CCORE
Collaborating Centre for
Operational Research and Evaluation

Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe

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Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
CCORE	Collaborating Center for Operational Research and Evaluation
CSO	Central Statistical Office
DHS	Demographic and Health Survey
EPI	Expanded Program on Immunization
FDGs	Focus Group Discussions
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MIMS	Multi-Indicator Monitoring Survey
MMR	Maternity Mortality Ratio
MoHCW	Ministry of Health and Child Welfare
MPs	Members of Parliament
NIDs	National Immunization Days
PNC	Postnatal Care
STI	Sexually Transmitted Infections
ToRs	Terms of Reference
UDACIZA	Union for the Development of Apostolic Churches and Zionists in Zimbabwe Africa
UNDP	United Nations Development Program
WHO	World Health Organization

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Executive Summary

This qualitative study on determinants of healthcare seeking behavior among Apostolic Faith community *(Vapostori)* was commissioned in December 2010 by the Collaborating Center for Operational Research and Evaluation (CCORE, UNICEF) in response to the need to understand beliefs and practices that lead to acceptance or rejection of preventive and promotive health and social practices among Apostolic religious groups in Zimbabwe, focusing on those practices that affect women and children. It sought to provide in-depth, rich description and understanding of the different groups within the Apostolic community, and offer evidence that would be used in generating and informing future communication strategies for health and social development in Apostolic communities as well as strategic recommendations for program interventions. In addition, the study also highlighted "best practice situations" where optimal collaboration between the Apostolic community and formal healthcare providers was identified by the respondents.

Key Findings

Based on analysis of data from secondary sources (desk review), in-depth interviews with 111 Apostolic members and 54 key informants, focus group discussions, and informal discussions, the key findings of the study revealed that:

- Religious teaching and church regulations of Apostolic Faith groups fundamentally shape healthcare-seeking behavior, and hence the differences in healthcare-seeking behavior among them can be attributed to differences in religious teaching and church doctrine (regulations) as well as levels of adherence to these teachings and doctrines. The finding concurs with Gregson et al (1999) conclusion that healthcare-seeking behavior can be explained by understanding religious teaching and church doctrine as well as adherence to these teachings. Johanne Marange, Johanne Masowe, and Madhidha apostolic groups have strict religious and moral codes, and tend to emphasize strong adherence to religious teachings, church doctrine and regulations. Consequently, these religious groups can be regarded as Ultra Conservative Apostolic communities, and they openly object the uptake of modern healthcare services and immunization.

- The heterogeneity of Apostolic Faith community is reflected in the varied groups and subgroups, which have differing religious teachings, doctrine, and regulations. The Apostolic community is not a homogenous religious entity, and therefore Apostolic religion comprises of several sects, and each with different interpretations of Apostolic teachings and practices. Others base their teachings and practices on the Bible, founders' philosophy and doctrine, "revelation from and of the Holy Spirit" or *Mweya*, mixture of beliefs including some aspects of African culture and religion, and modernity. Therefore, these different foundations of religious beliefs and teachings have led to multiple interpretations and different expressions of the Apostolic religion. The plurality of Apostolic beliefs, teachings, and practices results in different health-related decisions among members of the Apostolic community as well as competing positions on the uptake of modern healthcare services and vaccination. In view of these variations, the study emerged with a crude categorization of the Apostolic community that range from the ultra-conservative Apostolic groups to semi-conservative and liberal Apostolic groups, and these broad categories are based on the extent to which the Apostolic groups uptake modern healthcare services, modern medicines, and immunization as well as accommodate change in beliefs, teachings, rituals and practice in line with emerging new thinking.

- The religious teaching, doctrine and regulations of the ultra-conservative Apostolic groups (e.g., Johanne Marange, some subgroup within Johanne Masowe, and Madhidha), which emphasize faith healing and strict adherence to church beliefs and practices undermine modern healthcare-seeking. Often, violation of church doctrine or regulation on non-use of modern healthcare services attracts sanctions, which include confession, shaming (asked not to wear church regalia or *"kubvisiswa gamenzi"*, or re-baptism

(kujorodwa). These social controls often take a militaristic-type discipline in order to ensure strict adherence to the Apostolic group's norms, values, and beliefs.

- Semi-conservative and liberal Apostolic groups have ambiguous teachings and church doctrine related to use of modern healthcare services, and do not openly or strongly condemn use of modern health services but encourage members to seek spiritual counsel and faith healing first before utilizing modern healthcare services. Therefore, uptake of modern healthcare services is secondary after primary spiritual consultation.

- The Holy Spirit *(Mweya)* plays a central role in the spiritual life, beliefs, and faith healing of the Apostolic religious community. *Mweya* is believed to foretell and forewarn about any impending disease outbreak, tragedy, complications as well as how to treat illnesses. *Mweya* works through prophets and church (spirit-filled) members, and endows them with special healing and prophetic powers and gifts.

- The Apostolic members believe that the healing powers and spiritual gifts are endowed from God/*Mweya*, and used in promoting maternal and child health, facilitating child delivery, and restoring health to the sick. Hence, the strong belief in faith healing, healing rituals, prayer and power of *Vapostori* as well as the emphasis on the "Apostolic healthcare system", which is religiously constituted and justified as glorifying the work of God or the Holy Spirit. The ultra-conservative Apostolic groups deem the modern healthcare system as worldly (heathen) and glorify man above God. Consequently, these beliefs among ultra-conservative Apostolic groups act as a barrier to the uptake of modern healthcare services and medicines.

- Illnesses/diseases are deemed to have spiritual and religious undertones, and hence the strong tendency to spiritualize even medical conditions. Such beliefs about illness tend to reinforce the skewed bias towards faith healing while overlooking the importance of medical treatment. Hence, some Apostolic members forgo modern medical treatment, and such refusal can lead to serious health implications or deaths.

- Faith healing and healing rituals among the Apostolic community often associated with works of *Mweya*, prayers, sanctified (holy) water, sanctified stones *(matombo akayereswa)*, and use of "apostolic concoctions"; all these are perceived to have healing powers or deliver healing, cleanse impurities or evil spirits, maintain good health or restore it during sickness, and ensure improved quality of life and health of Apostolic members. In addition, there is a widespread belief that reliance on modern medicines and healthcare services reflects the level of one's faith, and it is generally associated with weak faith. Without affirming a moral judgment on the efficacy of faith healing or Apostolic healing rituals, the refusal by some Apostolic members to obtain medical treatment because of their adherence to religious practices can affect health negatively.

- Mixed views among Apostolic members regarding compulsory immunization initiatives and uptake of modern maternal and child healthcare services despite the negative views of ultra-conservative groups based on their strong religious beliefs and doctrine. In view of the religious objections of ultra-conservative Apostolic groups, their members secretly accessed modern healthcare services and preferred special outreach initiatives that enabled them to obtain medical assistance. In contrast, the majority of the key informants advocated the need for policy prescriptions and legal enforcement of compulsory immunization for children in the interest of public health and reducing vaccine-preventable diseases and deaths as well as exploring ways of encouraging professionally assisted delivery by pregnant women to mitigate maternal and pregnancy-related deaths and complications.

- Some religious beliefs, tenets and adherence to practices of the ultra-conservative Apostolic groups have negatively affected members' decisions about their healthcare by objecting to uptake of modern healthcare services and encouraging practices that increase risk to HIV and AIDS through polygamy, wife inheritance and pledging young girls to marriage. These factors contribute to negative health outcomes. However, it should be noted that some Apostolic tenets have positive implications for health outcomes and public health.

- Contrary to the general view that Apostolic faith followers feel discriminated against and stigmatized by health workers (Advocacy and Social Mobilization Taskforce 2010), this study revealed opportunities for collaboration between Apostolic members and formal health providers through positive engagement, dialogue, and information, education and communication (IEC) strategies especially with ultra-conservative groups) and health providers require improved dialogue and engagement with spiritual leaders in the churches and targeted information, education and communication (IEC) strategies.

Recommended Interventions

Based on the abovementioned key findings, the following key interventions are recommended:

- Information, Education and Communication (IEC): Improved IEC and promotional events to address misinformation and lack of understanding on health matters among Apostolic groups, particularly the ultra-conservative groups. The positive lessons from the anti-cholera campaign, particularly IEC and relationship building, can be replicated in other health promotion initiatives involving Apostolic communities.

- Dialogue and Engagement with Ultra-Conservative Apostolic Groups: Platforms for dialogue and engagement, particularly between formal health providers and ultra-conservative Apostolic communities (e.g., Johanne Marange, some variants of Johanne Masowe, Madhidha). The initiatives could include National Apostolic Leadership summits, religion and health sensitization workshops that target church leaders, influential women within Apostolic groups, youths, and men with the capacity to act as change agents. This requires collaborating with Apostolic religious bodies/ representatives (e.g., UDACIZA) in facilitating dialogue and strengthening opportunities for positive change and capacity building. This process is about building relationships and sustaining change with a long-term focus recognizing that this is a journey, and not a short-term fix approach. The dialogue and engagement processes should focus on building social networks that facilitate the spread of positive messages and information on health, gender, rights to health, and empowering theology[1].

- Capacity Assessment and Building: Capacity assessment of "Apostolic health centers" and midwives to ensure that "acceptable minimum health standards" are practiced to minimize risks to mothers and children as well as the lives of the Apostolic midwives themselves. This may require targeted training and skilling as well as promotional events that encourage referrals to modern healthcare facilities to nurture delivery by skilled attendants. These processes have policy implications, and may require innovative thinking and layering healthcare systems by creating linkages between formal, traditional and religious health systems.

footnotes

1 For a fascinating discussion on overcoming theological rigidity, promoting constructive engagement and positive response, addressing gender insensitivities, and sustaining healing in African churches, refer to "Living with Hope: African Churches and HIV/AIDS 1" by Chitando (2007).

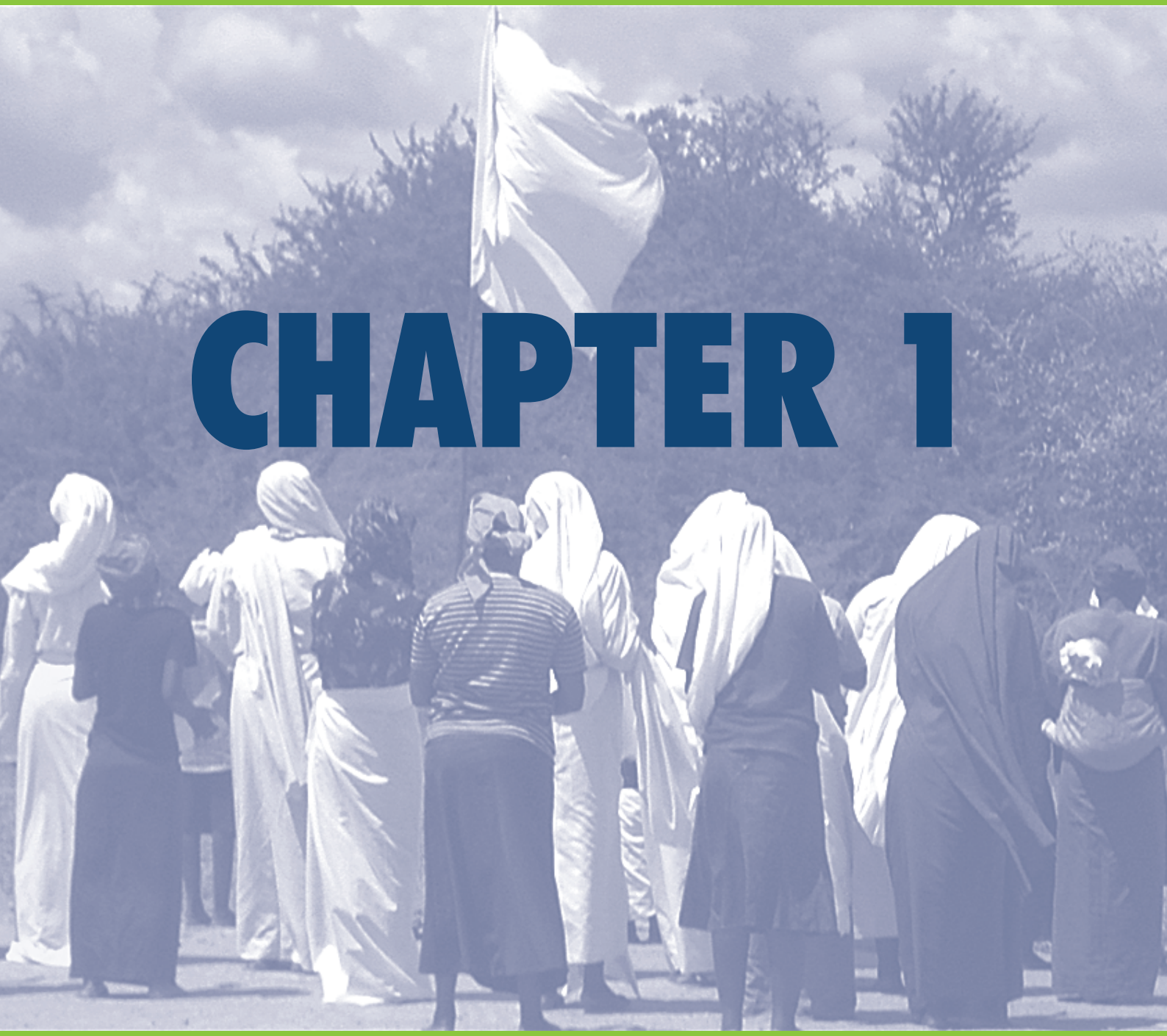
2 For detailed, interesting analysis of "when the right to health and the right to religion conflict", refer to Stone, Gable and Gingerich (2009).

