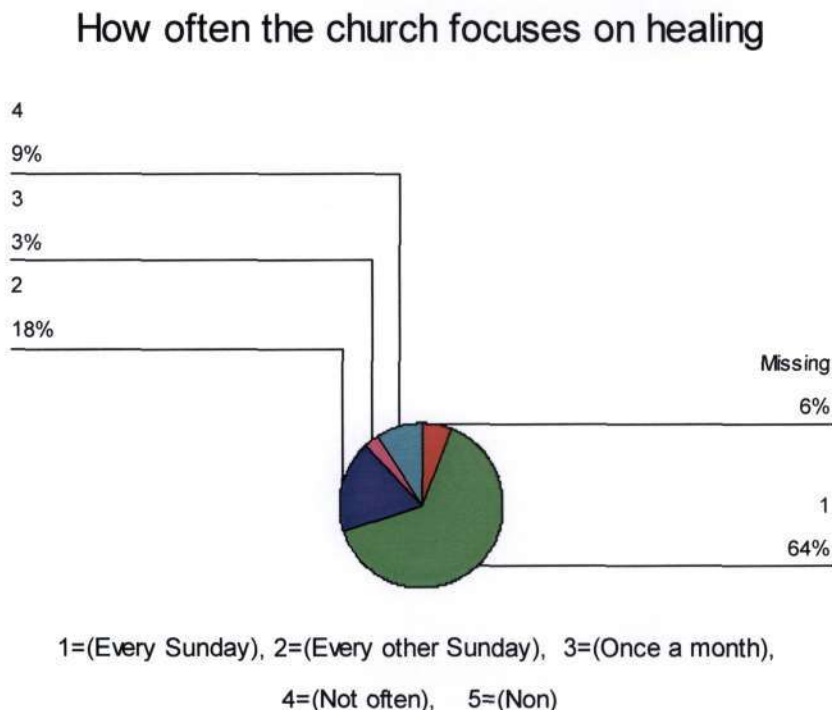


This question sought the respondent's opinion on why people attended his/her church. The results indicate that 48% of the respondents thought that people attended their church because of the preaching of God's word, 12% said the reason was good praise and worship and the preaching of God's word, 10% good praise and worship, 6% physical and emotional healing and the preaching of God's word, 5% physical and emotional healing, 4% good praise and worship, physical and emotional healing, relationships and the preaching of God's word, 3% good praise and worship and relationships, 2% good praise and worship, physical and emotional healing and the preaching of God's word, 2% relationships, 1% good praise and worship, physical and emotional healing and relationships, 1% good praise and worship, relationships and the preaching of God's word. The percentage of the population of respondents who did not answer the question was 2%.

4.3.3 The respondent's church and other health service providers

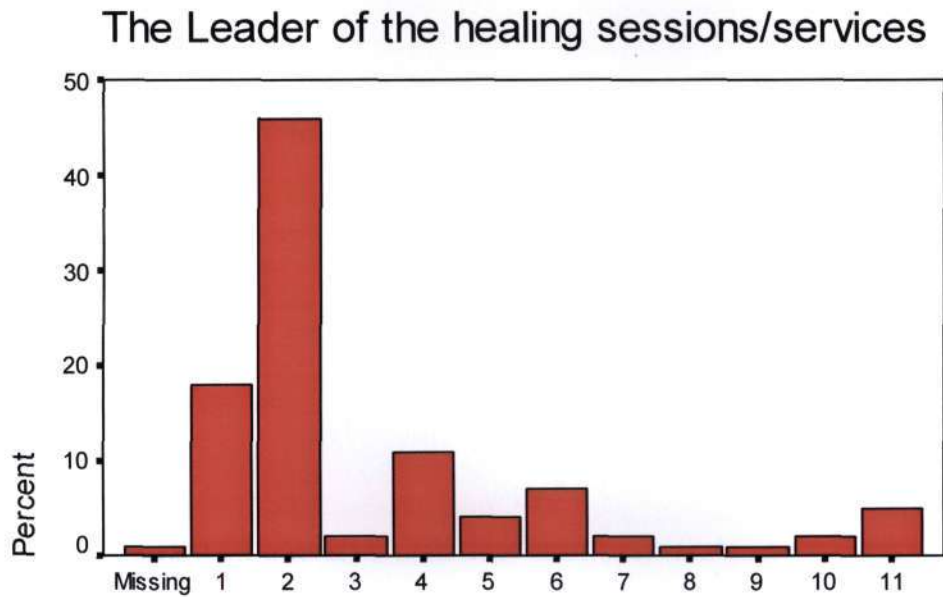
This section gives results to the third part of the questionnaire which sought the respondent's opinion and experiences with the healing sessions of their church. It also shows results of the relationship between the respondent's church and other health service providers and the wider society. The questions covered in this section are 3.1 to 3.13 as follows;

Figure 20 - Question 3.1



This question sought to find out how often the respondent's church focused on healing. The results indicate that 64% of the respondents' churches focused on healing every Sunday, 18% every other Sunday, 9% not often and 3% had no focus on healing at all. The percentage of the population of participants that did not answer the question was 6%.

Figure 21 - Question 3.2



Who leads healing sessions

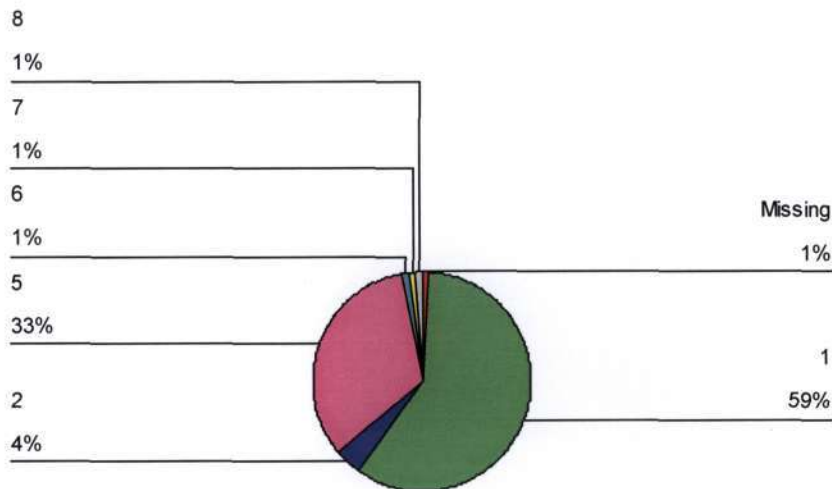
1=(The Bishop), 2=(The Pastor), 3=(Church Elders), 4=(Church Leaders),

6=(1&2), 7=(2,3&4), 8=(1,2,3,4&5), 9=(1,2,3&4), 10=(2&3), 11=(2&4)

The question sought to identify the leader of the healing sessions in the respondent's church. The results show that 46% of respondents indicated that their Pastor led the healing sessions in their Churches, 18% their Bishop, 11% their Church Leaders, 7% their Bishop and Pastor, 5% their Pastor and Church Leaders, 4% all Church members, 2% their Church elders, 2% their Pastor, Church elders and Church leaders, 2% their Pastor and Church elders, 1% their Bishop, Pastor, Church Elders, Church Leaders, and all the Church members, 1% their Bishop, Pastor, Church Elders and Church Leaders. The percentage of the respondents that did not answer the question was 1%.

Figure 22 - Question 3.3

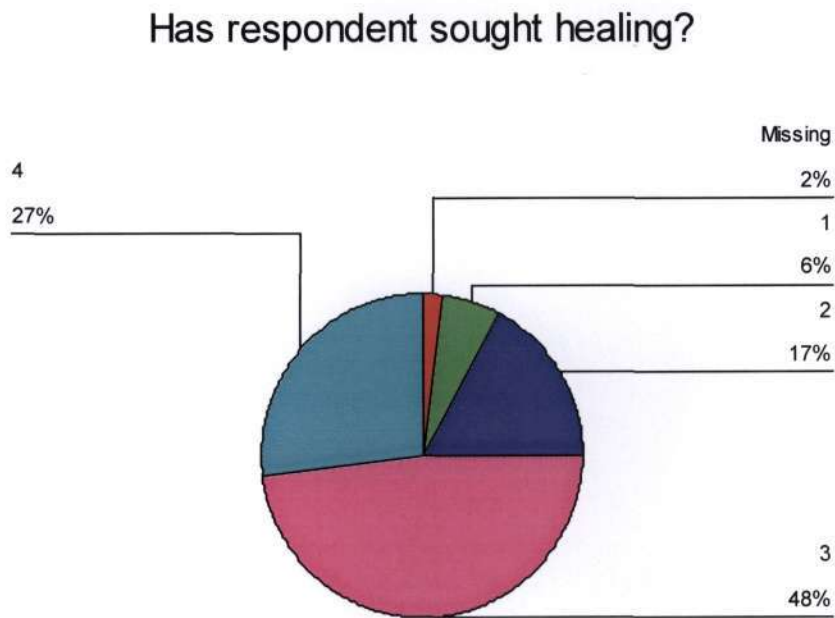
What the leader does to heal



1=(Laying hands), 2=(Anointing Oil), 3=(Prayers & anointed handkerchiefs),
 4=(other), 5=(1&2), 6=(1&3), 7=(1&4), 8=(1,2&4), 9=(holy water)

This question sought to find out what the leader of the healing sessions in the respondent's church did to heal. The results show that 59% of respondents indicated that the leaders of the healing sessions/services in their churches lay hands to heal, 33% said the leaders use both laying on of hands and anointing with oil, 4% anointing with oil, 1% laying of hands and with anointed handkerchiefs, 1% laying of hands and other, 1% laying of hands, anointing with oil and other.

Figure 23 - Question 3.4

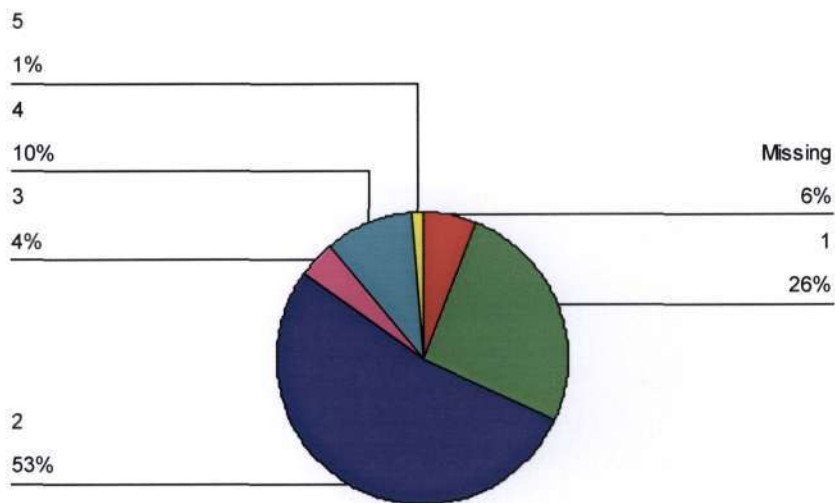


1=(Never), 2=(Once), 3=(A few times), 4=(Often)

This question asked the respondent if they had sought healing at their church. The results show that 48% of the respondents have sought healing a few times, 27% often, 17% once and 6% have never. The percentage of respondents who did not answer the question was 2%.