- Policy and Legislation: Encourage policy debate on legislating mandatory healthcare for children and pregnant women in the interest of promoting right to health while addressing fundamental religious questions. More research and debate is required in addressing the tension between religion and health or "when the right to health and the right to religion conflict"[2]. This study revealed that the religion of ultra-conservative Apostolic groups can conflict with women and children's right to health, and hence raises fundamental questions about human rights and the obligations of the State to protection and promotion of public health.
- Database and Baseline Survey: Development of database of professional medical personnel within the Apostolic community, and explore ways of engaging these medical professionals in building alliances, communicating and influencing positive changes in health seeking behavior among Apostolic members since they could act as a conduit of medical and health knowledge and intervention. The Apostolic members are likely to be receptive to health assistance from professional health personnel of their faiths. Mapping Apostolic groups in areas with low immunization coverage and poor uptake of maternal and child health services in order to plan for optimal collaboration and positive engagement as well as strengthen access to healthcare and other services (water and sanitation) aimed at benefitting the Apostolic community.

Report Structure

This Report presents the study's data and findings in the following format:

- Chapter 1 presents the background and context of maternal and child health situation in Zimbabwe as well as healthcare in Apostolic communities;
- Chapter 2 outlines the aims, objectives, and expected outputs of the study;
- Chapter 3 provides the research design and methodology, and clearly outlines the conceptual frameworks that guided the analysis as well as the challenges and limitations of this study;
- Chapter 4 presents the findings of the study;
- Chapter 5 provides the discussion and conclusion;
- Chapter 6 summarizes the key findings of this study and its general recommendations for strategies for program interventions and policy.



CHAPTER 1

1 Background

This chapter presents a brief overview of maternal and child health in Zimbabwe, and highlights health care in Apostolic communities. It is based primarily on desk review of existing data. This contextual understanding is important since it provides a perspective of health, religious and socio-economic development context and challenges. The chapter will familiarize the reader with the current health context of women and children in Zimbabwe as well as the challenges and religious factors that generally shape health-seeking behavior. This chapter also explores the influence of religious beliefs on health while unpacking the context within which this interaction takes place. Inasmuch as this study is about health and religion, other socio-economic factors and issues about accessibility, affordability, equity, and plurality of health-worlds (including use of alternative healthcare systems) cannot be overlooked since they interact in complex ways and influence health-seeking behaviors.

Health Context: Maternal and Child Health Situation in Zimbabwe

In Zimbabwe, the under-five mortality rate has risen from 77 per 1000 live births in 1994 to 82 per 1000 live births in 2005, and has continued to rise to about 86 per 1000 live births in 2009 (CSO 2009). When adjusted for HIV and AIDS-related mortality, the under-five mortality is approximated at 96 per 100 live births. However, HIV and AIDS remain one of the leading causes of under-five mortality in Zimbabwe, and approximately 95% of the pediatrics cases of HIV in children in this category are from mother-to-child transmission during pregnancy, childbirth, and/or breastfeeding. Given this challenge, preventing mother-to-child transmission and screening infants for HIV after delivery and throughout the breastfeeding phases could help reduce the numbers of children dying from HIV-related conditions. Reducing child mortality[3] is one of the eight Millennium Development Goals (MDG 4), and Zimbabwe has committed to reducing under-five child mortality by two-thirds[4] (UNDP 2011).

Zimbabwe has also committed to improving maternal health by reducing by three-quarters, between 1990 and 2015, the maternal mortality ratio. The maternal mortality ratio (MMR) has increased from 283 per 100,000 live births in 1994 to 725 per 100,000 live births in 2007. The worsening condition of maternal mortality ratio is cause for concern, and this has been partially influenced by the decline in the proportion of births attended by skilled health professions, fewer women completing at least four antenatal care (ANC) visits and returning to deliver in the institutions where skilled medical assistance at birth can be accessed. The 2009 estimates highlight that 39% of women who gave birth in the two years prior to the survey delivered without the assistance of skilled birth attendants.

The achievements of targets for Millennium Development Goal s (MDGs 4 and 5) have been constrained by various socio-cultural and economic factors. These challenges include systemic delivery weaknesses within the health system including deteriorating capacity and lack of responsiveness, unavailability of drugs and medical supplies, health services user fees, poverty and economic constraints, and socio-cultural issues. All these factors significantly affect the risks of child and maternal deaths. Most of the deaths are preventable if mothers and children utilized the appropriate modern healthcare services at the right time. Unfortunately, failure to access health care, unlike in the developed countries, increases the risk of maternal death for pregnant women. According to Iyaniwura and Yussuf (2009:111), the "risk of maternal death for a pregnant woman in developing countries is 1 in every 48 deliveries, the risk for a pregnant North American woman is only 1 in 3,200".

Other scholars note that North American maternal mortality rates are estimated at about 12 per 100,000 live births, sub-Saharan Africa has an estimated maternal mortality rate of 1000 per 100,000 live births (Gyimah, Takyi and Addai 2006). When compared with other regions such as Asia and Latin America, sub-Saharan Africa also performs poorly in child health, and approximately "a fifth of all children in sub-Saharan Africa die before their fifth birthday compared to less than a tenth reported in Asia and Latin America" (Gyimah et al 2006:2931). In addition, African countries also have the highest rates of childbirth-related deaths in the world, and as previously mentioned sub-Saharan African women have higher chances of dying during pregnancy or

footnotes

3 UNICEF estimates that "as many as half of all child deaths may be averted through inexpensive and relatively simple health practices" (Fosu 1994:1209).

4 UNDP (2011) "Keeping the Promise: United to Achieve the Millennium Development Goals", The Saturday Herald, 12 March 2011, p8-10.

childbirth than their counterparts in western countries. Declines in maternal survival chances due to lack of utilization of MH services inadvertently influence and undermine child survivorship. There is a growing body of literature that links "accessibility to, and utilization of MCH services in general, and particularly the use of PNC during pregnancy, and professional care during delivery, with improved child and MH outcomes" (Gyimah et al. 2006:2932).

Therefore, a positive association has been made between postnatal care (PNC) use and improved birth outcomes and child health since mothers using MCH services are most likely to receive preventive vaccinations and regular check-ups on conditions that increase risks for negative birth outcomes or pregnancy-related complications (Gyimah, Takyi and Addai 2006; Hove et al. 1999; Iyaniwura and Yussuf 2009; Mekonnen and Mekonnen 2003). PNC services provide opportunities for monitoring both the mother and child's health, and examination of mother's recovery from the effects of pregnancy, labor and delivery including "symptoms of anemia, urinary tract infection or of emotional distress or depression…breasts, abdomen and pelvis…to ensure that involution is complete and that any trauma sustained during delivery is fully healed" (Hove et al. 1999:26). In addition, the mother's pelvic floor is examined for any stress incontinence or dribbling; when she is found with any problem, she then receives treatment promptly. During PNC visits, the mother is also supported in addressing issues of contraception, mother and child's nutrition, and immunization; all these services are earmarked for improving the health of mothers and children. However, the non-utilization or poor uptake (less optimal) of MCH services has contributed to high maternal and child morbidity and mortality in developing countries as well as unnecessary, avoidable loss of lives (Gyimah et al. 2006; Iyaniwura & Yussuf 2009).

The socio-cultural factors, primarily religious beliefs, are an important dimension shaping people's health-seeking behaviors, particularly acceptance or rejection of modern healthcare assistance (UNDP[5] 2011). The United Nations Development Program (UNDP) notes that refusal of medical treatment or advice on the basis of religious beliefs influence health seeking and religion has "a strong bearing on the child mortality rate in Zimbabwe…[since] some religious groups do not allow their children to be immunized or their sick to be treated using modern drugs" (UNDP 2011:9). The reticence towards uptake of modern healthcare services such (including maternal and child health) has a direct consequence on maternal and child morbidity and mortality as it increases risks to avoidable illnesses, deaths, and vaccine-preventable diseases.

It is against this background that the study sought to understand the determinants of behavior that lead to acceptance or rejection of preventive and promotive health and social practices among the Apostolic community, especially religious objectors and practices that affect women and children. This study, in improving our understanding of factors that facilitate or inhibit utilization of modern maternal and child health services among Apostolic communities in Zimbabwe, is major contribution to existing knowledge on religion and health in Africa (Gyimah et al. 2006), and unpacks the influence of Apostolic beliefs, teachings, doctrine, practice, and faith healing (including healing rituals) on health decisions and ultimately health outcomes. This study richly describes how the Apostolic religion (rather religions given the multiplicity of sects with varied interpretations of Apostolic religion) drives religiously based beliefs and practices that may conflict health protection and promotion, especially when it advances practices that can be dangerous to physical health and discourage uptake of medical assistance (Stone, Gable and Gingerich 2009). However, it should be clearly noted that not all Apostolic religious beliefs and practices are detrimental to health or contribute to negative health outcomes; some of them can contribute to positive health outcomes.

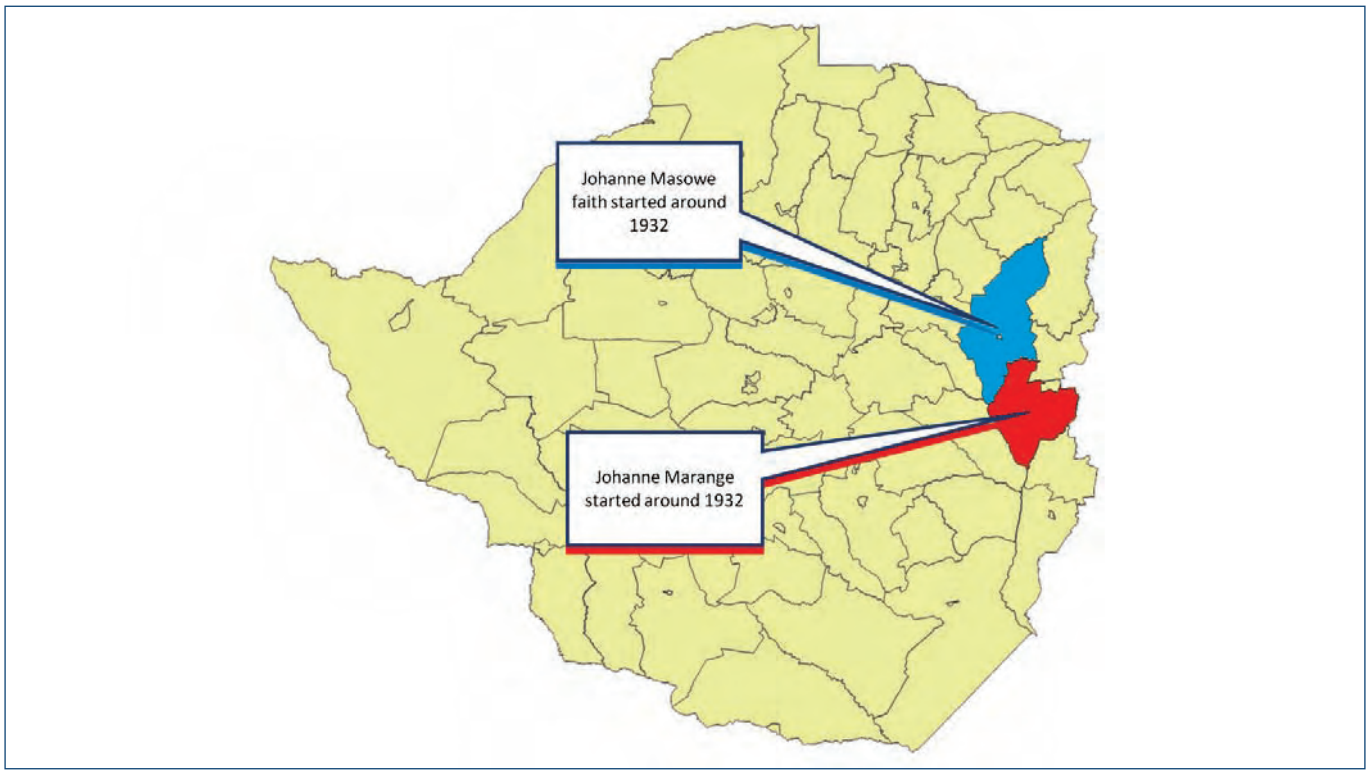
Brief Overview: Apostolic Community, Trends, and Health Matters

The Apostolic movement in Zimbabwe can be traced to Johanne Marange and Johanne Masowe groups which started in the 1930s in Marange and Makoni areas (see Figure 1 below) (Gregson et al. 1999; Mavunganidze 2008; Mukonyora 1998; Ranger 1999), and have since enabled other formations or variants of the dominant Apostolic groups to crop up.

footnotes

5 UNDP (2011) "Keeping the Promise: United to Achieve the Millennium Development Goals; Fast Facts", The Saturday Herald, 12 March 2011, pp.8-10.

Figure 1: Areas of Genesis of Major Apostolic Groups in Zimbabwe



Adapted from: UNICEF (2011) "Access to Health Services and Religion in Zimbabwe", 10 May 2011

Apostolic Community and Membership Trend

The Apostolic movement comprises hundreds of Apostolic faiths, and has an estimated population of over 2.5 million members. Its well-known umbrella faith-based organization, Union for the Development of Apostolic Churches and Zionist in Zimbabwe Africa (UDACIZA), has over 70 bishops, each representing a church in 10 provinces, and acts as a coalition of over 160 Apostolic groups. Other commentators estimate that the Apostolic community constitutes 6 percent of Zimbabwe's adult population, and 73 percent of its membership live in the rural areas. Sixty four percent (64%) of the membership are women, and the majority of the women are aged between 20 and 29 years, the marrying and child bearing age group. Only 13% in this age group are males[6] (The Sunday Mail 2005). The Apostolic community in Zimbabwe has been steadily growing over the years (see Figure 2 below), and this trend is based on estimated figures from the Zimbabwe Demographic and Health Survey and 2009 MIMS; this data speaks to the challenges of accessing reliable information in the absence of authentic database on the Apostolic community in the country. However, according to the 2009 MIMS, approximately 27% of households interviewed in this survey belonged to the Apostolic community.

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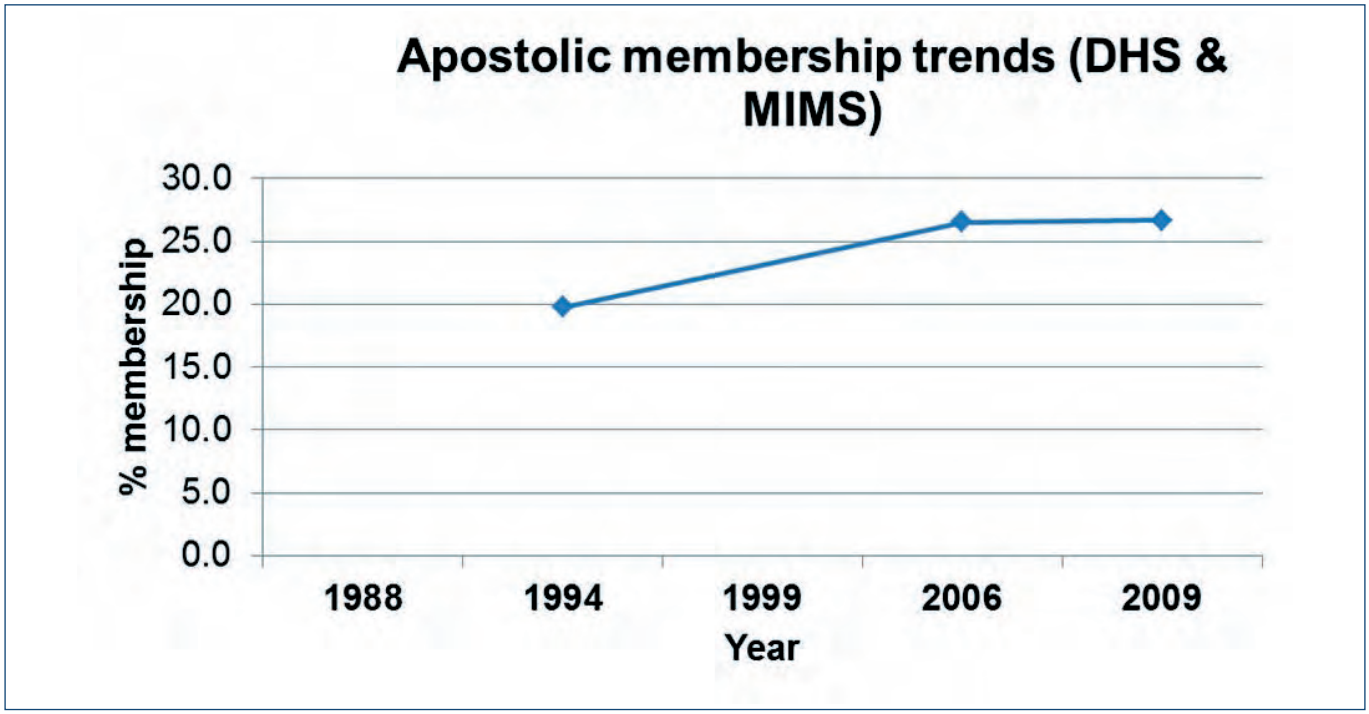
5 Sarah Tikiwa "*Vapostori* Sects Ban Polygamy", The Sunday Mail, 18 September 2005.

Figure 2: Apostolic Membership Trend



Adapted from: UNICEF (2011) "Access to Health Services and Religion in Zimbabwe", 10 May 2011[7]

Apostolic Religious Beliefs on Faith Healing and *Mweya*

From a religious standpoint, the Apostolic churches regard themselves as Spirit-type churches (Gregson et al 1999) or *chechi dzeMweya*, and consequently base their religious beliefs and practices primarily on *Mweya* or Spirit. In most instances, the spiritual realm is understood dichotomously: the Holy Spirit *(Mweya Mutsvene)* versus alien/ancestral /evil spirits *(mweya ye dzinza or mweya ye tsvina)*, and *mweya ye dzinza or mweya ye tsvina* take possession of living beings and negatively influence their health resulting in illnesses (Gregson et al. 1999). In contrast, the Holy Spirit or *Mweya Mutsvene* is antithesis of ancestral/evil spirits, and works to restore good health and quality of life of those who are faithful and observe religious tenets, teachings and regulations of the Apostolic churches (Daneel 1970; Daneel 1971; Daneel 1987; Presler 1999). *Mweya Mutsvene* is the source of spiritual revelation, prophecy, healing, instruction, and protection. Hence, in most cases, Apostolic leaders and faithful "teach faith-healing and regard sickness itself and use of medical services (traditional or modern) as signs of weakness of faith" (Gregson et al. 1999:188), and teach that sin can lead to sickness. They emphasize strict adherence to religious teachings and practices, compliance with normative values, and impose penalties on who violate church regulations and religious teachings (Gregson et al. 1999).

Mweya Mutsvene (Holy Spirit) serves as the divine force that guides the church, and equips prophets and some church members with special prophetic and healing powers. It is not surprising therefore that ultra-conservative Apostolic groups' (e.g., *Marange, Madhidha, and Masowe*) position on non-use of modern medicines, health services, and contraceptives are often attributed to the prophetic revelation given to the church founders or leaders by the Holy Spirit. Consequently, the membership of these ultra-

footnotes

7 UNICEF (2011) "Access to Health Services and Religion in Zimbabwe: Preliminary Findings", CCORE / UNICEF, Harare, Presentation by UNICEF's Equity Team (Social Policy), Stanley Gwavuya and Chifundo Kanjala, 10 May 2011.

conservative / fundamentalist Apostolic groups are less likely to use modern healthcare services primarily because of their religious beliefs, teaching, and church regulation as well as social control mechanisms to enforce adherence to these teachings (Gregson et al. 1999). From this understanding, one can conclude that the religious teaching, practices, and church regulations profoundly shape health-seeking behavior, and the ultra-conservative/fundamentalist Apostolic groups are likely to have a significant proportion of their membership suffering from or dying of conditions which can be addressed easily by medical assistance. However, the ultra-conservative Apostolic groups ascribe to religious beliefs that discourage use of medical treatments even though the condition may easily be treated or cured with modern medicine. Such refusal has often resulted in serious health implications, even death, for some members. Consequently, the ultra-conservative Apostolic faith has had dire consequences on maternal and child health.

Apostolic Community and Utilization of Maternal and Child Health Services

Strong evidence exists that indicate higher levels of maternal and infant mortality and morbidity among Apostolic communities compared with other religions in Zimbabwe (Zimbabwe Demographic and Health Survey 2005-2006), and that poor health outcomes among Apostolic women and children is linked to low or poor utilization of modern maternal and child healthcare services by members of the Apostolic communities[8] (see Figures below) especially among religious objectors or ultra-conservative groups which "do not allow their children to be immunized or their sick to be treated using modern drugs" (UNDP 2011:9). In the Figures 3 and 4 below, it is clear that Apostolic communities perform poorly in antenatal care (ANC) use against other religions, except against traditional religion in skilled birth delivery and delivery at health institution. The Apostolic communities also perform poorly against other religions in child immunization, with the exception of traditional religion in DPT immunization (CSO 2009).

Figure 3 presents a picture on the relationship between religious affiliation and utilization of maternal healthcare services in Zimbabwe, and the data indicates that the Apostolic religion predisposes its members to low utilization of maternal services. The Apostolic members are less likely to have at least 1 ANC visit compared to other religious groups, and equally score lower than other religious groups in terms of the four ANC visits. The Apostolic religion performs slightly better than traditional religion in terms of skilled birth delivery and delivery at health institution but significantly lower than other Christians and religions. UNDP (2011) states that fewer women complete at least four ANC visits and additionally fewer women deliver in institutions where skilled attendance at birth can be obtained. In 2009, it was estimated that "39% of women who gave births in the two years prior to the survey delivered without the assistance of a skilled birth attendant" (UNDP 2011:9). Poor or failure to uptake modern maternal health services has significantly contributed to maternal morbidity and mortality, mother-to-child HIV transmission when the mother is not aware of her HIV status, post-partum hemorrhaging, complications, and hypertension etc.

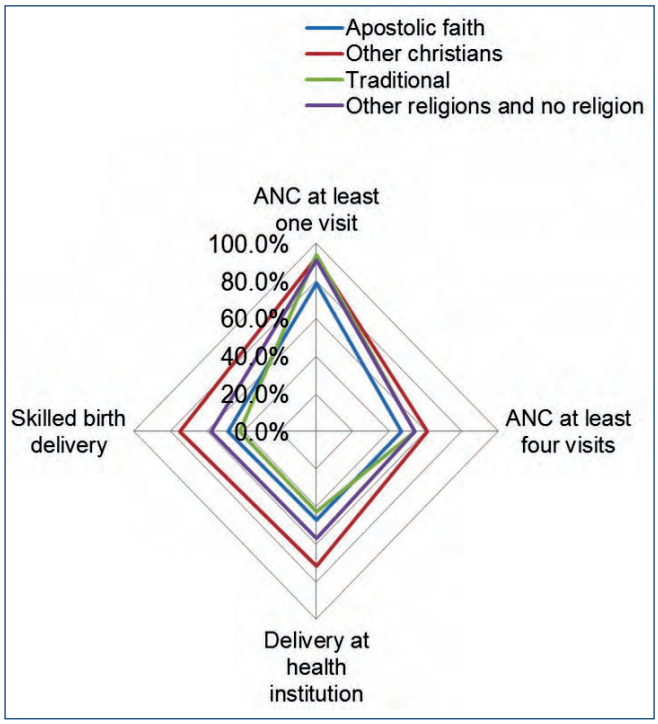
According to UNDP (2011), factors such as institutional delivery, skilled attendants at birth, and the type of religious affiliation significantly affect the risk of maternal deaths. It is extremely worrisome that only "5.4% of pregnant women knew their HIV status before pregnancy, and just 34% of pregnant women were tested for HIV during pregnancy" (UNDP 2011:9) despite the fact that HIV is a leading cause of maternal mortality. In the context of the Apostolic community, it is important to understand the influence of religious beliefs, teachings, and practices on factors that shape maternal health and healthcare seeking. Figure 3 illustrates the relationship between religion and healthcare service utilization, and therefore offering opportunities for religious and socio-cultural factors that drive non-use or use of modern healthcare services. This study recognizes that challenges in examining socio-cultural factors in Demographic and Health surveys (DHS) data: "Socio-cultural factors are not examined because this cannot be done by exploring DHS data" (Fosu 1994:1210). Therefore, this study unpacks the religious and socio-cultural factors that influence Apostolic members' decisions about healthcare seeking and uptake of modern medicines and healthcare services.

footnotes

8 Advocacy and Social mobilization Taskforce (2010) "Report on Advocacy, Social Mobilization and Communication Assessment among the Hard-to-Reach Groups: Harare, Chitungwiza, Bulawayo Metropolitan, and Bubi District in Matebelaland North Province", 10/05/2010.

In addition, this study explores the perceived value of medical assistance among Apostolic members and the religious philosophy and theology that shape members' attitudes toward modern medical services. It explains the religious foundations of the "Apostolic healthcare system" that emphasize faith-healing, healing rituals, prayer, and Mweya. As stated earlier, Apostolic beliefs, teachings, and practices tend to reinforce faith in faith-healing and strict adherence to church doctrine. Therefore, it is not surprising that Apostolic churches emphasize church-related interventions, which they deem as having a "spiritual competitive edge" over secular, modern healthcare services primarily through the belief that illnesses and diseases have "spiritual and religious undertones" (Gyimah et al. 2006:2933) and "spirits can influence the health of the living" (Gregson et al. 1999:187). Consequently, Apostolic members may have a greater propensity to not use healthcare services than other Christian and other religions based on their religious beliefs and perceptions of illness.

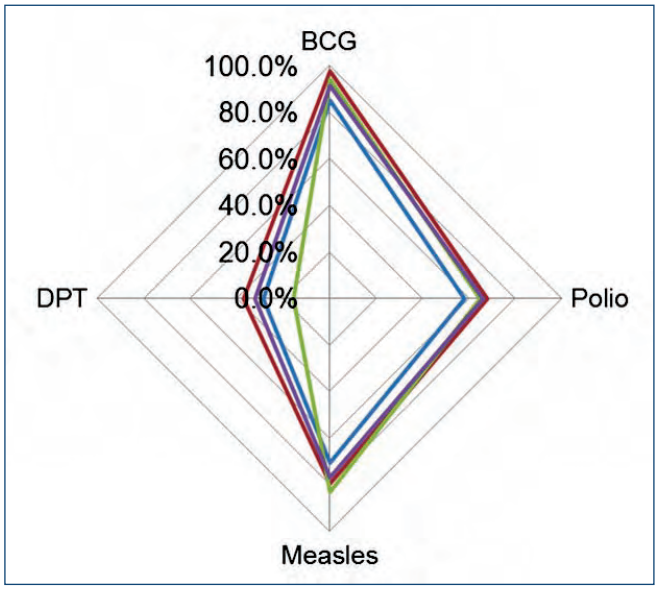
Figure 3: Maternal Health Service Utilization by Religion



Adapted from: UNICEF (2011) "Access to Health Services and Religion in Zimbabwe", 10 May 2011

In other words, it is often against Apostolic dogma, particularly among the conservative groups, to seek medical help from modern medical services and practitioners or traditional healers. Even in instances where serious need is real, and modern medical assistance may previous serious illness or death, some Apostolic groups emphasize faith and adherence to church doctrine and practices. In addition, children have died of common diseases which accounting for a large proportion of all infant and child deaths, which could have been avoided through vaccination and child health services. According to UNDP (2011), children of religious objectors are at high risk of not receiving vaccination and medical treatment. Figure 4 shows that children in Apostolic religion are less likely to have BCG immunization, measles and polio vaccination compared to other Christians and other religions.