Figure 24 - Question 3.5

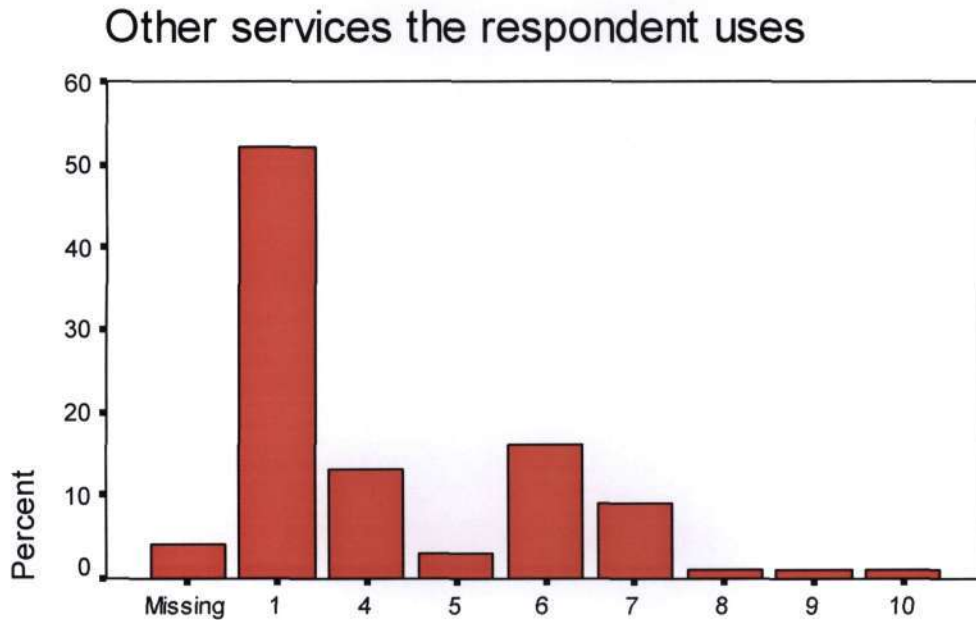
What happened when respondent sought healing?



1=(Healed instantly), 2=(progressive Healing), 3=(Not healed), 4=(Healed instantly, progressive healing), 5=(progressive healing, not healed)

This question sought to establish what happened when the respondent sought healing. The results show that 53% of the respondents were healed progressively when they sought healing, 26% healed instantly, 10% healed instantly and progressively, 4% not healed, 1% healed progressively and not healed. The percentage of respondents who did not answer the question was 6%.

Figure 25 - Question 3.6



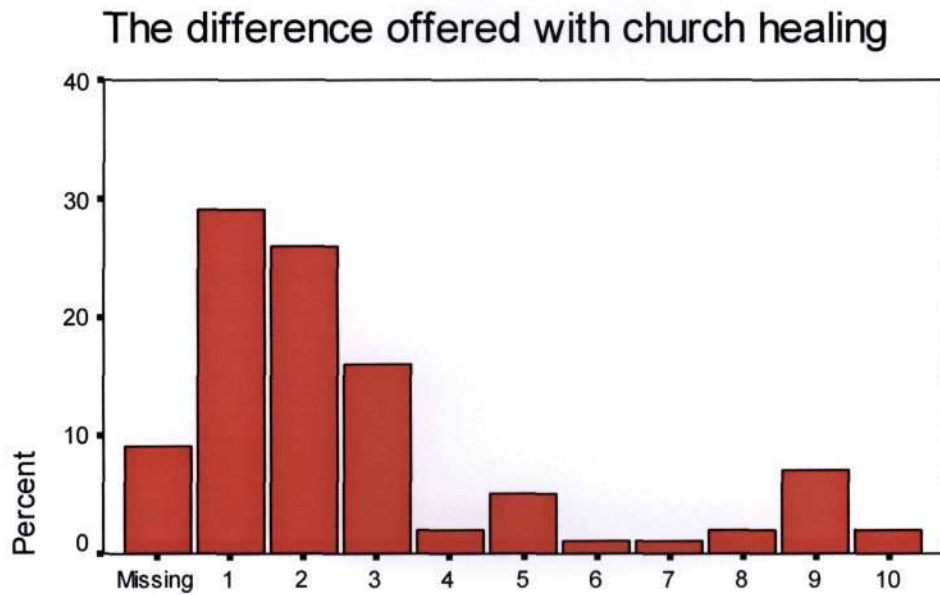
Others health services used

1=(Government Hospital),2=(Trad. healer),3=(Trad. med.),4=(Private Hosp.

5=(Church/ Mission Hosp.),6=(1&4),7=(1,4&5),8=(1&5),9=1&3),10=(4&5)

This question was asked to find out what other health services the respondent uses. The results show that 52% of the respondents use the government hospital for their health services, 16% use government and private hospitals, 13% use private hospitals, 9% government, private and church/Mission hospitals, 3% church/Mission hospitals, 1% government and church/Mission hospitals, 1% government hospitals and traditional medicines, 1% private and church/Mission hospitals.

Figure 26 - Question 3.7

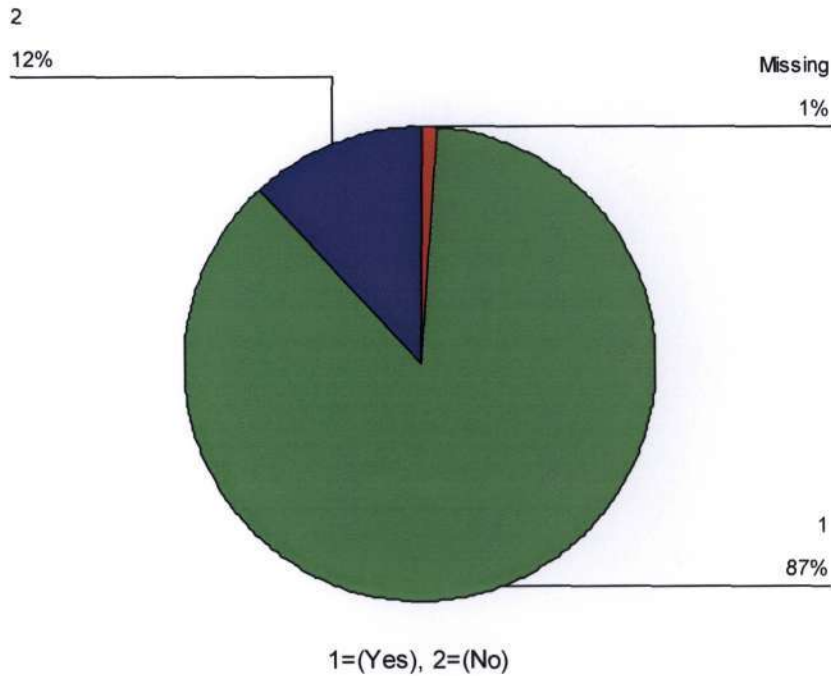


Difference offered by church healing

1=Personal touch&atten, 2=admin. freely, 3=No sideeffects, 4=other, 5=1&

6=1,2,3&4, 7=1&4, 8=1,2&3, 9=2&3, 10=3&4

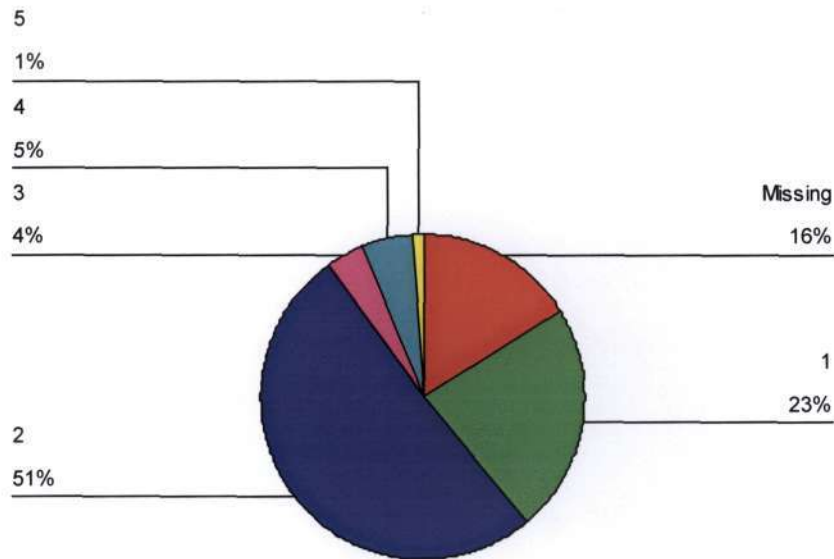
This question sought to identify the difference that church healing offers compared to other health services. The results show that 29% of respondents' view of the difference offered by church healing was the personal touch and attention, 26% said it is administered freely, 16% it has no side effects, 7% administered freely and no side effects, 5% personal touch, attention and free administration, 2% other, 2% personal touch, attention, administered freely and no side effects, 2% no side effects and other, 1% personal touch, attention and other, 1% personal touch, attention, free administration, no side effects and other. The percentage of the respondents who did not answer the question was 9%.

Figure 27 - Question 3.8**Has respondent encouraged others to seek healing from the church?**

This question was asked to find out if the respondent had encouraged others to seek healing from the church. The results show that 87% of the respondents had encouraged others to seek healing from their churches and 12% had not. The percentage of respondents who did not answer the question was 1%.

Figure 28 - Question 3.9

What happened when respondent encouraged others to seek healing?