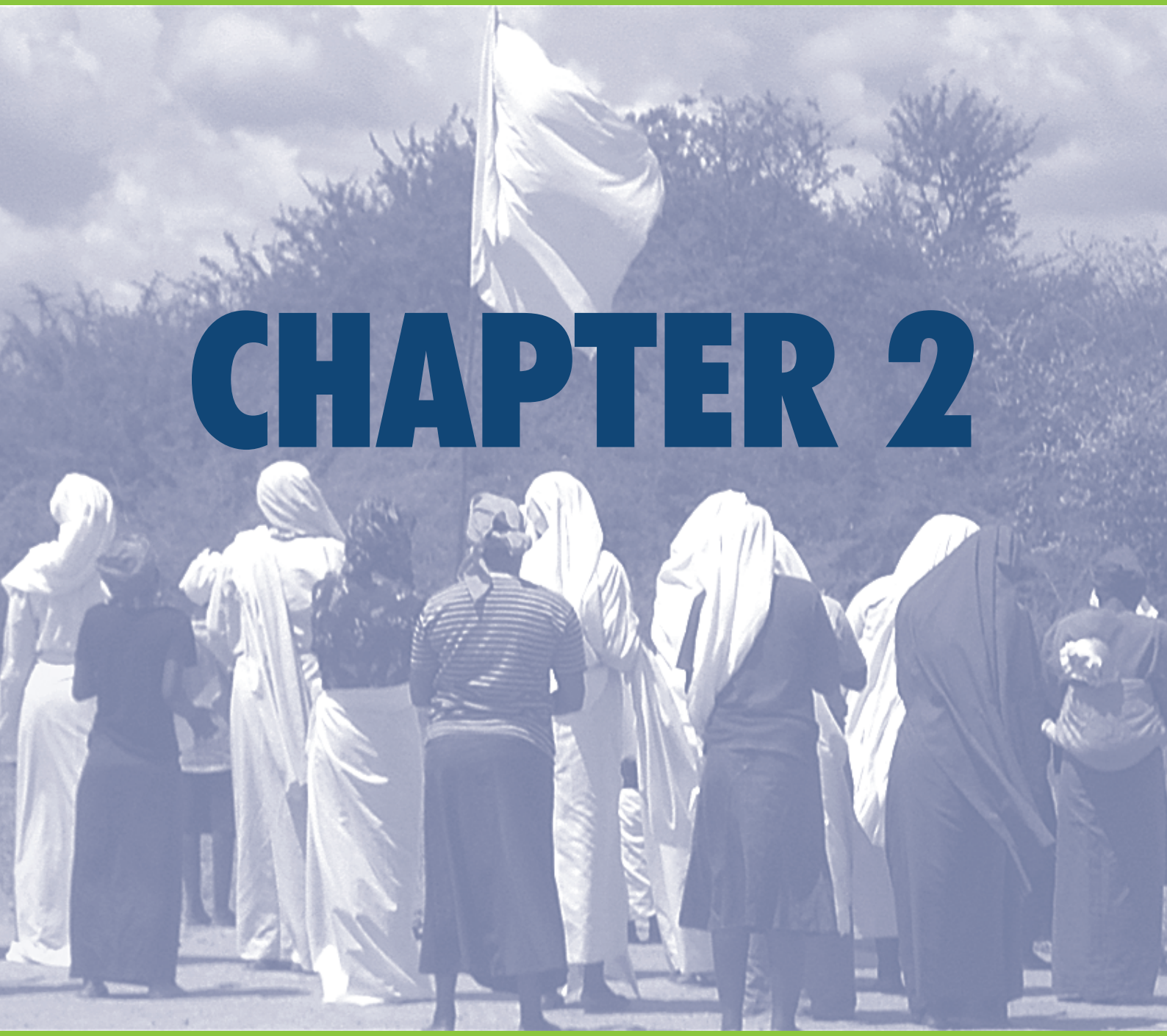
Figure 4: Child Health Service Utilization by Religion



Adapted from: UNICEF (2011) "Access to Health Services and Religion in Zimbabwe", 10 May 2011.

Despite this evidence from Multiple Indicator Monitoring Survey 2009 (CSO 2009), little is known qualitatively about the religious and socio-cultural factors among the Apostolic community that influence situational use and non-use of modern healthcare services as well as key determinants of health seeking behavior, particularly those related to women and children. It is against this background that this study sought to understand religious and socio-cultural factors that contribute to the marked lack of uptake of modern healthcare services among Apostolic communities in Zimbabwe. The study identifies the factors that influence use or non-use of health care services as well as explains their implications for health-seeking and health-related practices

recognizing that religion is a paramount predisposing factor which tends to override the need for modern medical assistance despite the severity of the illness. Some scholars argue that the effects of predisposing factors such as religion are stronger than the need factors in Zimbabwe (Fosu 1994), and therefore justifying qualitatively unpacking health beliefs and religious and socio-cultural factors that influence decisions on health, health-seeking and uptake of modern health services among the Apostolic community in Zimbabwe.



CHAPTER 2

2 Aims and Objectives

This section presents the purpose of the study and the specific objectives that guided it. It highlights the expected outputs, and presents the research questions that informed the study.

Aims of the Study

The purpose of this study was to understand the determinants of behavior that lead to acceptance or rejection of preventive and promotive health and social practices among Apostolic communities, and focus on those practices that affect women and children. This required elucidating religious beliefs and practices and various factors that influence healthcare-seeking behavior and use or non-use of modern healthcare services. This formative study was expected to generate findings and evidence that would assist in the development of specific strategies for program interventions as well as inform future communication strategies for health and social development in Apostolic communities.

Specific Objectives

The specific objectives of the study were to:

- Provide a deeper understanding of the philosophy behind certain religious groups
- Identify beliefs that may hamper or facilitate health seeking behavior among the religious groups, with a special focus on women and children
- Identify and describe "best practice situations" i.e. where collaboration with formal health care providers has been optimal
- Use the evidence from the study to provide clear recommendations that will inform a strategy for program interventions

Expected Results

It was expected that the study would lead to:

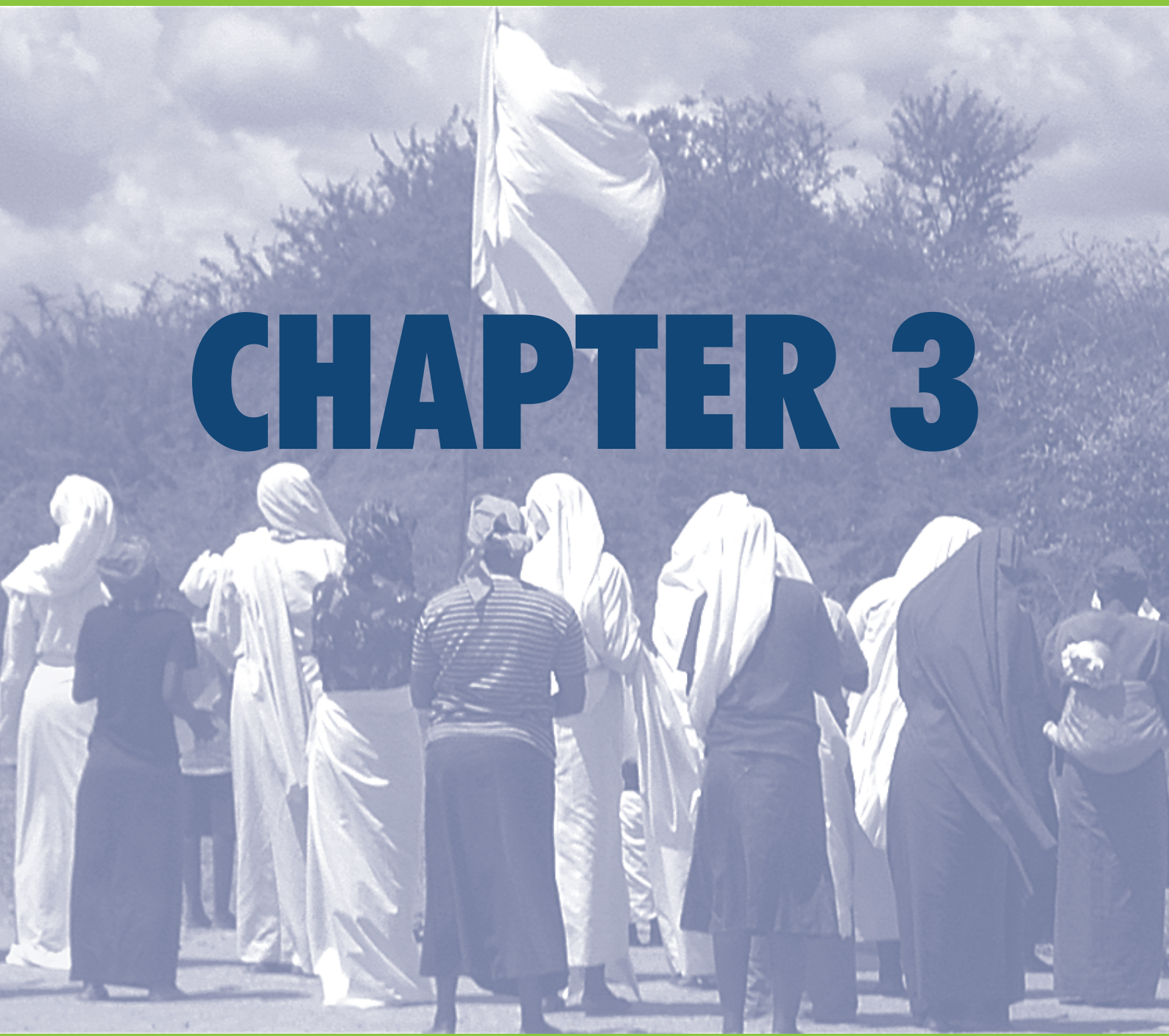
- An improved understanding of existing cultural and social barriers and social capital that may hinder and/or facilitate health seeking behavior and curative behaviors in different groups of the Apostolic community in Zimbabwe
- A clearly defined and articulated implementation strategy that addresses differences in attitudes, health seeking and curative behaviors likely to exist between certain religious groups
- A final validation activity with selected members of the Apostolic community to endorse the way forward
- A research report with clear recommendations for strategic action, including an on-going research plan for testing program strategies
- Stakeholder meeting to disseminate findings

Research Questions

This study was guided by the following research questions:

- What is the Apostolic philosophy that determines health-seeking and uptake of modern healthcare services among Apostolic members in Zimbabwe? Is the philosophy uniform across the various Apostolic groups?
- What religious teaching and regulations influence use or non-use of modern healthcare services, particularly those related to women and children? What are the influences of the manifestations and interpretations of Apostolic religion on health-seeking and uptake of modern healthcare services?
- What role does faith (spiritual) healing and Apostolic healing rituals play in influencing behavior that lead to acceptance or rejection of preventive and promotive health and social practices among religious objectors? What is the perceived value of modern medical service in healthcare among Apostolic groups?
- How is collaboration between Apostolic communities and formal health care providers perceived? Which interventions have been deemed successful ("best practice situations") or unsuccessful, and why?
- What is recommended for improving uptake of modern healthcare services (including maternal and child health services) among Apostolic groups in Zimbabwe?

In order to achieve the objectives of the study, meet the expected results, and answer the research questions, the study adopted a qualitative research design (Fossey et al. 2002; Seidel 1998) and appreciative enquiry (Bushe 2007; Cooperrider et al. 1999; Cooperrider and Srivasha 1987; Cooperrider and Whitney 2000; Cooperrider and Sekerka n.d.; Cooperrider and Srivastva 1987; Fitzgerald, Murrell and Newman 2001; Sandu 2011) as well as employed a hybrid analytical framework that incorporated relevant constructs from the Health Belief Model (Fulton et al. 1998; Glanz, Rimer and Lewis 2002; Janz and Becker 1984; Nutbeam and Harris 1998; Strecher and Rosenstock 1997) and the Religio-Cultural Thesis (Fourn et al. 2009; Goldscheider 1971; Gregson et al. 1999; Gyimah, Takyi and Addai 2006; Thomas 1994).



CHAPTER 3

3 Methodology

This chapter outlines the methodology and analytical frameworks employed in this study. This formative study was conducted over a six month period (December 2010 – April 2011), and carried out in phases: preparatory phase, data collection phase, data analysis phase, writing preliminary findings report and presenting preliminary findings for review, and writing the final report incorporating comments from the review process. The study was designed to respond to the objectives defined by CCORE and UNICEF, and Table 1 below presents the methodology approach.

Table 1: Methodology Process

Broad issues for investigation	Data aspects to be included in research	Methodology
Apostolic Religion and Health	• Apostolic religion and health in Zimbabwe • General health statistics on women and children (focusing on MCH) • Health delivery system • Peer reviewed publications by established authors on religion and health, particularly on the utilization of MCH services	• Desk review of secondary data on religion and health. Internet searches; electronic database search for existing literature on religion and health in both developed and developing countries • Desk review: Summarize and compile the data on Zimbabwean context, and MDGs 4 & 5 as well as review reports and grey material on religion and health in electronic and hard copies.
Deeper understanding of philosophy of Apostolic groups	• Characteristics of Apostolic groups • Organizational & religious structure • Services and support provided; "Apostolic" alternative healthcare system • Leadership • Normative values and adherence to church teaching and regulations	• In-depth interviews with Apostolic members and leadership • Desk review of secondary data on Apostolic religion; general literature on religion and health
Beliefs influencing health seeking behavior, with special focus on women and children	• Religious teaching, doctrine, regulations, doctrine and practices • Faith-healing and healing rituals • Role of prophets (spiritual leaderships) and *Mweya* • Beliefs about illness and healing • Beliefs on maternal and child health • Barriers to uptake of modern healthcare services	• Individual in-depth interviews (open-ended questions) & key informant interviews • Desk review • Focus group discussions • Informal discussions • Visits to places of worship and observe rituals
"Best practice situations" & optimal collaboration	• Collaborative experiences between Apostolic groups and healthcare providers • Opportunities and limitations to collaboration • Perceptions of service (including gaps & opportunities in services) provided by healthcare providers and responses of Apostolic communities	• Individual in-depth interviews and key informant interviews • Desk review and gray literature on the 2008-2009 Cholera and 2009-2010 Measles outbreaks in Zimbabwe

Broad issues for investigation	Data aspects to be included in research	Methodology
Recommendations & strategies for program interventions	• Potential for positive engagement • Addressing gaps and barriers or constraints in improving health outcomes among Apostolic communities • Capacity building • Scope and scale of support to existing "Apostolic maternal services" • Policy and practice issues related to MCH services	• Key informant interviews

The qualitative methodology was well-suited for understanding the religious beliefs, philosophies, teachings, and church regulations that hamper or facilitate health seeking behaviors among the Apostolic groups. In view of the primary aim of this study, it was apparent that the qualitative approach would provide "rich" and "deep" data, and better understanding of health seeking behavior from the actors' standpoint. Therefore, it was more suited than quantitative approaches in exploring actors' interpretations and address the image of social reality of the actor, which is socially constructed by the actor. Qualitative methods also allow researchers to get closer to the subject/people ("seeing through the eyes of the subjects") they are investigating, less inclined to impose inappropriate conceptual frameworks on them, and offer flexibility in the conduct of the research as one can easily respond to emerging issues.