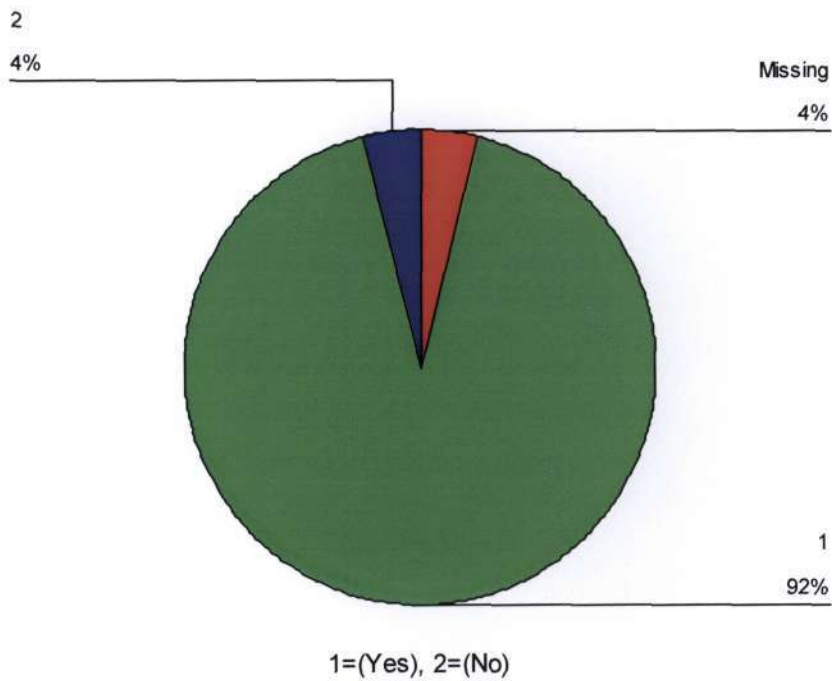


1=(Healed instantly), 2=(healed progressively), 3=(not healed), 4=(1&2),
5=(2&3)

This question sought to establish what happened when the respondent encouraged others to seek healing. The results show that 51% of those who were encouraged to seek healing by the respondents were healed progressively, 23% were healed instantly, 5% healed instantly and progressively, 4% not healed, 1% healed progressively and not healed.

Figure 29 - Question 3.10

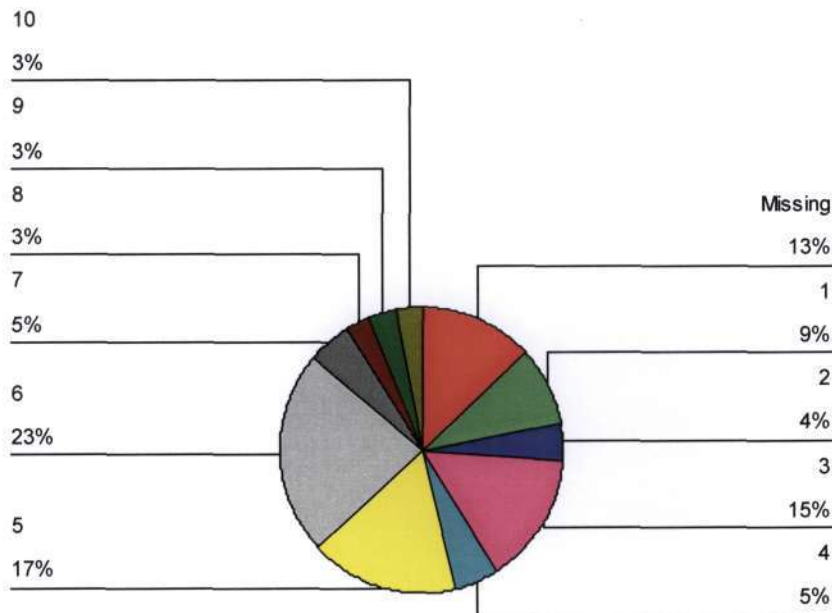
Does the church encourage the respondent to use other health services?



This question was asked to find out if the respondent is encouraged to use other health services by their church. The results show that 92% of the respondents are encouraged by their churches to use other health services and 4% are not. The percentage of respondents that did not answer the question was 4%.

Figure 30 - Question 3.11

Why the respondent's church encourages use of other health services.



This question sought to establish why the respondent was encouraged to use other health services by their church. The results show the following respondents' opinion on why their churches encourage use of other health services;

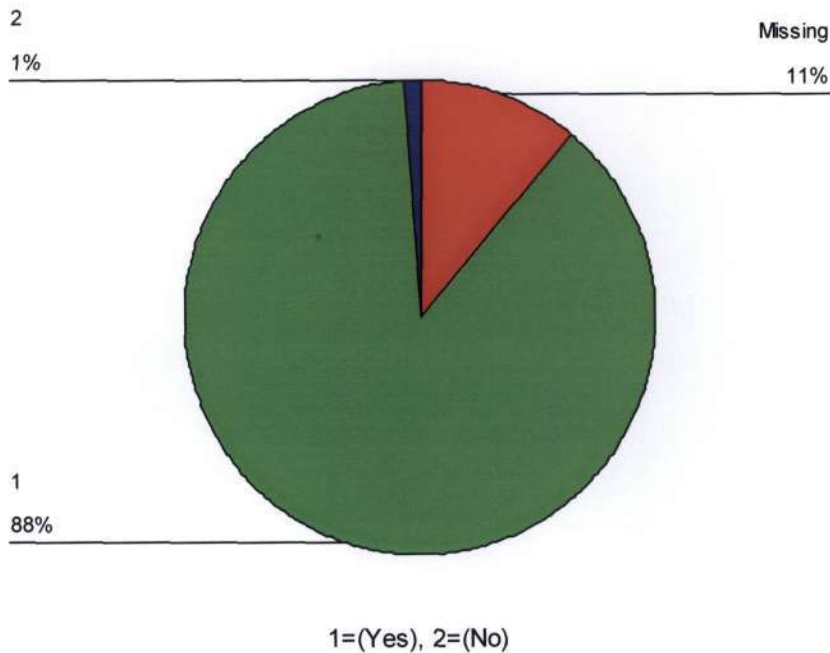
- 23% (6) - God works in many ways and hospitals and health personnel can also be used by God.
- 17% (5) – Medicine helps to heal and supplement the day-to-day life for physical health because faith without works is dead and some illness need medical attention not only prayer.
- 15% (3) – Health facilities are important for investigations, some diseases need trained people like surgery and they are means through which one would know his/ her health status.

- 9% (1) – Scientific medicine has no spiritual connection and are not sinful, certain services are not good for Christians such as traditional healers and divination.
- 5% (4) – We take medicine with prayer, medicine works with prayer, medicine cooperates with the laws of God to help the patients recover and it is not always that everyone is healed through prayers.
- 5% (7) – One with weak faith and some who have not yet believed in the Lord Jesus Christ can get healing from hospitals.
- 4% (2) – N/A
- 3% (8) – Scientific medicine is not harmful to the body and there is nothing wrong with it.
- 3% (9) – Those who can afford, it is not sinful.
- 3% (10) – It is a means to evangelise the health personnel.

The percentage of respondents who did not answer the question was 13%.

Figure 31 - Question 3.12

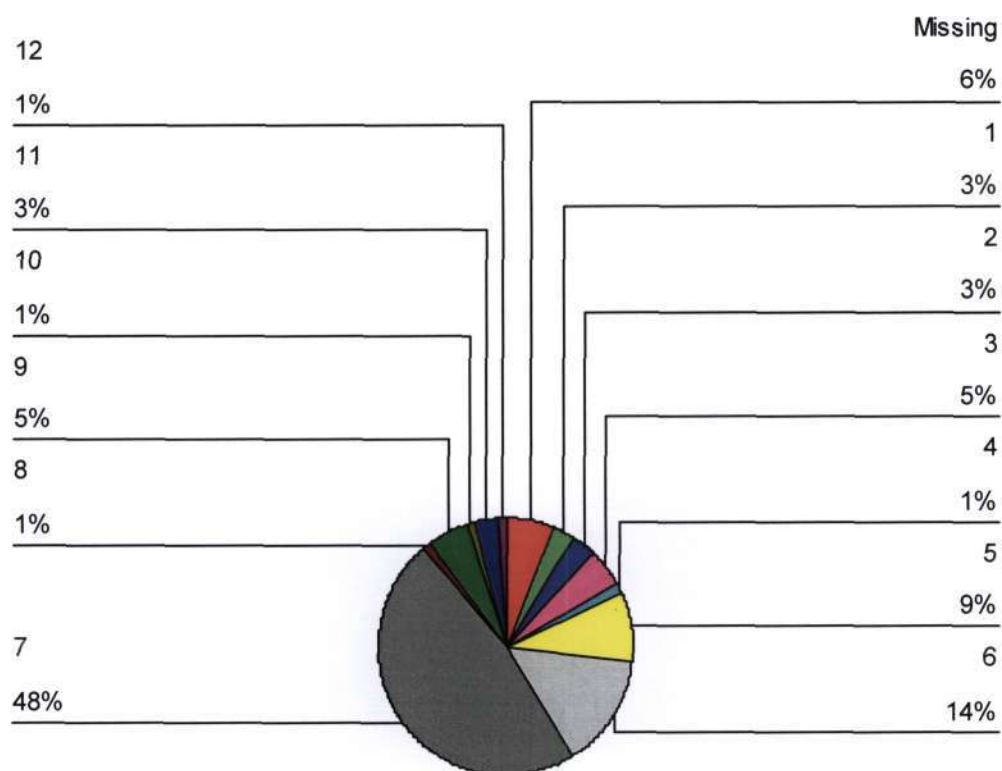
Does the respondent think that the church makes a contribution to a healthy society?



This question sought to find out the respondent's opinion as to whether their church was making a contribution to a healthy society. The results show that 88% of the respondents' opinion was that their churches were making a contribution to a health society and 1% thought they were not. The percentage of respondents who did not answer the question was 11%.

Figure 32 - Question 3.13

How the respondents see their church making a contribution to healthy society



This question sought to identify what contribution the respondent saw their church to be making to a healthy society. The results show the following respondents' view on how they saw their churches make a contribution to a healthy society;

- 48% (7) – Through prayer in the ministry of healing, and spiritual clinics¹³⁰ which are run for free, people are healed and they are effective in their occupation. The church encourages people to seek healing and is able to provide holistic healing.
- 14% (6) – Through donations and development works, encouraging the sick in visits and counselling.

¹³⁰ The term spiritual clinics used by the respondents in this dissertation refers to church based in-house facilities specifically meant for healing ministries.

- 9% (5) – By promoting good morals, encouraging faithfulness between couples, teaching on need to love others and maintaining good health habits.
- 5% (3) – Through discussing HIV/AIDS and being proactive on social issues like immunization campaigns.
- 5% (9) – Through evangelism which brings change in the lives of people as they receive Jesus Christ as their Saviour and Lord.
- 3% (1) – They have built a clinic and are involved in spiritual healing, provide medical facilities.
- 3% (2) – Doctors in the church give talks on health issues.
- 3% (11) – Through prayer, encouraging people and visiting hospitals.
- 1% (4) – Through prayers of intercessions.
- 1% (8) – N/A
- 1% (10) – Through prayer and teaching people on how to maintain better health.

The percentage of respondents who did not answer the question was 6%.

4.4 Conclusion

This chapter has given the research methodology used in this study and the process of data collection. The chapter has also provided the data analysis based on the data that was collected during the field research.