Selection of Study Sites

The study employed qualitative data collection methods to gather the information on Apostolic communities' religious beliefs, practices, and church practices that influence health-seeking and use or non-use of modern healthcare services.

The choice of areas selected for in-depth research was largely determined by:

- The estimated number of Apostolic groups in the area, including fair representation of the diversity as well as homogeneity of Apostolic community;
- Diversity of geographic regions/areas in Zimbabwe, and thereby enabling a cross-sectional perspective or insights on the Apostolic community in the country;
- The history of cholera and measles outbreak, and potential for offering insight and lessons on responses to public health challenges (Ministry of Health and Child Welfare 2010a; Ministry of Health and Child Welfare 2010b; Tsoka and Ngwenya 2010; World Health Organization 2010a; World Health Organization 2010b) ;
- Ease of access to research participants given the sensitivity surrounding the Apostolic community in Zimbabwe

The decision-making process in the selection of the areas involved consultation with CCORE/UNICEF, Ministry of Health and Child Welfare (MoHCW), World Health Organization (WHO), and discussions with some healthcare providers and representatives of UDACIZA. This process was designed to ensure relevance and stakeholder engagement in the study. Stakeholder involvement in the study was critical, and selected stakeholders provided critical feedback and participated in research planning and actively facilitated the implementation of the research project. The Ministry of Health and Child Welfare and other relevant authorities granted clearance for the research.

The study was carried out in Harare (Budiriro, Epworth, and Glen View), Chitungwiza and Seke, Bulawayo Metropolitan, Gwanda, Buhera, Masvingo urban, Mutare urban, and Marange (see Figures 5 and 6 below).

Figure 5: Map of Specific Study Sites

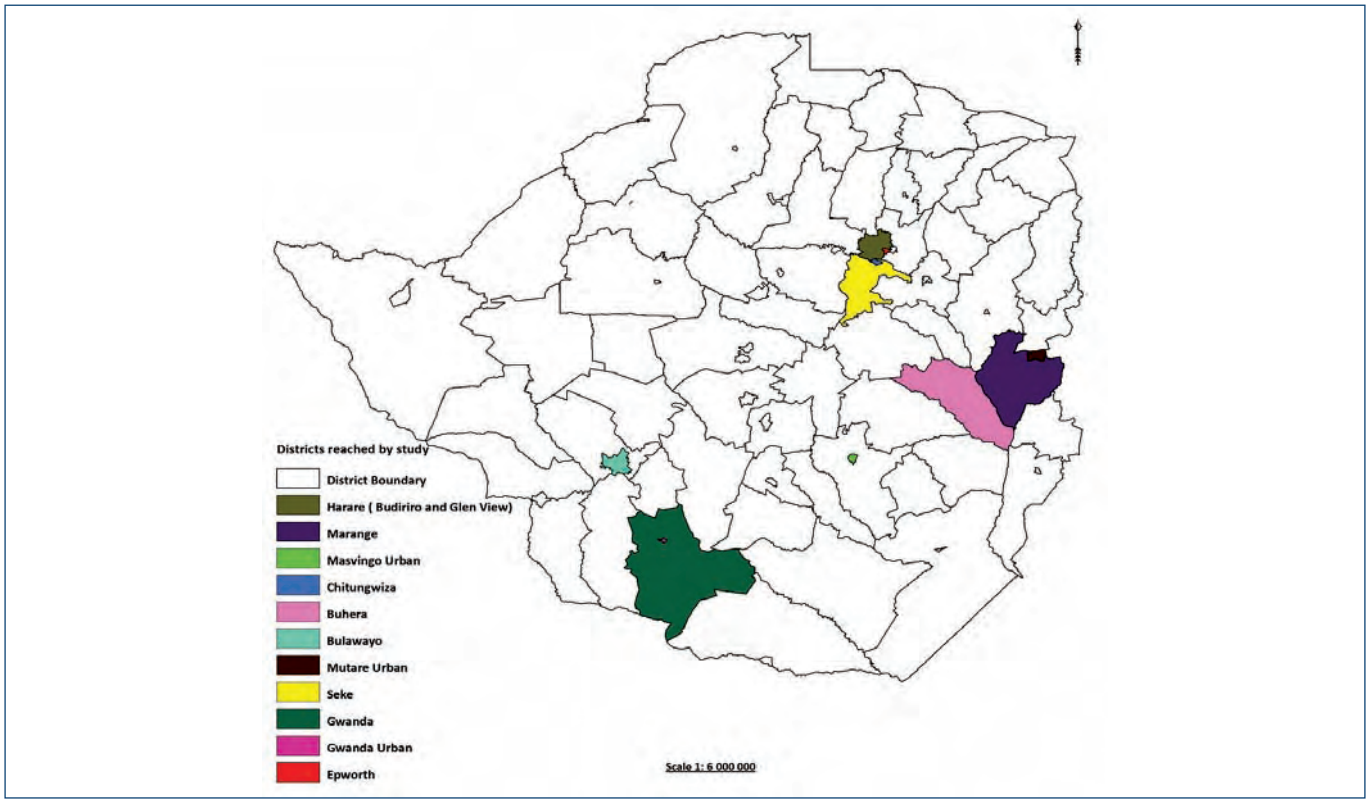
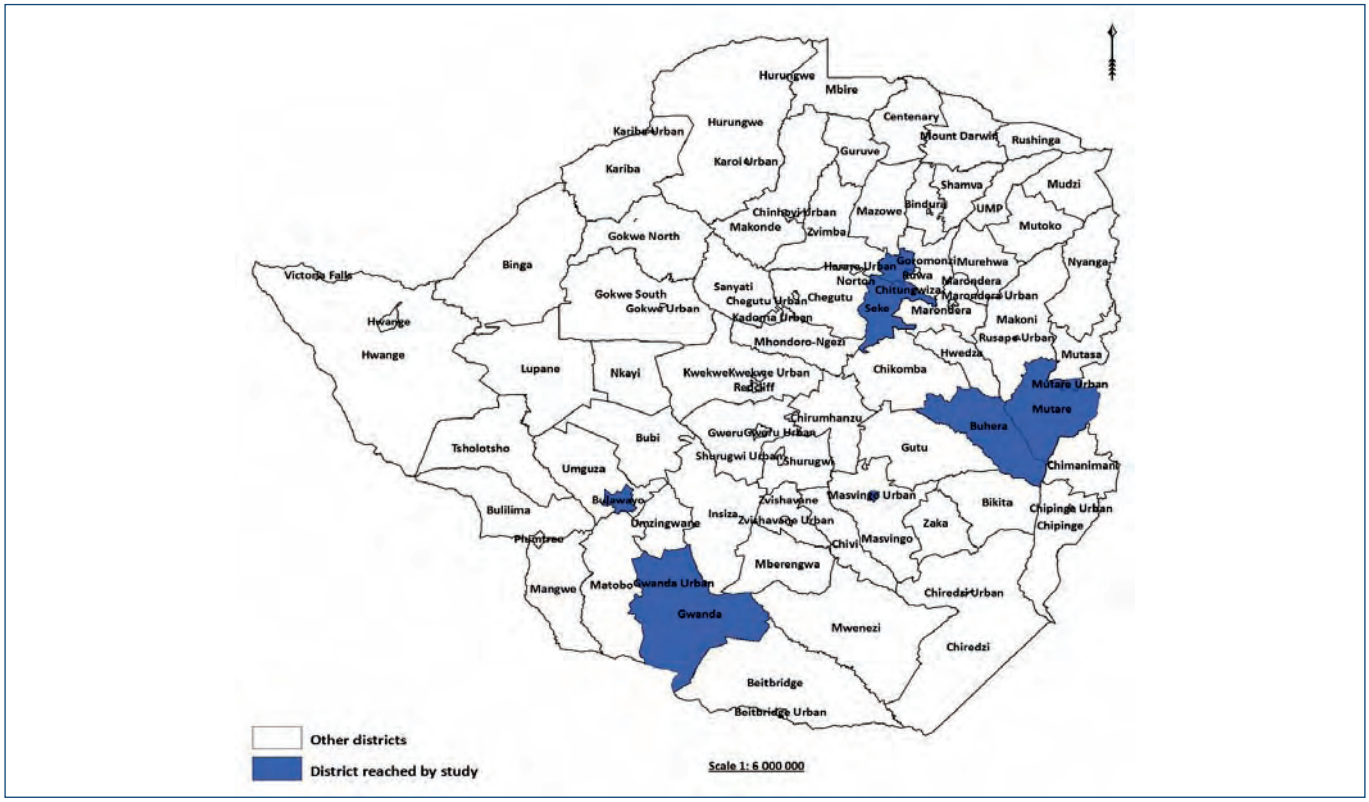


Figure 6: Map of Study Districts



Some of these areas were selected primarily for the dominance of certain Apostolic groups (e.g., Mutare and Marange areas for the Johanne Marange Apostolic faith; Gwanda for the Madhidha group; Chitungwiza and Seke because of the high proportions of various groups of the Apostolic community; Budiriro, Glen View and Epworth primarily due to the previous high incidences of cholera and measles; Bulawayo Metropolitan and Mutare to understand urban responses to religion and health challenges). Marange, Seke rural, Buhera, and Gwanda were the rural sites, selected because of the presence of ultra-conservative Apostolic groups (religious objectors) as well as provide insights on interactions of religion, poverty and low literacy rates since rural areas are generally more disadvantaged that urban areas in a number socio-economic variables.

The research team was encouraged to consult with local authorities, government officials, and local residents in mapping areas (villages, sections of townships, or geographical areas) where there was great opportunity to conduct interviews with Apostolic members. The team comprised two researchers (male and female), and each team was responsible for conducting key informant interviews, in-depth interviews with members of the Apostolic groups, and facilitate focus group discussions (FDGs) if granted official permission by the authorities to do so. It proved very difficult to gain clearance to gather people for the focus group discussion, and hence only three focus group discussions were conducted in a private area with Apostolic youths and leaders from one of the Apostolic groups. This process did not require recruiting Apostolic members openly in public spaces since those who participated in the FGDs were approached at a workshop and place of worship.

Sampling

The sample was focused on individual members (youths and adults) of the various segments of the Apostolic community and key informants including healthcare providers (at national, provincial, district, and local levels), health workers and community health workers, law enforcement agencies (police), community leaders, and religious leaders. It also included personnel from key stakeholder institutions with previous experience working with Apostolic groups and general community in health initiatives, special outreaches, and during disease outbreaks. The sample comprises individuals living in the selected study sites, and the respondents were (interviewees) were identified through snowballing. Purposive sampling was used to make the research more practical and ensure effective accessibility to the participants. This was important since our objective was to collect data from a diverse spectrum of Apostolic religious groups, consciously targeting "religious objectors", and accessing key informants.

This was an exploratory, formative study using a qualitative[9] survey among Apostolic faith followers and leaders, targeting both Apostolic groups that are reticent towards uptake of modern health services and others that are non-reticent. Similarly to Fourn et al. (2009), this study purposefully targeted certain Apostolic faith groups that are well-known for objecting the use of modern health services and medicines. These Apostolic groups have been labeled "religious objectors" or "hard-to-reach groups"[10] (Madzingira 2010). In the absence of sampling frame, we selected the Apostolic members non-randomly and approached potential interviewees as they traveled from places of worship or through referrals or snowballing (Seidman 1998). Upon identification, we discussed with the potential interviewee the purpose of the study as well as read and explained the consent form. After this discussion, only participants who agreed to participate in the study through consenting were recruited or retained in the sample. Other participants expressed reservations to sign the consent form, and opted for verbal consent. In such instances, the researchers respected the participants' wishes and ticked the "proceed with interview" section on the survey form.

The interviews were carried out away from places of worship to given the participants a sense of anonymity and confidentiality as well as avoid drawing attention from other church members. Protecting the participants was very important because some Apostolic groups forbid their followers to discuss "church affairs" with non-members, particularly journalists and researchers, and expect the members to maintain secrecy. The key informants were mainly key role players in healthcare service provision, Apostolic faith leaders, law enforcement and government authorities, and representatives of stakeholders of key health and religious issues.

footnotes

9 In view of our analytical objectives, qualitative research approach was suitable to describe variations within Apostolic religion, and describe and explain the relationship between Apostolic teachings and doctrine and health-seeking and practices. Qualitative research enabled us to describe the group norms and experiences as well as gave us the flexibility in exploring aspects of the study as they emerged. Therefore, we had an iterative study design, and adjusted data collection and research questions according to our evolving learning.

10 Madzingira, N (2010) "Study Report on "Hard to Reach Groups" for Vitamin A Supplementation during the Child Health Days in Zimbabwe", Report submitted to Helen Keller International & Ministry of Health and Child Welfare. November 2010, pp20-21.