Following the questionnaire which is used as the research tool in this study, the results compiled from the data analysed show that the FHPCs attendants who responded to this questionnaire were committed to their churches. They gave their opinions and views on why people attend FHPCs and they identified what contribution their churches are making to their health as attendants and the society at large. They also pointed out the relationship between their churches and other health service providers.

The next chapter will seek to interpret these results in line with the background information on the health and well-being in Ndola presented in Chapter 2 and the literature review on religion and health presented in Chapter 3. **CHAPTER 5**

RESEARCH FINDINGS, INTERPRETATION AND IMPLICATIONS

5.1 Introduction

The previous chapter provided details of how the research was conducted, showing the process followed to obtain the data during the field research done in Ndola, Zambia among FHPC worshippers. It focused on the research methodology applied in the study to answer the main research question asked in Chapter 1. The chapter provided an analysis of the data collected.

This chapter now provides an interpretive discussion of the findings seen in Chapter 4 in relation to the literature giving the context of the study as observed in Chapters 2 and 3. It further discusses the findings in the light of the ARHAP theoretical framework provided in Chapter 3.

It is important here to refer to the purpose of this study before proceeding to interpret the data. The main question that this study seeks to answer is;

“What kind of impact do FHPCs have on health-seekers and to what extent can they be understood as a religious health asset?”

To answer this main question, the research sought to look at the following research questions also highlighted in Chapter 1;

1. Why are many people in Ndola attracted to seeking healing and well-being from FHPCs?
2. What do health-seekers receive from FHPCs?
3. Is there a relationship between socio-economic pressures and the emergence of FHPCs?
4. In what ways do these FHPCs have an impact upon the health and well-being among health-seekers in Ndola?
5. How does the healing of FHPCs relate to health provision by other agencies?

6. What does this research help us understand about religious health assets in general?

In undertaking this research the objectives therefore were:

1. To gain an insight into the reasons why health-seekers in Ndola attend FHPCs?
2. To analyse the contribution that FHPCs might be making to the health of people in Ndola
3. To contribute to the growth of knowledge and theory in the ARHAP research project.

Having reflected the research questions and the objectives of the research, below is my interpretation as the researcher of the data collected from FHPCs worshippers.

5.2 Finding one: FHPCs provide a home for people in need of social networks¹³¹

The first interpretation that can be made from the data in Chapter 4 is that FHPCs provide a social network which enables the people faced with much poverty, sicknesses and diseases and the impact of the Structural Adjustment Programme, to have a sense of identity, belonging and purpose. This in turn helps to support and provide life skills which promote health and well-being.

It is evident, based on the data from the research findings, that there are a lot of people attending FHPCs with the majority of FHPCs having more than 200 attendants, (see 4.3.2).¹³² There is also an overwhelming commitment of 96% to every Sunday church attendance among the attendants (4.3.2).¹³³ Therefore, many people in Ndola attend FHPCs and are fully committed to these churches' teachings, activities and way of worshipping God. Seeing that there are a number of people who attend FHPCs, it is important to establish as to what kind of people attend these churches. This will be done with a focus on the background information of the people who attended FHPCs.

¹³¹ A social network is here used in the same context as social capital. This refers to social memberships and relationships that people develop as a survival strategy.

¹³² Figure 18 Chapter 4

¹³³ Figure 17 Chapter 4

Facts provided by the research data in Chapter 4 are that FHPCs are not family traditional churches or churches attended only by a certain kind of people with a similar background. FHPCs are attended by people of various age groups, languages, gender and educational backgrounds.

Figure 5 and Figure 6 (see 4.3.1) clearly show that FHPCs draw committed worshippers from wide age groups, and not just one particular age group. It must however be pointed out that of all the people who participated in this research, 69% were people under 35 years, 31% were between the ages from 35 years to 45 years and only 6% were above 46 years old. This does not mean that FHPCs only draw their attendants from among the young people. Several reasons account for the 69% of the people who are below 36 years old and are committed worshippers in FHPCs. It is however important to state that this points to the fact that Ndola, and Zambia as a nation, has a huge population of people within the age range of 15 years to 40 years. As observed in Chapter 2 (2.1), the burden of poverty and diseases has led to the drop of life expectancy in Zambia to an alarming 37 years. It is therefore the young people in the age range of 37 years and below that account for a larger number of the population in Zambia. This does not however mean that the older people have all died, but only proves the fact that they are highly outnumbered.

It is therefore concluded that FHPCs are not just places of worship for the youths and teenagers only; but that people of all age groups attend these churches and that the young people are in majority based on the various impacts on the adult population in Zambia.

It is important to also note that FHPCs are not homogeneous, but are attended by people from various tribal groups. 31% of the respondents were Bemba, which is the major language on the Copperbelt. It is amazing to observe that 26% of the respondents did not have their home languages provided for in the questionnaire, despite the fact that the questionnaire covered all the major languages spoken in Ndola. This proves the fact that FHPCs are multi-cultural and multi-lingual and multi-racial as evidenced in (4.3.1).¹³⁴

¹³⁴ Figure 8 Chapter 4

Therefore it can be concluded that cultural influences and traditional ways of life are not the main reasons why people attend FHPCs.

The gender of respondents provides a clear picture that FHPCs are neither male nor female dominated. They are attended by both male and female equally. 51% of the respondents were male and 49% were female (4.3.1).¹³⁵

FHPCs also draw people of various educational backgrounds. The education results indicate that 55% of the respondents have tertiary education, 38% secondary education and only 6% have primary education (4.3.1).¹³⁶ This is clear evidence that FHPCs are a home for both the educated people and the uneducated and yet they all are committed to the activities that take place in these churches.

The fact that FHPCs attract people of all ages, are not homogeneous, are dominated by both male and female and also accommodate both the educated and uneducated is a clear indication that there is something that draws people to FHPCs, which is beyond cultural adherence, uniformity or class. The question still however remains unanswered, “what attracts people to FHPCs?”

There are many reasons why people go to FHPCs, but in this section, it must be pointed out that most people who have migrated into Ndola went there to seek employment and education. This in itself has its own implications especially socially, where traditional setups of tribe mates and extended families living closely have been disrupted. It is a huge challenge in situations of critical bad health in cases of HIV/AIDS and other diseases highlighted in Chapter 2 which need a supportive social context. Therefore, many people have found a home among FHPCs worshippers and are comfortable to break their traditional and cultural bearers and worship among a diverse group of people. Such a group as pointed out above provides a good social network through groups such as the men’s fellowships, women’s fellowships, youth fellowships and widows/widowers fellowships. It is these social networks that lead to many people in Ndola to have a sense

¹³⁵ Figure 6 Chapter 4

¹³⁶ Figure 9 Chapter 4

of belonging, identity and purpose among their fellow FHPCs worshippers, despite the fact that they are different in age, gender, language and educational backgrounds. It is therefore such social networks that were identified in Chapter 3 (3.3.) as a means of support and providing life skills which promote health and well-being.

Based on the above fact, we could therefore conclude that FHPCs contribute to health and well-being by being a social network for the people from different backgrounds. However, it is important here to further observe that there is a struggle with openness on marital status as over a quarter of the participants in the research did not indicate their marital status (4.3.1).¹³⁷ A follow-up on this would be an investigation of the social implication that one's marital status would have in the context of Ndola. What would generally be observed is that in the era of HIV/AIDS, there is much stigma socially attached to widowhood. It is important to also state that the HIV/AIDS pandemic has accelerated the growth of disease and consequently the growing need for social support which these FHPCs seem to be providing.

Having looked at the background information of the representation of the population in the area of this study and the implications thereof, the next section will focus on what the FHPC attendants seem to be receiving from their churches.

5.3 Finding two: People are attracted to attending FHPCs in Ndola because of the need for holistic healing

Based on the responses of the 100 respondents who participated in this research, it is clear that most people are attracted to FHPCs because of the preaching of Gods word, spiritual songs and prayers for physical healing which they receive and which bring about holistic healing into their lives.

Figure 19, (4.3.2) reveals the fact that more than 48% of the people who attend FHPCs do so based on the preaching of God's word, which they receive from these churches. It must be pointed out that most messages that are preached in FHPCs are those messages

¹³⁷ Figure 7 Chapter 4

that dwell on prosperity and divine healing as noted above in Chapter 1 (1.2). These messages are positive and dwell on the blessing of holistic healing that God has promised in the bible for God's people. Therefore, when people receive these words, they have hope to live despite the hard circumstances they may be experiencing and face the future with much courage. It could therefore be concluded that the messages that are preached at FHPCs enable most people who attend these churches to live with a very positive view of life and faith in God.

Other than the preaching of God's word, Figure 19 (4.3.2) also reveals that 26% of the respondents pointed out the fact that they attend FHPCs because of the good praise and worship at these churches. It must be stated here that the songs and dancing which are found in FHPCs are different from what is done in other churches. Here, there are songs sang with much emotions and meditation. Other songs are sang with much dancing and shouting with loud musical instruments.

It can also be observed from Figure 19 that, of all the 100 people who participated in this study, 18% clearly stated that physical and emotional healing are among other reasons as to why they attend FHPCs. These people see physical and emotional healing plus praise and worship and the preaching of God's word as the reasons why people attend their churches. It is therefore clear that the preaching of God's word, praise and worship and prayers for physical and emotional healing bring about a huge difference in the lives of the people who attend FHPCs, and as such, much commitment and numerical growth within the FHPCs can be observed.

It could therefore be concluded under this heading that, according to their own testimonies, people who go to FHPCs receive healing. The healing that these people receive might be different from the healing understood and explained in scientific terms, but the fact remains that the people who attend FHPCs receive healing through the preaching of God's word, spiritual songs and prayers for physical and spiritual healing. It is evident that the preaching of God's word is the key player in the healing process.

5.4 Finding three: The emergence of FHPCs is related to poverty in Zambia

Though there is no clear evidence on the relationship between the emergence of FHPCs and the socio-economic pressures in Ndola, it is clear that FHPCs are addressing huge socio-economic needs in people's lives within a context of poverty, unemployment and the burden of sicknesses and diseases. It is these socio-economic needs that FHPCs are addressing which have led to spontaneous growth in the last 13 years. When Figure 14 (4.3.2) is examined, it can be observed that 45% of the FHPCs attended by the respondents were started in last the 13 years, (26% between 8 – 12 years, 21% between 4 – 7 years and 4% between 3 years and less). And when Figure 15 (4.3.2) is examined, it is amazing to observe that only 11% of the respondents have been attending FHPCs for more than 13 years and that 37% of the respondents are new members to FHPCs because they have been attending their churches in the last 3 years and 29% have been attending FHPCs in the last 7 years. Based on the interpretation above, it is clear that FHPCs have grown in membership and many others have been started in the last 13 years a period when Ndola has experienced much poverty and the impact of the Structural Adjustment Programme.¹³⁸

Having established the fact that there have been more people joining FHPCs in the last 13 years and more FHPCs started in that period, it is important to now observe the social economic situation of the people who are attending FHPCs.