Piloting the Survey Instrument and Training of Research Assistants

The initial draft interview guide was piloted by Dr. Maguranyanga among members of the New Vision Apostolic Church in Harare suburbs of Borrowdale, Mandara and Greendale as well as with members of Johanne Masowe *Chishanu* in Hatcliffe. Pilot interviews enabled the respondents to actually answer the questions and comment on the interview guide. The first interview guide was long, and respondents suggested reducing the number of questions and provided useful feedback on content and structure of questions in the interview guide. Changes were then made on the content and structure of the interview guide to incorporate feedback, including comments from key stakeholders.

A training session for the 16 research assistants, mainly university graduates in social sciences, was conducted to familiarize them with interviewing techniques and nurture common understanding of the interview questions translated from English into vernacular languages. The training session was conducted over a two-day period. The research assistants then practiced interviewing techniques in-houses, and deployed to pre-test the vernacular interview guide. After the pre-test sessions, they re-grouped and provided feedback to the Project Leader, Dr. Maguranyanga. This whole process served to familiarize the research team with the English version of the interview guide and translate it into vernacular languages, address data collection issues, and build an appreciation of the sensitivity of the research subject. Having completed the pre-tests, the research team revised and finalized the interview guides.

Data Collection Methods

We used multiple data collections tools to gather data for this study, and these included:

In-depth interviews were conducted with male and female Apostolic members from a wide spectrum of Apostolic religious groups, and deliberately focusing on identifying a significant proportion of members of the "religious objectors". This focus on "religious objectors" was aimed to meet the objectives of the study. A total of 111 in-depth interviews were conducted with members of the Apostolic community.

Key informant interviews were designed to establish the views of religious leaders, key stakeholders of health and religious issues, and those involved in law enforcement, program interventions, and have mandate over local jurisdiction, socio-economic development, and public health issues. Religious leaders who had agreed to participate in the survey were retained in the sample, and they also facilitated the voluntary recruitment of some members of the church. However, we made sure that the followers were not interviewed in the presence of church leaders.

Focus group discussions (FDGs) were held with youths and a group of leaders from one of the Apostolic religious groups. The challenges of convening FGDs in public spaces were previously highlighted; however, we gained in-depth, rich data from the conducted three FGDs.

Ethnographic methods entailed combining both observations and informal interviews/discussions; and the observations focused on capturing religious practices, healing rituals, and actions among Apostolic religious groups. We visited places of worship and interviewed some of the church leaders and "midwives" to gain better understanding of healing rituals and their beliefs about faith healing. The conversational, informal interviews were aimed at exploring emergent issues that were not originally included in the interview guide but pertinent to understanding Apostolic religious issues and lives of Apostolic members. These two methods yielded invaluable data and insights, particularly on symbols, rituals, healing concoctions, and helped in understanding and identifying determinants of behavior.

Photographs were taken with consent/permission from church leaders and individual Apostolic members. The photographs included pictures of places of worship, religious artifacts and symbols, and some members of the Apostolic community in the process of worshipping.

Desk review of existing data included focused searches of academic databases for current literature and electronic platforms such as BioMed Central, Project Muse, and University of Michigan e-library. The search included terms used in combination: religion and health, faith healing, public health, health care, maternal health, maternal and child health (MCH), MDGs in Africa, African instituted churches etc. We downloaded research reports and peer-reviewed publications and journals of established authors, and contacted via email some of the authors for guidance on additional relevant material. We received responses from Professor Léonard Fourn (University of Benin, West Africa) and Professor Slim Haddad (University of Montreal, Canada). Grey literature such as newspaper articles, unpublished research reports and papers, and commentaries were gathered from the web, and reviewed. This web-based literature was equally usefully in contextualizing issues, and exploring areas for probing and in-depth understanding through interviews.

The data collection process was designed to ensure collection of material that was relevant and of interest to the study. The core research team undertook the desk review and assisted in the development of the study design and tools to ensure that they met the objectives of the study.

Ethical Considerations

Once the survey instruments had been finalized, Dr. Maguranyanga, the researcher, approached the Ministry of Health and Child Welfare for formal approval of the study and ethical clearance of the interview guides which had a consent form on them. The application received unconditional approval, and an official letter was issued to the research team to proceed with the study. We also sought permission to conduct the research from respective local authorities, community leaders, religious leaders and representatives of the Apostolic community (UDACIZA), government authorities, and the respondents themselves. Only respondents who consented to study after having been explained the purpose and nature of study and the rights of the interviewees were included in the sample, and subsequently interviewed. The consent form highlighted confidentiality and confirmed that the respondents' identity would remain anonymous. In addition, the participants were informed that they could terminate the interview at any given moment without questions or any negative consequences. Participants were also informed that the findings of the study will be shared with stakeholders, including UDACIZA. The majority of the respondents indicated their willingness to participate in the survey (interviews) verbally without necessarily signing the consent form and others signed the forms. In general, the socio-cultural dynamics in Zimbabwe nurture oral consent more than written consent, and hence the respondents consented orally to be interviewed. The original interview notes and field data that emerged from the research are securely kept at a private location, only accessible to the researcher since some of them contain names of the respondents.

Given the political sensitivity of the Apostolic community in the country, we deliberately initiated clearance procedures with key agencies; and this effort was designed to satisfy legal compliance, protect participants and the research assistants by following the required protocols. We were fortunate to obtain the necessary approvals and permission, with the exception of the Marange area, which remains a protected area requiring a tedious clearance process. We struggled to get permission to conduct FDGs in public areas in all the selected study sites but only conducted FDGs in Harare because of the special relationship we had established with some Apostolic youths and church leaders at a workshop and place of worship respectively.

Data Management and Analysis

All the majority of the interviews were first captured on hard copies (hand written notes) in vernacular languages, and then translated into English and typed. The translated versions were checked to make sure that no information had been misrepresented or lost in the direct translation. The interview notes with questionable translation were reviewed and improved on to restore the meaning and information without adding to the original words. Corresponding references were assigned to both the original handwritten interviews and the translated, typed interviews. The typed English transcripts were formatted in MS Word for export to NVivo 8, qualitative data analysis software. Then two files, individual interviews and key informant interviews, were created for analysis in NVivo 8, and each file contained MS Word transcripts and the attributes (socio-demographics). Each document (transcript) and attributes had a corresponding/matching code number assigned to represent the interview.

Initially the transcripts were read manually to understanding the issues, and pull out themes and other classifications of data from the interview texts as well as gain an appreciation of the responses (both in vernacular and English translation). The English transcripts (MS Word formatted) were analyzed using NVivo 8, and the researcher systematically coded the interviews and created themes and subthemes. Additional themes emerged from the key informant interviews and focus groups using NVivo coding. Similarly to Fourn et al. (2009), we carried out content analysis of the statements of individual responses and FGDs, and arrived at key messages after compressing the data according to the major themes emerging from the respondents' statements. We also analyzed information in terms of how frequently it appeared as well as took account of the context in which it was used. Most importantly, the development of themes and categories were guided by study objectives, and used emergent patterns growing out of the data or standing out were developed in this report.

The findings from the comprehensive, preliminary data analysis were presented to CCORE/UNICEF and selected stakeholder representatives that also included an official from MoHCW, a religious studies expert from the University of Zimbabwe, and a representative from UDACIZA. After the receiving feedback on the preliminary findings, further data analysis was done to explore issues and answer questions that had been posed as well as prove or disprove the assumptions made at the initial stages of the research. The objective was to strengthen the analysis and achieve saturation in analysis, and thereby fully answering the research questions and examining the guiding assumptions

made earlier. Where gaps existed, complementary data collection was conducted to gain additional insights.

Limitations

The study is primarily limited by its design requiring an overview of religion and health among Apostolic communities in Zimbabwe, which is a mammoth task methodologically given the diversity of the Apostolic groups and lack of database on Apostolic religious groups or churches in the country. No one really knows how many Apostolic churches exist in the country, and the Apostolic groups are spread over geographically and "under every tree" and the Apostolic faiths differ in a number of ways despite sharing same names. This created challenges, and we had to delineate the Apostolic religious groups we interviewed for practical purpose and accessibility. Our primary focus on "religious objectors" was largely driven by the need for a sample that conforms to the theoretical framework, and thus allowing the research to become the answer rather than a method or researcher going in purely search of a problem. In our quest for answers, we ensured that we recorded as many activities and conducted as many interviews as necessary to "saturate" the categories being developed through an iterative data analysis process. We ensured that "theoretical saturation" was established on each key category of interest before we moved to the next issue.

In view the limited nature of this study, we caution against making generalizations to the population of interest (the entire Apostolic community in Zimbabwe). It is imperative that the reader pays attention to the concepts or categories, and the study does not emphasize representative sampling and generalization like quantitative studies. Rather, it places importance on theoretical sampling, insights, and opportunities for extrapolation[10].

The other limitations were:

- Non-randomized sample and the focus on a limited number of Apostolic religious groups, primarily "religious objectors" instead of a representative sample of Apostolic churches in the country;
- The research was carried out during a period of uncertainty and political sensitivity surrounding the Apostolic community, and this made it relatively difficult to penetrate some of the Apostolic groups;
- General suspicions towards researchers conducting fieldwork among this highly contested religious community, particularly with the possibility of elections in the country;
- Restrictions on public gathering and bureaucratic constraints in clearance procedures and approval made it difficult to conduct FGDs and access some study sites;
- Lack of access to the core leadership of dominant Apostolic groups, and hence the data on leadership influence on health-seeking behavior of members of the "religious objectors" was largely from third party sources;
- Challenges in direct translation of each interview from vernacular to English, and minimizing misrepresentation, loss of meaning or information in the process;

Analytical Frameworks

The study applied the Appreciative Inquiry approach, which enabled understanding of positive elements within the Apostolic religion in an effort to eliminate preconceived, negative assumptions about Apostolic religious groups. From an analytical angle, this study was largely guided by the Health Belief Model (Fulton et al. 1998; Glanz, Rimer and Lewis 2002; Janz and Becker 1984; Nutbeam and Harris 1998; Strecher and Rosenstock 1997) and the Religio-Cultural Thesis (Fourn et al. 2009; Gregson et al. 1999; Gyimah, Takyi and Addai 2006) to understand the determinants of behavior that lead to acceptance or rejection of preventive and promotive health and social practices among the Apostolic community, particularly religious objectors to uptake of modern healthcare services. We acknowledge that no single framework is sufficient to explain all the conditions that stimulate and affect healthcare-seeking. Therefore, we were attracted by an eclectic analytical framework or something of a hybrid approach that took the best elements of the two analytical frameworks (Health Belief Model and Religio-Cultural Thesis) to facilitate deeper understanding of health seeking among the Apostolic religious groups, particularly determinants of behavior and social practices, primarily those affecting women and children.

footnotes

[11] According to Patton (1986:206), extrapolations are "modest speculations on the likely applicability of findings to other situations under similar, but not identical conditions. They are logical, thoughtful and problem-oriented rather than purely empirical, statistical and probabilistic".

Appreciative Inquiry

Appreciative inquiry approach (Bushe 2007; Cooperrider, Barrett & Srivastva 1995; Cooperrider 1996) was used to explore and describe positive elements within the Apostolic community, and identify internal capacities, strengths, and activities they deemed effective in promoting health and dealing with illness among Apostolic members. In applying elements of Appreciative inquiry, we enabled members of the Apostolic community to share positive elements, search for solutions that already exist in Apostolic organizational or community context as well as amplify what works and focus on life-giving dynamics. With appreciative inquiry, we were able to explore what the Apostolic members viewed as "life-giving" in their religious beliefs and practices related to health (including maternal and child health) without purely focusing on problems and hence we focused on successful elements and experiences that could inform learning and change. We realized that previous research had often ignored things deemed effective among Apostolic groups and offering solutions, and disproportionately focusing on problems and negative attributes. In our quest for balance, we explored Apostolic activities (including healing rituals, faith-healing, and concoctions) which are deemed to promote and restore health in face of health challenges and disease outbreaks. The discussions with members of the Apostolic community unlocked answers on religious foundations of Apostolic health promotion and MCH interventions as well as strategies they engage in sustaining behavioral change. Therefore, appreciative inquiry enabled us to understand the Apostolic members and eliminate false assumptions since "when you get to know someone you realize that they aren't exactly what you imagined them to be"[12].

In discovering positive attributes, "stories", and experiences of the Apostolic community, and highlighting "successful elements" in collaborative activities, this study offers opportunities for stimulating core positive change and re-examining present problems in ways that enable problem-solving and further analysis as well as questioning "success stories" and their transferability in similar or different situations. Recognizing that this was a formative study, we focused our efforts on the "discovering" and searching for the meaning of "religion and health" among Apostolic groups, and how they construct health/illness – recognizing that reality itself is socially constructed. Consequently, meanings of health and illness, and behavioral responses are largely socially constructed. This understanding provides insights which can catalyze transformation and unlock opportunities for positive change (behavioral, socio-cultural) in an effort to improve health outcomes and quality of life of Apostolic members.