When Figure 10 is examined, it is clear that of the 100 people who participated in this research as respondents, only 36% of them are in formal employment and the other 64% are either students (part-time and full-time), personal business men and women¹³⁹ or housewives (see 4.3.1). These statistics bring to light two important facts. First, they reveal levels of unemployment in Ndola, Zambia and second, these statistics clearly show the fact that most FHPCs attendants find themselves in a context of not having a stable income or receive little income because of the impact of the Structural Adjustment Programme in Zambia as stated in Chapter 2 (2.3.1).

¹³⁸ African Religious Health Assets Programme, "Appreciating Assets, p.68

¹³⁹ The kind of business that most men and women are involved in is the re-selling of groceries as a strategy of survival which is either in a small wooden store or rented brick shops.

The second fact that needs observing under this heading is the marital status of most respondents which is also highlighted in 5.1. Despite the fact that most people who participated in the survey are at an age where they are eligible to marry or get married, the study reveals that of the 100 respondents, only 35% are married (4.3.1).¹⁴⁰ The 32% of the respondents who indicated that they are single could possibly also cover the 18% of the respondents who indicated in Figure 5 (4.3.1), that their age range is between 15 – 20. Only 7% of the respondents stated that they are widows and 26% of the respondents avoided to answer this question which as earlier suggested could be that there is much stigma around widowhood in Zambia and it could also suggest that they are either divorced, widows or widowers. These people who might have a social stigma of being widows, and have to struggle for their livelihood have found home within the FHPCs.

It has therefore been observed that people who are unemployed, widows/widowers and single parents have found home in FHPCs. These people are committed to attending church services in FHPCs. It could therefore be concluded that FHPCs are meeting real needs among people faced with unemployment, poverty and the impact of HIV/AIDS through the messages on prosperity and divine healing, praise and worship and the prayers for physical and emotional healing. This is therefore in line with what was observed in Chapter 3 (3.3), that spiritual songs, prayers and the sacred scriptures have a positive impact on people as these bring about resilience and hope in life. FHPCs have a huge impact on the health and well-being of people in Ndola, such that they are always visited by people who want to join them.

5.5 Finding four: FHPCs are contributing to health and well-being alongside other health providing entities in Ndola.

When the centrality of healing and the promotion of health and well-being among FHPCs in Ndola is examined, it is clear that these churches are perceived to be contributing to health and well-being along with other health providing agencies.

¹⁴⁰ See Figure 7 Chapter 4

Figure 20 (4.3.3), reveals that 64% of the respondents' churches focus on healing every Sunday and 18% focus on healing every other Sunday. It can be observed that, of the 100 respondents, 3% stated that their churches do not focus on healing, but the rest of the respondents, excluding the 6% who did not answer this question, did indicate that their churches focus a lot on healing. What this means is that these FHPCs have a special ministry of healing in their church as seen in Chapter 1 (1.2). FHPCs set time aside as special time to pray for the sick, read scriptures and provide counselling. It is clear that the people who attend these healing services find them very moving, inspiring, invigorating, and captivating (3.4.2.1 in Chapter 3).

The promotion of health and well-being by FHPCs is also evident in the fact that the people who attend these churches and receive healing and well-being are also committed to inviting other people outside their churches to visit FHPCs for healing. Figure 27 (4.3.3) shows that 87% of the respondents took time to go out into the communities of Ndola to encourage other people to go to their churches for healing. It is also interesting to observe that, of all the people who were invited for a healing service, 80% were said to have been healed either instantly or progressively.

Figure 29 (4.3.3) is yet further evidence on the fact that FHPCs are perceived to be contributing to health and well-being alongside other health providing entities in Ndola. It can be observed that 92% of the respondents said that their churches encourage people to visit other health services such as hospitals and clinics. This then seriously questions the assumption that FHPCs do not believe in scientific medical healing. They commented that they encourage people to visit other health services because they believe that,

1. God works in many ways and hospitals and health personnel can also be used by God, (response by 23% of the respondents).
2. Medicine helps to heal and supplement the day-to-day life for physical health because faith without works is dead and some illness need medical attention not only prayer, (response by 17% of the respondents).
3. Health facilities are important for investigations, some diseases need trained people like surgery and they are means through which one would know his/her health status, (response by 15% of the respondents).

4. Scientific medicine has no spiritual connection and is not sinful, certain services are not good for Christians such as traditional healers and divination, (response by 9% of the respondents).
5. We take medicine with prayer, medicine works with prayer, medicine cooperates with the laws of God to help the patients recover and it is not always that everyone is healed through prayers, (response by 5% of the respondents).
6. One with weak faith and some who have not yet believed in the Lord Jesus Christ can get healing from hospitals, (response by 5% of the respondents).
7. Scientific medicine is not harmful to the body and there is nothing wrong with it, (response by 3% of the respondents).
8. Those who can afford, it is not sinful, (response by 3% of the respondents).
9. It is a means to evangelise the health personnel, (response by 3% of the respondents).

Even though 13% of the respondents did not answer the question, the above responses are a clear indication that FHPCs are involved in promoting health and well-being in Ndola along with other health providing agencies. It is also interesting to observe that, of all the respondents that took part in this study, Figure 31 (4.3.3) shows that 88% of the respondents stated that their churches are contributing to health and well-being. This response is further clarified in Figure 32 (4.3.3) where the respondents provide specific ways they feel their churches are contributing to health and well-being in Ndola.

1. 48% state that their churches are contributing to health and well-being through prayers in the ministry of healing and spiritual clinics which run for free. In these clinics, they stated that people are healed and become effective in their occupation.
2. 19% of the respondents stated that their churches are contributing to health and well-being through donations, development works and encouraging the sick through praying, visiting them and providing counselling.
3. 10% stated that their churches are contributing to health and well-being by promoting good morals, encouraging faithfulness between couples, teaching on need to love others and maintaining good health habits.

4. 5% pointed out that their churches are contributing to health and well-being by openly discussing HIV/AIDS and being proactive on social issues like immunization campaigns.
5. 5% pointed out that their churches are contributing to health through evangelism which brings change in the lives of people as they receive Jesus Christ as their Saviour and Lord.
6. 3% observed that their churches are contributing to health and well-being by being involved in spiritual healing and that they have built a clinic.
7. 3% observed that they have medical doctors in their churches who give talks on health issues.
8. 1% said that their churches are contributing through prayer and teaching people on how to maintain better health.

Based on the facts stated above, it could be concluded under this heading that FHPCs are contributing to health and well-being in Ndola. They are also working alongside other health providing agencies to promote health and well-being.

5.6 Finding five: People who go to seek healing from FHPCs receive healing through prayers, anointing with oil, the preaching from God's word and through spiritual songs.

Though it might be difficult to comprehend scientifically, it can be observed that based on the respondents' testimonies, they perceive that they receive healing when they go to healing services in FHPCs. They receive the healing through prayers, the anointing with oil, the preaching from God's word and through spiritual songs. The respondents stated that they receive instant and progressive healing.

It is interesting to observe from Figure 23 (4.3.3) that 48% of the respondents claim that they had sought healing a few times, 27% had often sought healing and 17% had once sought healing. Only 6% indicated that they had never sought healing and 2% declined to answer this question.

When these results are further examined together with those in Figure 24 (4.3.3) it can be observed that 53% of the respondents testify that they were healed progressively, and that 26% were healed instantly. Those that were healed instantly and progressively were 10%. 1% had once been healed progressively and then at another point, they were not healed. What is observed here is that, of the 100 people who participated in this study, 90% had an experience of being healed when they were prayed for, and only 4% stated that they were not healed. 6% did not respond to this question.

It is important to also observe that, that there are various ways in which FHPCs administer their healing practices. In this study, as shown in Figure 22 under 4.3.3 the administration of healing identified were: the laying on of hands, anointing with oil and use of holy water and hankies that have been prayed for by the faith healer.

Therefore, based on the testimony of healing by the respondents in this study, it is clear that the people who go to seek healing from FHPCs perceive that they do get healed. This healing is administered through the various practices as mentioned above.

5.7 Finding six: Notable differences between FHPCs' healing process and other health providing entities are personal care, free service and the absence of side effects.

When the administration of healing provided by FHPCs is compared to that of other health providing services, it is interesting to note that most respondents feel that the administration of healing offered by FHPCs is better than that which is offered by other health providing services.

Based on the data in Chapter 4, Figure 26 (4.3.3) 29% of the respondents stated that the administration of healing at FHPCs has a personal touch and attention. It is important to note here that it is mostly the Bishop or the Pastor who conducts the healing services in that they are identified as the persons who have the gift and anointing to pray for the

sick.¹⁴¹ Amateurs are usually not part of the healing services. Therefore, prayer is taken as a sacred time and an exercise of faith. The laying on of hands and anointing with special oil (mostly olive oil) is the most traditional process of praying for the sick by the Bishop or the Pastor.¹⁴² People are satisfied when they get prayed for by the Bishop or the Pastor because they feel cared for and provided with all the attention they need by the representative of God.

Looking at the economic struggles that most residents in Ndola have, it is interesting to observe that some respondents stated that they see the healing that is administered at FHPCs to be better than the one administered at other health providing services in that it is administered freely.¹⁴³ Others felt that this kind of healing administered at FHPCs is better because it has no side effects.

The responses provided above are in line with Chapter 2 where it was observed that many people have lost faith and hope in government health provision, through hospitals and clinics. Because of the brain-drain, the shortage of essential drugs and the general poor provision of health care, many people have now turned to FHPCs to seek healing and well-being. When they go to FHPCs they feel cared for and provided with personal attention. This motivates them to seek more prayers for healing and also to encourage other people to seek healing from these FHPCs.

5.8 Finding seven: Worshippers at FHPCs display a strong sense of agency in their search for health.

When we examine Figure 23 under 4.3.3 we observe that 92% of the respondents have sought healing from FHPCs either a few times, often or once. We also observe in Figure 25 under 4.3.3 that all the respondents who participated in the survey have sought healing from either government hospitals, mission hospitals or private hospitals.

¹⁴¹ Figure 21 Chapter 4

¹⁴² Figure 22 Chapter 4

¹⁴³ Figure 26 Chapter 4

Other than seeking healing from the FHPCs or other health providing agencies, we also observe that 87% of the respondents did indicate that they had encouraged others to seek healing from their churches.