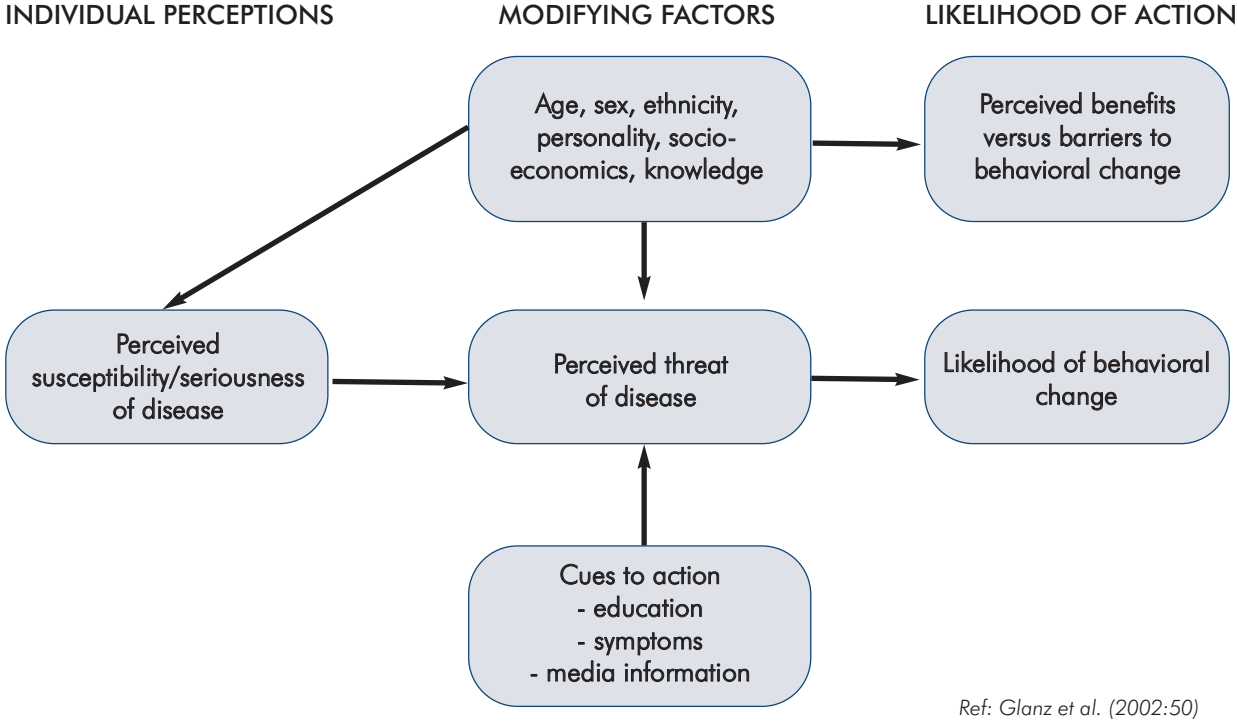
The Health Belief Model

The Health Belief Model seeks to explain health behavior by better understanding beliefs about health. It sought to explain why individuals participate in public health programs including immunization and general health checks (Nutbeam and Harris 1998). It focuses on attitudes and beliefs of individuals, which influence the likelihood of an individual taking action related to a given health problem. The Health Belief Model (HBM) predicts that "individuals will take action to protect or promote health if them perceive themselves to be susceptible to a condition or a problem, and if they believe it will have potentially serious consequences: the perceived threat" (Nutbeam and Harris 1998:19). When the individuals believe a course of action is available which will reduce their susceptibility or minimize the consequences, and the benefits of taking action outweigh the costs or barriers, then they are likely to seek health care services. The HBM also incorporates "modifying elements" such personal characteristics, social circumstances, and impact of cues for actions (personal experience and media influences). The concept of self-efficacy was incorporated into the model to take into account the belief in one's competency to take appropriate action (Glanz et al. 2002; Nutbeam and Harris 1998). See Figure 7 below for a diagrammatic illustration of HBM. The Health Belief Model was found useful in this study because it offered conceptual lenses for understanding the Apostolic members' beliefs about health problems, perceptions of susceptibility to diseases, seriousness of diseases, perceived barriers to taking action, and perceived benefits of specified action. The findings of the study clearly show that the Apostolic members' beliefs about health, diseases, and acceptable behaviors are largely shaped by religious beliefs, teaching, and church regulation. While HBM was a useful analytical framework in understanding modifying factors that influence health behavior, we noted that preventive and promotive health behaviors among the Apostolic members are primarily religiously-determined. In order to take into account the "religious construction" of health and health-seeking behavior, we adopted the Religio-Cultural Thesis (Fourn et el. 2009; Gregson et al. 1999; Gyimah et al. 2006).

footnotes

12 Whitney, D & Cooperrider, D.L (2000) "The Appreciative Inquiry Summit: Emerging Methodology for Whole System Positive Change", *Journal of the Organization Development Network*, 32: 13-26

Figure 7: Health Belief Model

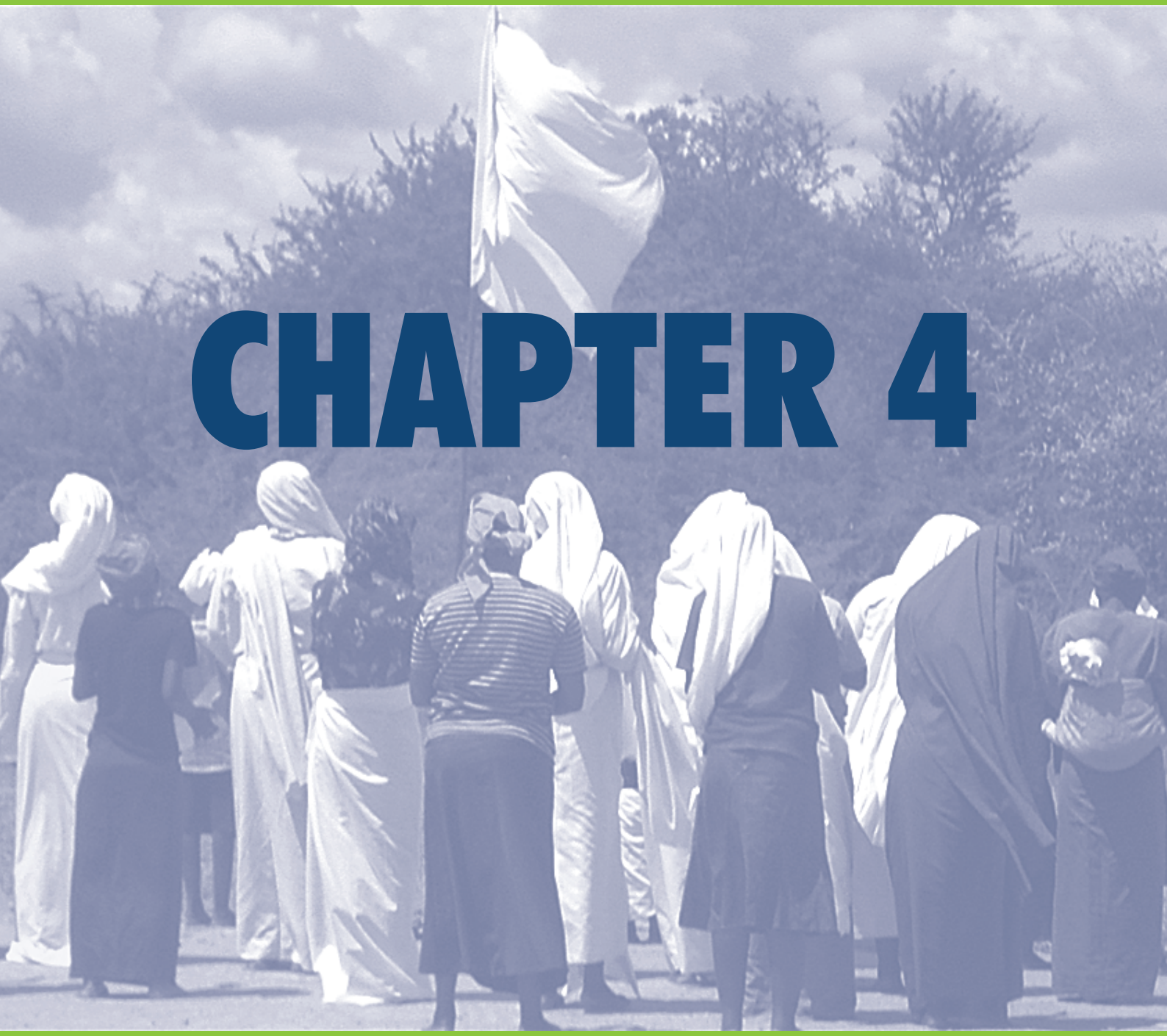


Religio-Cultural Thesis

The Religio-Cultural Thesis complemented HBM in explaining the overriding influence of religious and cultural processes on health behavior, and was most appropriate in drawing attention to religion as a critical factor that facilitate or constrain the utilization of MCH services (Fourn et al. 2009; Gyimah et al. 2006). Addai (1999) reiterates that religion influences attitudes and a wide range of behaviors such as reproductive behavior, HIV preventive behavior, and use of health services. This religious influence in behavior, attitudes, and use of modern health services cannot be underestimated in Africa given the significance of religious beliefs and practices among Africans. Similarly to Fourn et al. (2009), Gregson et al. (1999), and Gyimah et al. (2006), this study articulates how religion influences use of modern health services, primarily MCH services by paying attention to religious teaching, beliefs, practices, and church regulations that reinforce non-use of modern health services among religious objectors. Therefore, the Religio-cultural thesis enabled us to understand the beliefs that "some diseases and sicknesses have spiritual and religious undertones" (Gyimah et al. 2006:2933), and thus determining non-use of modern medical services. The utility of the Religio-cultural thesis rests in its capacity to explain why and how utilization of healthcare services and health-behavior is mediated by religious orientations and beliefs, which often attribute sickness and death (maternal and child) to spiritual forces.

Gregson et al. (1999:187) state that the Shona people believe that "spirits can influence the health of the living", and hence the "Spirit-type" churches like Apostolic religious groups emphasize the influence of the Holy Spirit. This spiritualization, which is premised on religious beliefs, tends to influence use of modern health services and dictates acceptable interventions regardless of other factors. It is therefore not surprising, as the findings indicate, that Apostolic religious beliefs, teaching, philosophical ideals, and church regulations have largely shaped Apostolic members' health-related behavior, decisions to use modern health services, and choices about where to seek first consultation when ill (Gyimah et al. 2006).

Both HBM and Religio-cultural thesis present opportunities for understanding health beliefs and religion as a social structure that influence decisions about health and healthcare seeking. As we will demonstrate in the next sections, health beliefs, perceived susceptibility, perceived threats, and the decision to use or not use modern healthcare services and options available in addressing health challenges are largely determined by religious beliefs, teachings, philosophy, church regulations (formal or informal), and faith in faith-healing and the Holy Spirit (Gregson et al. 1999).



CHAPTER 4

4 Findings

This chapter presents the findings from the study, and captures the different religious beliefs, doctrine and practices of the Apostolic groups. The findings are presented in a way that enables the reader to appreciate the heterogeneity of the Apostolic community, which has serious implications for programming, policy, and interventions.

Socio-Demographic Characteristics

Table 1 highlights the socio-demographic characteristics of 111 Apostolic interviewees in terms of age, marital status, education, household income, and other variables. It also covers demographics of key informants. Apostolic female respondents constituted 55.9% and 44.1% were males, and the key informant sample comprised 21 females (38.9%) and 33 males (61.1%). The gender demographics of the sample (Apostolic interviewees) closely resemble the estimated gender distribution within the Apostolic community or the average national gender distribution. The results reiterate the claims made by others that women make up more than half the estimated Apostolic population. The majority of the respondents was married, under the age of 35, and had secondary and primary education. Few very respondents had tertiary education. These demographics raise fundamental questions about the association between religion and education, and religion's influence on maternal and child health. How does Apostolic religious beliefs, teachings and practices influence the majority of women at child-bearing age, in marriage, and their ability to use MCH services? This question calls for closer examination of Apostolic churches' moral proscriptions and normative expectations that shape women's MCH behavior.

Of the 54 key informants who participated in the survey, 27 respondents expressed that they have previously been involved or currently involved in health promotion initiatives that aimed at the Apostolic community as a target group while 23 key informants stated that they did not have the experience in health interventions targeting the Apostolic groups.

Table 2: Socio-Demographic Statistics Summary of Apostolic Interviewees

Socio-Demographic Characteristics of Apostolic Interviewees	N	Frequency	Percentage
Gender	111		
Male		49	44.1%
Female		62	55.9%
Age of Apostolic Interviewees in years	111		
Under 20		4	3.6%
20-34		52	46.8%
35 +		49	44.1%
N/A		6	5.4%
Marital Status	111		
Single		10	9%
Married		87	78.4%
Widowed		8	7.2%
Divorced		4	3.6%
N/A		2	1.8%
Level of Education	111		
Primary		33	29.7%
Secondary		62	55.9%
Tertiary (Higher)		11	9.9%
N/A		5	4.5%
Household Income	68		
<$149		25	36.8%
$150-$249		19	27.9%
$250-$349		11	16.2%
$350-$449		8	11.8%
>$450		5	7.3%
Period in Church	96		
<4 years		29	30.2%
5-9 years		12	12.5%
10-14 years		7	7.3%
15-19 years		9	9.4%
20-24 years		6	6.3
>25 years		33	34.4%
Estimated Number of Church Members	82		
<40		5	6.1%
50-74		16	19.5%
75-99		12	14.6%
100-124		9	11%
>125		40	48.8%

Apostolic Heterogeneity: Religious Beliefs, Teachings and Health Matters

The findings highlighted the diversity of the Apostolic community (see Tables 3 and 4 below for summarized differences among the Apostolic groups represented in this study), which has important implications on our understanding of Apostolic faith as not theologically homogenous. The "white garment" churches *(Vapostori)* are varied, and consist of various Apostolic groups with theological divergences, beliefs, values, teachings, regulations, and practices. Understanding the theological differences, and the nature and extent of similarities is useful to avoid the "homogenization" of the Apostolic religious community, which has had negative implications in engaging them and designing health interventions. In our effort to avoid the pitfalls of homogenizing the Apostolic religion, we distinguished the Apostolic religious groups based on their beliefs on the uptake of modern health services and medicines. The analysis, while not yet fully conclusive, yielded interesting differences among the Apostolic religious groups and how these affect use of MCH services.