When we analyse this information, we observe that FHPCs worshippers display a strong sense of agency in their search for health. They make use of local knowledge and wisdom to seek healing from FHPCs and other health providing agencies. They have not sat back to have experts come to their communities to provide solutions for healing and well-being for them amidst growing levels of poverty and poor health provision in their communities. Even in the face of disappointments from western forms of health provisions that are not sustainable at all times because of poor economic policies, these health-seekers make use of the assets present in their own communities and leverage such assets for their health and well-being. This then makes it clear that the poor people are not stupid. They have had to decide to get back to more sustainable health provisions that are not affected by the Structural Adjustment Programme, the political climate of the nation and unfair global trade rules. It might be argued scientifically or from the western medical point of view that people do not get healed when they visit FHPCs or traditional healers. The fact is that the people who go to these places claim that they get healed and they therefore continue to visit these places. This shows clearly that people in Zambia, especially the poor, have come up with contextual strategies for survival which might seem foolish to the mind of western scientists and the formally educated. We therefore could conclude under this heading that, FHPCs worshippers, and indeed most Zambians are agents of their own health and well-being.

So far it has been observed that FHPCs contribute to health and well-being in Ndola, and that many people turn to these entities for their social, emotional and spiritual healing and well-being. Having established these facts about FHPCs, the next section will examine the contribution that this study is making to the ARHAP's ongoing research.

5.9 Finding eight: The contribution that this study makes to the ARHAP's ongoing research

The main objective of ARHAP, as stated in Chapter 3, is to identify, assess and map religious assets in Africa and make such information accessible to faith and health leaders, organizations such as the World Health Organization (WHO), government and private policy makers, so as to make a difference to people's lives in Africa. What we have identified and analysed about FHPCs makes a contribution to ARHAP in the following ways:

First, the research that has been happening within ARHAP has focused on 'formal' churches and formal health programmes. Nevertheless, ARHAP understands that religion may function as a health asset in other less formal and less tangible ways. Therefore this research focused on FHPCs which are less formal and less tangible in nature, and it has been seen from the interpretation of the results of the research that FHPCs contribute to health and well-being. It has also been seen that, based on the ARHAP's definition of a religious health asset, FHPCs are indeed a religious health asset. The definition is:

A religious health asset is an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The notion of RHAs captures the basic idea that assets carry value and may be leveraged for greater value. If they are not used, then they remain at rest, but always available for use through some agentive act. We are also using the term broadly to encompass any religion or faith; particularly we include here those assets typical of African religions.¹⁴⁴

FHPCs are a religious health asset located within the communities' own religious framework and are entities that contribute to the development of public health. FHPCs have also been observed as being assets that are held by the people and assets upon which people draw support and hope from in times of socio-economic difficulties and health problems.

¹⁴⁴ African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa" appendix c.

The people who receive healing from FHPCs also draw in other community people to benefit from these religious assets, and as such these people visit FHPCs to receive healing. It therefore can be concluded without any doubt that FHPCs are religious health assets and that they have a huge impact on people's health and well-being, as observed above. This research therefore brings to light for ARHAP the fact that FHPCs are indeed a religious health asset and that they greatly contribute to health and wellbeing.

Second, this study authenticates the ARHAP matrix (Figure 4) as a workable framework and thereby contributes to its development and the development of the body of knowledge within ARHAP. It can be observed that based on the ARHAP theoretical framework, FHPCs works very strongly in the 2nd quadrant – intangible assets – making use of factors such as the word, prayer, ritual and an ongoing relationship between the 'pastor' and the congregation to impact directly upon health. Through this they also have an ongoing effect upon quadrant 4 – upon general well-being (indirect health outcomes).

The tangible and intangible ways that FHPCs contribute to health and well-being are stated below.

5.9.1 Tangible ways in which FHPCs contribute to health and well-being

A number of FHPCs have church buildings, and these are used during the week to run spiritual clinics where health-seekers are provided with facilities that meet their spiritual, emotional and physical needs.¹⁴⁵ Most FHPCs' buildings are also open from Monday to Friday and people go to these buildings to pray and seek counselling from either the Bishops or the Pastors. In other communities, FHPCs premises are used as pre-schools or as immunization centres whenever there is a breakout of diseases or when there is a national campaign for children immunization against polio or measles.

¹⁴⁵ Figure 32 Chapter 4

5.9.2 Intangible ways in which FHPCs contribute to health and well-being

There are several ways that FHPCs contribute in intangible ways to health and well-being as observed in this research. Counselling is one of the contributions identified in the research. The FHPCs spend time with the sick listening to them and encouraging them. Figure 32 shows that most people seek counselling from FHPCs. This kind of counselling is done in such a way that the sick person speaks to the Pastor and as the Pastor or Bishop listens, he/she then speaks words of prophecy to the sick in the form of a revelation from God. Thus “prophetic” counselling is very vital among FHPCs and is one of the key ways FHPCs contribute in intangible ways to health and well-being in Ndola. Some of the other intangible ways observed in the ARHAP matrix and stated in the data in Chapter 4, that FHPCs contribute to health and well-being are, prayer, resilience, health-seeking behaviour, motivation, responsibility, commitment/sense of duty and the like.

All the analysis above show the fact that the ARHAP theoretical matrix can be used to access and analyse what religious health assets are and the contribution they make to health and well-being in Ndola. Therefore, as pointed out above, this study authenticates the ARHAP matrix as a workable framework and thereby contributes to its development and the development of the body of knowledge within ARHAP.

5.10 FHPCs’ and traditional healers

So far, this research has dwelt much on the strengths of FHPCs. It is however important to also note a weakness of FHPCs, namely that they want to have nothing to do with traditional healers. They see them as demonic and ungodly. Figure 25 (4.3.3) shows that of the 100 respondents who participated in the study, only 1% indicated that they use traditional medicines. 99% did not see traditional healers or medicines as the other health service they can use. Also in Figure 30 (4.3.3) it can be observed that 9% of the respondents indicated that traditional healers are not good for Christians.

In as much as the traditional healers would have their own areas of weakness, the response of FHPCs towards traditional healers is not good in that it denies and limits the

health-seekers' opportunity to further explore and employ other religious health assets available to them within their context.

5.11 The challenge that this study brings to health policy makers in Ndola

There is need to make visible the health assets held by FHPCs. Given that most people are skeptical of FHPCs in Ndola, it is important that the impact of the health assets that are held by FHPCs are made visible to health policy makers as well. When these assets are leveraged by health policy makers and aligned with the existing government and privately owned health services, there could be a huge difference made in the health situation of people in the communities of Ndola.

5.12 Conclusion

This chapter sought to interpret the research results provided in Chapter 4, and through the interpretation it has been observed that FHPCs are hugely contributing to health and well-being in society and could rightly be called a religious health asset. The chapter has also sought to explain the contribution that this research makes to the ARHAPs' ongoing research on religious health assets. This chapter finally stated the challenge that this research presents to health policy makers in Ndola, Zambia.

The next chapter will provide some theological insights on issues in this dissertation and it will reflect on how they challenge the Church in Ndola and Zambia at large.

CHAPTER 6

THEOLOGICAL REFLECTION ON ISSUES RAISED IN THE DISSERTATION

6.1 Introduction

This dissertation has so far raised several social and health issues affecting people in Ndola. The dissertation has also discussed the contribution of religion to health and well-being and has interpreted and analysed the implications of the data collected during the field research among FHPCs. Thus far, however, the dissertation has only provided a social analysis of the research. It is important at this point to note that people's struggles for health and well-being calls for a need to work towards the development of a clear and contextual theology of health, healing and suffering.

It must immediately be observed that there are several schools of Christian thought in Zambia on aspects of sickness and suffering. Some Christians believe that sickness is from God who desires to punish people who are unfaithful, while others believe that all sickness is from the devil. There are also some people who ask why God allows people to suffer and die of dehumanizing diseases. Such theological debates need contextual theologies to be developed, so that people who suffer from all forms of diseases are aware of God's place in their lives when they pass through sickness and suffering.

As a way of contributing to the need for a contextual theology on health, healing and well-being in Zambia, this chapter will therefore take the findings of the research and provide a theological reflection around four key insights on issues that emerge from this dissertation. In this way, while we may not provide a full and comprehensive theology of health and healing, we can point to some important elements that need to be present.

The theological challenges that emerge are directed to all churches, not just FHPCs, and the term 'Church' in this chapter carries this wider ecumenical meaning.

6.2 The *missio Dei* as healing: a challenge to the *missiones ecclesiae*

The first key theological insight that emerges from the research concerns the *missio Dei* and the challenge that this presents to the Church. Chapter 2 of the dissertation made it clear that many people in Ndola, especially in townships in which the research was conducted Mushili, Lubuto, Twapia and the like, are living in unhygienic and deplorable health conditions. Such living conditions that people in Ndola are subjected to are a violation of their human dignity and the God-intended integrity for humans. God created all humans in God's image, and as such, they were all created to love and worship God and to live in dignity and integrity as God's stewards for all creation.¹⁴⁶ It is such dignity and integrity that many people in Ndola have been deprived of and denied because of the lack of good health provision. Many people are dying as a result of HIV/AIDS, tuberculosis and malaria every day, after much suffering and humiliation. People's human rights to accessing health and well-being from some government health institutions and other health service providing institutions have been violated, and this has led to the dehumanizing health conditions for the people.

A key theological question that emerges from this is: how can God allow innocent children to get infected and affected with HIV/AIDS? How can the loving God allow a situation where the parents of young children die of HIV/AIDS and those children end up as street kids? Why does evil prevail over good? Part of the answer to this is to recognize that God has been at work in promoting health and well-being among people who suffer from sickness, disease and other forms of oppression. Healing is a key aspect of the *missio Dei*, the work of God.

First, we observe that God has been committed to giving life and sustaining it since creation through the provision of laws that enable people to live healthy lifestyles and by preventing people from engaging in activities that would risk their lives. When God's people lived in accordance to the laws and commandments provided to them in the bible,

¹⁴⁶ Genesis 1: 27: God created man (sic) in His (sic) own image, in the image of God he created him (sic) male and female He (sic) created them. God blessed them and said to them, "Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish of the sea and the birds of the air and over every living creature that moves on the ground," (N.I.V).

they usually protected themselves from sickness and disease that were caused by activities that put their lives at risk, which the laws of God consider as sin.

Second, we also observe that during the life and ministry of Jesus on earth, he was committed to promoting life and well-being. Jesus was committed to ensuring that God's people live in good health. When speaking to his disciples, Jesus stated that, "I have come that they might have life and have it to the full."¹⁴⁷ Jesus demonstrated this statement in practical ways at two levels. Wherever he went, he prayed for people to be restored to good health and therefore live free from sickness and disease.¹⁴⁸ Also, the redemptive death of Jesus Christ on the cross restored human dignity which had been lost as a result of sin and broken human relationships. This redemptive act of God brought health to people as they experience forgiveness, redemption and reconciliation to God and one another. Jesus' life and death on the cross is a clear indication that amidst sickness, disease and other forms of oppression, God is present and among people who are suffering.

Third, the *missio Dei* as the work of healing is a challenge to the *missiones ecclesiae*, the work and ministry of the Church, which is called to be God's agent reaching out to people who are sick and dehumanized by disease. Churches serve communities with the sole purpose of honouring their creator God. I must point out that the purpose of the Church on earth is that it fully participates in bringing about abundant life/health to people as it continues to participate in the *missio Dei*.¹⁴⁹ Since the *missio Dei* is about bringing peace, justice and abundant life to people, when the Church participates in the *missio Dei*, it is engaged in life-giving activities which promote the abundant life/health that Jesus died for on the cross. As the Church in our generation gets involved in social ministry such as hospitals, HIV/AIDS hospices or ministries to the aged, it is involved in the *missio Dei* for "which the Church has been privileged to participate."¹⁵⁰ This

¹⁴⁷ John 10: 10, "A thief comes only to rob, kill and destroy. I came so that everyone would have life and have it fully," (Contemporary English Version).

¹⁴⁸ Matthew 4: 23, "Jesus went all over Galilee, teaching, in the Jewish meeting places and preaching the good news about the kingdom. He also healed every kind of disease and sickness." (N.I.V.).

¹⁴⁹ Steve De Gruchy, "Integrating Mission and Development: Ten Theological Theses," *International Congregational Journal* 5, No.1 (2005) p.27.

¹⁵⁰ David J. Bosch, *Transforming mission: Paradigm shifts in Theology of mission*, (Maryknoll: Orbis, 1990) p.393

involvement in the *missio Dei* is God's mission on earth for the people's well-being. When the Church gets involved in the *missio Dei*, it does so as commanded by God, and as such it is God working to promote health and well-being through the Church. This then is an indication that God is at work among people who are sick and has not abandoned them. As the Church engages in activities such as spiritual teachings, evangelism or youth clubs, it helps to promote healthy lifestyles as God's agent on earth for proclaiming and promoting God's kingdom.¹⁵¹

As the research amongst FHPCs shows, many people turn to the Church in their search for health and well-being. They have identified the Church as a place and source of their healing and well-being. This is clearly seen in the rate of church attendance among FHPCs as revealed in this research. We observe that people are desperately in need of the Church's ministry of healing. They receive this healing mainly through listening to the preaching of the word of God as seen in Chapter 4. Through such preaching people understand God's laws which they seek to live by as they seek to live a healthy life style. Through the preaching of God's word, people are also enabled to value their life as they realize that Jesus died for them that they might have live to the full. It must also be pointed out that the healing sought for in FHPCs is not only effected through the preaching of God's word, but also through praise and worship, the process of praying for the sick and laying on of hands.

The challenge that the ministry of healing among FHPCs in Ndola poses to other churches in Zambia is that there is currently a great opportunity for the Church and its leaders to work with people who are sick and to fulfill the commandment of the Lord Jesus that they are the salt and the light of the earth.¹⁵² And, when the Church engages in the ministries of healing, it then demonstrates God's love and care for God's people.

¹⁵¹ Anthony Allen, "The Church as a health promoting community: The Jamaican experience," *Life style and health, Contact magazine*, Number 169 (April – June 2006).

¹⁵² Matthew 5: 13, "You are the salt of the earth. But if the salt loses its saltiness, how can it be made salty again? It is no longer good for anything, except to be thrown out and trampled by men..." (N.I.V).

6.3. The importance of the gathered community of faith, in terms of its inclusivity and its worship, for healing and well-being.

The second theological insight that emerges from issues raised in this dissertation is the importance of the gathered community of faith, through its inclusivity and its worship, for healing and well-being among God's people.

Firstly, we have seen how the healing church is an inclusive community. We observe that FHPCs are very diverse in terms of the kind of people who attend their Sunday services. FHPCs have people of different ages, tribes, educational backgrounds and represent almost an equal population of both female and male. As presented in Chapter 5, most of the people who attend FHPCs are dislocated from their villages of birth or tribal settlements and extended family close support. When they become members of FHPCs they gain a sense of family and get to belong to the family of Christians. This is a clear demonstration of what the bible discusses, that all believers in Jesus are one body in Christ Jesus and that they belong to the family of God.¹⁵³ The sense of family and inclusivity is seen as hugely contributing to healing and well-being to many people who attend FHPCs. Despite their many differences one to another, many people who go to FHPCs have a sense of belonging in life in that they feel part of a family. It is this sense of family, unity and belonging that this dissertation identifies as contributing to health and well-being among people who attend FHPCs. I must also state that the sense of family and belonging one to another brings about care for the sick and motivation and resilience for the sick amidst much sickness and diseases.

Second, it is observed in the findings that the way the worship services are conducted in FHPCs each Sunday creates a sense of family and belonging. The preaching of the word of God, the liturgy, songs of hope and unity or specific healing rituals are all done in unity and care for one another. This research has shown that people who go to FHPCs claim that the word of God brings healing and well-being to them. This is clearly

¹⁵³ Galatians 3:26-28, "You are all sons (sic) of God through faith in Christ Jesus, for all of you who were baptized into Christ have clothed yourselves with Christ. There is neither Jew nor Greek, slave nor free, male nor female, for you are all one in Christ Jesus. If you belong to Christ, then you are Abraham's seed and heirs according to the promise," (NIV). See also Ephesians 4:25, "Therefore each of you must put off falsehood and speak truthfully to his neighbour, for we are all members of one body," (N.I.V.).

demonstrated in Chapter 4, under 4.3.2, Figure 19, where we observe that the word preached among FHPCs seems to be the main reason why people go to FHPCs. 48% of the respondents who participated in the field research indicated that people attend church at FHPCs because of the preaching of God's word. Thus the fact remains that people find help, peace and comfort with the word that is preached at FHPCs. Therefore the word preached at FHPCs is the word of healing which brings about faith and hope in the lives of people. The sick, the depressed and the unemployed go to listen to the word preached at FHPCs and this word has impact on their lives. It is this same word that then results in sessions of prayers for healing and prosperity. There is a connection between the preaching of the word and the healing. The preaching of the word and the praying for the sick have a connection in that they are both done by the Bishops, Pastors and Apostles in FHPCs. The preaching of the word of God comes first and is followed by the praying for the sick and the people with personal problems. Therefore the preaching of the word, which dwells on God's promises to God's people as stated in the bible, is central among most FHPCs. Worship is also seen as being cardinal among FHPCs services. A number of respondents stated during the field research that praise and worship is yet another reason why people attend FHPCs. People must feel at peace and in close relationship with God and with one another as they sing songs of praise to God.

This aspect of healing to do with the gathered community of faith reminds us that the Christian faith is not just about individuals and private beliefs, but it is about belonging to a community of faith, the body of Christ. This community of faith is inclusive, and this inclusivity is demonstrated in the diversity of the people who attend FHPCs. This is also practically demonstrated in the unity and sense of family that FHPCs attendants demonstrate during the preaching of God's word, the time of praise and worship, prayers for healing and other rituals that take place during the church services. This in turn is a challenge to other churches to take inclusivity seriously and order their services in a way that the preaching of God's word, praise and worship and their liturgy serve to meet people's anticipation and desire for change, as they seek health and well-being.

6.4. The Church is one partner amongst others in the work of healing, and its unique contribution is to challenge others to think of health more holistically.

The third theological insight that emerges from issues raised in this dissertation is that the Church contributes to healing and well-being alongside other health providers. The contribution that FHPCs are making is part of the huge contribution that the Church in Zambia is making to health and well-being. This challenges the perceptions by some critics that churches are places where people go to give their tithes and offerings which enrich the Pastor who then preaches utopian promises from the bible.

As we reflect on how the Church is working with other health providers, we can note three things. First, it is clear from the research that FHPCs understand that God is fully involved in the process of healing, and that God is not only limited to healing people in the context of the Church itself but God also heals through hospitals and clinics owned by both the government and private practitioners. We observed that people who go to FHPCs realize that the Church is a partner for health provision along with other health providing agencies, in that the respondents to the research pointed out that their churches encourage them to seek healing and well-being from other health providing agencies. In 4.3.3 under Figure 29 it is revealed that 92% of the respondents stated that their churches encourage them to use other health services. It is evident that the people who attend FHPCs are comfortable to seek healing from hospitals in that they are convinced that God heals even through hospitals and clinics. Clearly then, the Church understands itself as one partner amongst others in the work of healing. Second, it is also clear that the Church is a major partner amongst other health providing agencies such as government hospitals, traditional healers or private hospitals/clinics in providing health and well-being. Many people turn to the Church to seek healing and support in their quest for health.

Third, the Church is not only a major partner amongst others in the work of healing, but in its unique contribution to health and well-being, it challenges other health providers to think of health more holistically. When we analyse the difference that has been noted between the Church and other health providing agencies in this dissertation, it is clear that the Church's approach to healing is holistic and other health providing agencies do

not look at health in such a holistic way. Other health providing agencies seek to provide only physical healing to the sick, whereas the Church seeks to provide the social, spiritual and physical well-being to the people. This then is the unique contribution that the Church makes to a clear understanding of health, and other health providing agencies need to begin thinking of health in a more holistic way.

Clearly then, it could be concluded under this heading that the Church must be taken as one partner amongst others in the work of healing based on the contribution it is making to people's well-being. And, through its unique contribution to health and well-being, other health providing agencies ought to be challenged to think of health more holistically.

6.5. Health cannot be divorced from a wider framework of God's Shalom, which provides a socio-political challenge to the Church

The fourth theological insight that emerges from issues raised in this dissertation is that health cannot be divorced from a wider framework of God's Shalom. Yoder argues persuasively that the message of Shalom, which the prophets preached in the Old Testament, is God's vision for the World.¹⁵⁴ God's desire is that people might live in health and well-being and at peace with each other and with God. This message of socio-political peace is therefore central to God's message of Shalom which also refers to God working towards the transformation of the social structures to promote "peace and equality for all of God's people."¹⁵⁵ Therefore, the message of Shalom encourages people to live in unity and peace with themselves, with one another, with the environment and with God.¹⁵⁶ This is the context in which the bible understands the fullness of health and well-being.

Given this, it may be argued that the commitment to healing that FHPCs are engaged in does not fully embrace God's vision and the message of Shalom. Chapter 2 shows that health is closely related to the socio-political context in Zambia, and that the poor health provision is as a result of poverty, expensive medical provision, dilapidated

¹⁵⁴ Perry Yoder, *Shalom* (London: Hodder & Stoughton, 1987) p. 2.

¹⁵⁵ Perry Yoder, *Shalom*. p.2.

¹⁵⁶ Nicholas Walterstorff, *Until Justice and Peace Embrace* (Grand Rapids: Eerdmans, 1983).p.72.

infrastructures and poor community services by government. In as much as we have observed that FHPCs are contributing to health and well-being, there is need to point out that FHPCs and other churches need to engage in works that would seek to bring about the transformation of the socio-political situation in Zambia. Rather than just limit their ministry of healing within their church buildings, FHPCs and other churches need to also engage in prophetic ministries where they would speak openly in condemnation of the poor socio-political situation in Zambia which has mainly been caused by poor political decisions and bad governance. Thus FHPCs and other churches should engage in other social programmes that seek to alleviate poverty and thereby alleviate the growing levels of HIV/AIDS, malaria and tuberculosis. When FHPCs and other churches in Zambia engage in the prophetic ministry and programmes that would seek to alleviate the increase of sickness and diseases, they would be participating more in God's vision of Shalom. This then is a challenge to FHPCs and other churches to not only engage in the works of healing within their churches, but to also engage with political leaders through a strong prophetic ministry that would seek to challenge the ever growing neglect of community people by political leaders.

6.6 Conclusion

This chapter has provided a theological reflection around four key insights on issues that emerge from this dissertation, as a way of contributing to the need for a contextual theology on health, healing and well-being in Zambia. The chapter has presented the fact that God's work on earth, the *missio Dei*, is committed to seeing God's people living in dignity and integrity as they are created in the image of God, and this is a challenge to the Church as it seeks to participate in the *missio Dei*. The chapter also pointed out that as a gathered community of faith, FHPCs hugely contribute to health and well-being in that people from diverse backgrounds find a sense of family and belonging among their fellow worshippers. It has been observed in this chapter that the contribution that the Church makes to health is holistic and presents a challenge to other health providing agencies that see health as only in the physical sense. Finally, this chapter ended by observing that health can not be divorced from the wider framework of God's Shalom, which provides a socio-political challenge to the Church.

The next chapter is the conclusion to this dissertation and will present the summary of the dissertation.

CHAPTER 7

SUMMARY AND CONCLUSION

7.1 Introduction

This study sought to answer the question as to what impact FHPCs have on the health-seeking strategies of health-seekers in Ndola, Zambia. The study also wanted to establish whether FHPCs could be considered as a religious health asset.

To achieve this, the study analysed the general situation of health provision in Zambia. Here it was noted, based on literature and the researcher's own observations, that there is a crisis in health provision in Zambia. Thus using the ARHAP concepts, research work and the theory matrix, it was realized that a great number of people in Zambia, amidst such poor health provisions, have turned to religious health assets, such as religious-run clinics and hospitals, FHPCs or traditional healers. This helped to establish the fact that religion contributes greatly to health and well-being in Zambia, though the sad fact observed was that most policy makers and organizations such as the World Health Organization (up till now) seem to cast a blind eye to the impact that religion has on health provision in Zambia.

7.2 Comments on the findings

This dissertation has identified FHPCs as providing a home for people in need of social networks which enable the people faced with much poverty, sicknesses and diseases and the impact of the Structural Adjustment Programme, to have a sense of identity, belonging and purpose. It has also pointed out that people are attracted to attending FHPCs in Ndola because of the need for holistic healing. The dissertation has clearly shown that the emergence of FHPCs is related to poverty in Zambia. FHPCs have also been identified to be contributing to health and well-being alongside other health providing entities in Ndola and that the people who go to seek healing from FHPCs do receive healing through prayers, anointing with oil, the preaching from God's word and

through spiritual songs. It is also evident that the notable differences of FHPCs' healing process from other health providing entities are personal care, free service and absence of side effects. It is clear from the research that worshippers at FHPCs display a strong sense of agency in their search for health. Finally, it has been observed that the contribution this study makes to the ARHAP's ongoing research is identifying the FHPCs as a religious health asset.

Based on the findings of this dissertation, it is clear that many people in Ndola have unswerving faith, trust and hope in God through the word, praise and worship that are presented through FHPCs. FHPCs are the fastest numerically growing churches in Zambia. The attendants go to church every Sunday and are also committed to the mid-week meetings during the weekdays. Therefore, based on the ARHAP theory matrix, this research has located FHPCs in the intangible assets and direct and indirect outcomes quadrant assets. The intangible nature of contribution to the well-being of FHPCs attendants can be felt, experienced and appreciated by them.

When most people analyse the healing activities of FHPCs in Ndola, it is difficult for them to understand exactly what takes place in these entities. But, it is important to state here that, having done this research and drawing on the findings, I am convinced that there is something happening to the health of those that go to seek health and well-being from FHPCs, which other health providing entities are not providing in Ndola. Most people in Ndola, see FHPCs as contributing to healing alongside other health providing agencies in Zambia. It could therefore be concluded that people's health needs are being met by FHPCs, and as such this makes them a very strong religious health asset.

7.3 Theological insights arising from this dissertation

There are four key theological insights that have emerged on issues in this dissertation. It has been observed that God's work on earth, the *missio Dei*, is committed to seeing God's people live in dignity and integrity as they are created in the image of God, and not to live dehumanized lives of sickness and diseases. From the contribution that FHPCs are making in Ndola to health and well-being it has been observed that inclusivity and the act

of worship are important elements for healing and well-being. It is also clear that the Church is one partner amongst others in the work of healing, and in its unique contribution it challenges others to think of health more holistically. The holistic nature of healing which is promoted among FHPCs has been seen as being a challenge to other health providing agencies who see health only from a physical sense. Finally, it has been observed that health cannot be divorced from a wider framework of God's Shalom, which provides a socio-political challenge to the Church. Therefore, FHPCs and other churches need to engage more in programmes that are aimed at social transformation unlike only concentrating on healing within their church buildings.

7.4 Conclusion

This research sought to investigate the impact that FHPCs have on health-seekers and the extent to which FHPCs could be understood as a religious health asset. In seeking to gain an understanding on the impact that FHPCs have on health-seekers, the research sought to gain insight into the reasons why health-seekers in Ndola attend FHPCs, to analyse the contribution that FHPCs might be making to the health of people in Ndola, to contribute to the growth of knowledge and theory in the ARHAP research project and to theologially reflect on what this might mean for the Church in Ndola.

Based on issues that have emerged from this research, it has become clear that FHPCs have a huge impact on the health-seeking behaviours of many people in Ndola who live amidst a situation of poverty and poor provision of health services. People who go to FHPCs have stated in this research that they receive healing when they go to FHPCs worship services in that these churches provide social networks for them, holistic healing, healing alongside other health providing services and they also are cost effective. It could be concluded that FHPCs can rightly be called Religious Health Assets.

Since many people in Ndola are turning to FHPCs for their healing, it is therefore important that policy makers in both the Church and public health sectors draw on these assets in implementing effective public health policies. Policy makers could engage into

dialogue with FHPC leaders and work together on health issues to improve the health conditions of the poor in Ndola and Zambia as a whole.

In conclusion, I want to state that there is need to further research on the issues of healing and well-being in Ndola, Zambia. It would be important to have research done into the kind of diseases that people get healed from when they visit FHPCs. This could be a research that ARHAP could conduct in future.

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**APPENDIX A: Health-seekers and faith-healing charismatic ministries -
questionnaire**

Section 1 - Tick where applicable

1.1. Age:

- 15 – 20
- 21 – 24
- 25 – 30
- 31 – 35
- 36 – 40
- 40 – 45
- 46 and above

1.2. Sex

- Male
- Female

1.3. Marital Status

- Single
- Married
- Widowed

1.4. Home language

- Lamba
- Bemba
- Nyanja
- Tonga
- English
- Other specify _____

1.5. Educational level

- Primary school
- Secondary school
- College/ University

1.6. Occupation

- Personal Business
- House wife
- Student
- Formal employment

1.7. Years lived in this community

- 0 – 3
- 4 – 7
- 8 – 12
- 13 and above

Section 2 - Tick where applicable and fill in where necessary

2.1. Name of church _____

2.2. Township/ Location of church _____

2.3. How long has the church existed (Months/ Years)?

- 0 – 3
- 4 – 7
- 8 – 12
- 13 and above

2.4. How long have you attended (Months/ Years)?

- 0 – 3
- 4 – 7
- 8 – 12
- 13 and above

2.5. How many others from your household attend this church? _____

2.6. How often do you go to your church in a month?

- Every Sunday
- Every other Sunday
- Once a month
- Not often

2.7. About how many people attend this church?

- 10 – 20
- 21 – 50
- 51 – 100
- 100 – 150
- 150 – 200
- Above 200

2.8. Why do you think people attend this church?

- Good Praise and Worship
- Physical and emotional healing
- Relationships
- Preaching of God's word

Section 3 - Tick where applicable and fill in where necessary

3.1. How often does the church have a focus on healing each month?

Every Sunday
 Every other Sunday
 Once a month
 Not often
 Non

3.2. Who leads the healing service/ sessions?

The Bishop
 The Pastor
 Church Elders
 Church Leaders
 All the Church members

3.3. What does he/she do?

Laying of hands
 Anointing with Oil
 Holy water
 Prayers with anointed handkerchiefs
 Other specify _____

3.4. Have you sought healing?

Never _____
 A few times _____
 Often _____

3.5. What happened?

Healed instantly
 Progressive Healing
 Not healed

3.6. Which other health services do you use?

Government Hospital
 Traditional Healer
 Traditional Medicines from herbalist
 Private Hospital
 Church/ Mission Hospital

3.7. What is the difference offered by church healing?

- Personal touch and attention
- Administered freely
- No side effects
- Other Specify

3.8. Have you encouraged other people to come to the church for healing?

- Yes
- No

3.9. What happened?

- Healing was received instantly
- Healing was received progressively
- Healing was not received

3.10. Does the church encourage you to use other health services?

- Yes
- No

3.11. Why/why not? _____

3.12. Do you think your church makes a contribution to a healthy society?

- Yes
- No

3.13. If yes, How _____

APPENDIX B: Health-seekers and FHPCs – consent form***Introduction:***

My name is Audrey Matimelo. I am undertaking research towards my Masters Degree at the University of KwaZulu-Natal in South Africa. This research is being undertaken to try to understand more deeply the perspectives and concerns of people who turn to Faith-Healing Pentecostal Churches for health and healing.

I understand that you attend such a church, and so I would request that you would answer a few questions to help us understand this better.

It should only take 10 minutes. You will not be asked your name.

There will be no payment for this, and you may stop answering the questions at any time.

If you are happy for me to continue, would you please sign below?

I have been informed of the purpose of this research.

I understand that I will be answering a questionnaire and that my answers will be used with others in a research report.

I understand that my name will not be recorded anywhere.

I understand that there is no payment for this.

I understand that I may stop answering questions at any time.

Signed: _____

Place: _____

Date: _____

Research supervisor: Prof Steve de Gruchy

University of KwaZulu-Natal, South Africa

Telephone: +27 33 260 6273.