The findings pointed that the dominant "religious objectors" (whom can be classified as ultra-conservative (fundamentalist) Apostolic groups because of their total objection to use of modern health services) have strong beliefs and emphasize strict adherence to church teachings and doctrine while the semi-conservative and liberal Apostolic groups emphasize faith healing and consulting spiritual leaders prior to seeking professional medical assistance. While they do not openly object to use of modern health services, they also do not openly and actively promote modern healthcare-seeking as the first priority when ill. Within the semi-conservative and liberal Apostolic religious groups, the absence of clearly articulated, institutionalized regulations against non-use of modern health care services present an avenue for members within these groups to seek modern health services despite normative emphasis on faith healing.

Therefore, a blanket assertion that all Apostolic groups *(Vapostori)* object the use modern health services (including MCH services) is erroneous given the variability of nature, level, and extent of refusal. Some Apostolic groups (e.g., *Johanne Marange, Madhidha,* and segments of *Johanne Masowe [ye Chishanu; ye Sabata*), and *Mughodhi* are the ultra-conservative and teach against use of modern healthcare services and place strict emphasis on faith-healing. In contrast, the other groups provide a measure of leeway which enables their members to seek modern healthcare services (Tables 3 and 4 below).

Table 3: Apostolic Groups covered in the Sample

Broad categorization	Ultra-Conservative Apostolic Groups	Semi-Conservative Apostolic Groups with Relatively 'Liberal' Views
Apostolic churches/ groups represented in the sample	**Johanne Marange** (n=24 respondents or 21.6% of the sample) **Madhidha** (n=3 respondents or 2.7% of the sample) **Johanne Masowe** (the founding church) and some subgroups including *Johanne Masowe yeSabata*) *Johanne Masowe Apostolic groups are extremely heterogeneous, and hence difficult to differentiate them. The interviewees explained that the founding Johanne Masowe is conservative while the break-away subgroups are semi-conservative and 'liberal' in their religious views on use of modern health services and socio-cultural issues.	**Johanne Masowe groups** (n=51 respondents or 45.9% of the sample): *Johanne Masowe Chishanu; Johanne Masowe Chishanu Jerusalem; Johanne Masowe Chishanu Madzibaba; Johanne Masowe Chishanu Dare raJacob; Johanne Masowe Chishanu Nguwo Chena; Johanne Masowe Chishanu Nguwo Tsvuku; Johanne Masowe ye Vadzidzi; Johanne Masowe Nyenyedzi Nomwe; Johanne Masowe Gosheni; Johanne Masowe Zion; Johanne Masowe Mugovera* etc. **Paul Mwazha** African Apostolic Church (n=18 respondents or 16.2% of the total Apostolic sample) **Other Apostolic groups** (n=15 respondents or 13.5%) St Michael; *Zviratidzo Zvemapostori;* Adventist Apostle – *Zvidzidzi;* Zion St Agnes *yekwaChikamba; Zvidzidzi Zvevapostori; Mughodhi* Apostolic Church; Hosanna Apostolic Church; *Jekemisheni; Madzibaba Chishanu;* Bethsaida; *Zvikomborero Zvavapostori;* Zion Apostolic Church; *Guta raMwari*

Table 4 below presents a comparative highlight of the similarities and differences between the ultra-conservative and semi-conservative (relatively liberal) Apostolic groups based on analysis of the data from the individual Apostolic respondents.

Table 4: Comparison between Ultra-Conservative and Semi-Conservative Apostolic Groups

Perspectives on:	By Ultra-Conservative Apostolic groups (e.g., Johanne Marange, Johanne Masowe, Madhidha)	Semi-Conservative Apostolic Groups with relatively 'liberal' views (e.g., Mwazha, some Masowe subgroups, other minor Apostolic groups)
Religious and health beliefs	- Rigid, strict moral prescriptions and proscriptions - Explicit church doctrine & theology, linked to founding leaders - *Mweya* (Holy Spirit) a central figure/spiritual force - *Mweya* foretells impending disease outbreaks/illnesses or accidents as well as protects against illness - Power of prophets (through whom the Holy Spirit works) and faith healing - Diseases/illnesses caused by sin, evil spirits & ancestral spirits, and as punishment from God - Susceptibility and severity of disease subject to the Holy Spirit and one's faith - Faith in God/*Mweya* rather than modern medical services - Strict adherence to church beliefs, teaching and doctrine on matters pertaining to religion and health - Death from sickness as a will of God	- No clearly articulated church doctrine - Somewhat 'flexible' moral proscriptions & church philosophy relatively adaptable to emerging demands - *Mweya* as a central figure or spiritual force - *Mweya* foretells disease outbreaks or possible illnesses as well as how to avoid them Illness/disease caused by sin, evil spirit *(mamhepo)*, ancestral spirits *(mweya yedzinza)*, and/or avenging spirits *(ngozi)* - Some medical conditions are spiritual but manifest physical symptoms - Acknowledge the possibility of purely medical conditions, which are deemed 'worldly' diseases - *Mweya* and prayer protect against illness -Believe in faith healing and power of the Holy Spirit in healing any disease - Death from sickness as a will of God - Acknowledge that humans are susceptible to disease/illness if they sin, are misaligned with the Spirit, and/or fail to take care of themselves
Use of modern health (medical) services and medicines	- Not permitted at all (totally forbidden by church doctrine) - Prohibits use of bio-medicines - Use of modern medical services deemed exhorting man above God - Modern medical services as "heathen" and "of the devil" - Reflects weak faith - Encouraged to use Apostolic church "clinics" or "healing centers" only	- Acknowledged and accepted as secondary option to faith healing or use of church (Apostolic) treatment, healing rituals, and prophetic consultation - Selective use of modern medical services depending on the nature of the medical condition or personal choice, conviction or level of faith - Modern medical services used after the 'waiting period' involving 'prayers of faith' - May use modern medical services if one's faith is deemed weak - In dealing with severe medical complications, emergency medical conditions including accidents and obstetric complications, toothaches etc. - Situational use of conventional medical treatment

Maternal health	- Use of modern maternal health services forbidden - Only 'health services' within the Apostolic church are accepted - Apostolic elderly women or women with special anointing or healing powers from the Holy Spirit provide antenatal and postnatal care - Pregnant women deliver in 'makeshift maternal clinics' or at home with assistance from Apostolic elderly women - Faith healing and healing rituals seen as effective in delivering maternal health -Pregnant women experiencing obstetric complications are forced to confess sin and adultery	- Modern maternal health services may be used concurrently with 'Apostolic health services' such as consulting elderly women in the church, delivering at 'Apostolic makeshift maternity clinics' with the help of the Apostolic elderly women - Prayer, holy water, healing rituals, and spiritual consultation (with Mweya) are critical in promoting and ensuring maternal health
Child health and immunization	- Use of bio-medicines and modern child health services forbidden - Faith healing and Apostolic healing rituals and concoctions deemed effective in treating child diseases as well as protecting children against diseases - Children with measles are quarantined and treated with special concoctions - Parents forbidden to have sex when child has measles otherwise they child would die - Parents have to confess their sin, including the sin of adultery, if a sick child is to survive - Death of child from some diseases is God's will	- Use of modern child health services and bio-medicines (including immunization) is accepted as a matter of individual choice, conviction or determine one's level of faith - Faith healing and healing rituals (including use of holy water and special concoctions) emphasized while using modern medicines and health services - Parents forbidden to have sex when a child has measles otherwise the child would die or sickness persist
HIV and AIDS	- HIV and AIDS result of sin or sinful living including promiscuity - HIV/AIDS caused by demonic/spiritual forces - HIV/AIDS is a "worldly disease" that does not exist among righteous and dedicated Apostolic members - HIV/AIDS can be avoided by marrying virgins or women within the Apostolic community, and being faithful and prayerful - *Mweya* foretells or forewarns if partner or prospective partner is HIV positive - Church forbids use of antiretroviral treatment (ARVs) - Skeptical about HIV testing since *Mweya* can diagnose HIV status	- Mixed views about HIV and AIDS - Some groups encourage HIV testing and use of ARVs - Generally, HIV/AIDS is associated with sin, promiscuity, adultery, and evil spirits - Widespread view that HIV/AIDS can be avoided by marrying women within the Apostolic community, and young men are encouraged to marry virgins - *Mweya* foretells if partner or prospective partner is HIV positive
Socio-cultural practices	- Polygamy, wife inheritance, and child pledging permissible, and often associated with prophetic revelation - Educational opportunities for the girl child are limited due to early marriage, church doctrine, and undervaluation of a girl child	- Mixed views on polygamy, wife inheritance, and child pledging, and some semi-conservative Apostolic do not encourage these practices - Conditional acceptance of polygamy and wife inheritance depending on circumstances

Socio-cultural practices continued...	- Higher education not valued for fear of perceived contamination by secular education -Founding church leaders extremely influential in defining acceptable and non-acceptable social and cultural practices but emphasis is placed on the prophetic revelation from God	- Church leadership plays a key role in defining what is acceptable or non-acceptable social practices but acknowledges changes in the context

Ultra-Conservative Apostolic Groups: Johanne Marange and Madhidha

The Marange and Madhidha Apostolic groups have strict doctrine and moral proscriptions related to use of modern health services. For Marange Apostolic church, the strict doctrine on non-use of modern health services and biomedicines can be traced back to prophesy, visionary experiences, and faith healing of the founder, Johanne Marange (Mavunganidze 2008). The leaders "teach faith-healing and regard sickness itself and use of medical services (traditional or modern) as signs of weakness of faith" (Gregson et al. 1999:188), and deem periodic sexual abstinence curative in the context of illness in the family. The respondents from the ultra-conservative Apostolic groups stated:

> "We do not believe there is HIV/AIDS in the church so I cannot contract these diseases. These diseases are for non-believers" (28 year old male, Johanne Marange)

> "All my eight children have never been immunized. If a child gets measles, parents should not engage in sex. However if other wives have sex with your husband, your child will continue being sick. If you take your child to the clinic, the Holy Spirit will find out and the prophets will know when you enter the gate at church. Therefore, you are supposed to confess and repent, and then be cleansed before you are accepted back in church" (46 year old widow, Johanne Marange)

Both Marange and Madhidha Apostolic churches teach that sin leads to sickness, and HIV and AIDS is often linked to sexual sin, adultery, "promiscuity" or having pre-marital sex. Members are taught that the Holy Spirit reveals prophetically who has committed sexual sin or adultery, and the elderly members (with spiritual authority) in the church carry out physical checks on those people they suspect to be engaging in immoral behavior and practices. In some instances, the church can penalize the "immoral person" by confiscating the church regalia (white garments/ multicolored robes) or ask the person to publicly confess one's sins or seek forgiveness from the church elders. These social control mechanisms (punishments and shaming for offenders) serve to reinforce strict adherence to the church's moral proscriptions and regulations, and avoidance of modern medicines and healthcare services.

Among the religious objectors, health, sickness and diseases are largely linked to spiritual forces. They attribute the root of sickness and illness to sin, ancestral/evil spirits or demonic affliction. Consequently, this explanation downplays the role of modern medical services since spiritually-related illnesses require spiritual attention and treatment (cleansing by the Holy Spirit, holy water or healing rituals in the church):

> "We have pastors who teach us how we should walk in the fear of sin especially adultery that can lead to exposure to sexually transmitted infections (STIs)… We are taught how not to corrupt our bodies with biomedicines whatsoever" (41 year old female. Madhidha)

> "God gives everlasting life and love. Swine flu was prophesied at the shrine and we were instructed on preventive measures. We have faith in the Holy Spirit, whom we always seek for advice before we do anything" (27 year old female)

The spiritualization of illness/disease thus make the Apostolic members from the ultra-conservative (religious objectors) churches object the use of modern health facilities since they are perceived to be of no benefit to the things of the spirit:

> "We weigh and consider which is more powerful; prayers or modern medicines. That is why most of the members of the Apostolic churches would rather use healing sessions at the church rather than hospitals" (57 year old female)

> "If you fall ill from diseases caused by evil spirits and general weakness of the body, then you cannot go to the hospital. We go to the prophets who will pray for us and give us holy water until we are cured. Witchcraft and evil spirits cause these illnesses" (18 year old female, Johanne Marange)

Despite these restrictive moral proscriptions on non-use of modern medicines and health services regardless of the seriousness of the health condition, according to the findings, some members of the ultra-conservative Apostolic group secretly access modern health services and take advantage of enforced vaccinations and outreach initiatives by healthcare providers to receive medical treatment.

Both Johanne Marange and Madhidha Apostolic males strongly believe that they are less susceptible to, or have very low risk of, HIV/AIDS infection because they are encouraged to marry virgins and within their church as well as being faithful and avoiding extra-marital affairs. In addition, they believe that HIV/AIDS is a result of sin and demonic influence but they will not get it because of their allegiance to the Ten Commandments. They indicated that "one may have contracted the disease prior to joining their church, and upon joining they may get better through spiritual healing". Johanne Marange Apostolic group discourage the use of condoms, regarded as promoting prostitution. The Marange Apostolic church encourages polygamy among its members, which is a risk factor to HIV infection and spread in case one person in the sexual network has the virus[13]. Interestingly, other commentators have emphasized "clean polygamy"[14], which is predicated on people minimizing the number of sexual partners despite their religious beliefs.

Johanne Masowe Apostolic Groups

Johanne Masowe is not a homogenous Apostolic religious community but rather comprises various groups/units with distinct theological differences, teachings and church regulations. The discussion of these differences is beyond the scope of this paper, and could be a separate subject on its own. However, this study unearthed the various strands of Johanne Masowe and some of the differences they have in relation to teaching, beliefs and practices that affect women and children.

From the abovementioned Tables 3 and 4, it is apparent that Johanne Masowe subgroups place emphasis on faith healing despite their acceptance of modern health services. Consequently, most of the respondents among the Johanne Masowe faith stated that they would visit or visited hospitals a secondary resort after spiritual consultation and faith healing rituals or feeling that faith healing has failed quickly deliver desirable health outcomes. Only in few instances did the members from the ultra-conservative and semi-conservative Apostolic groups ("religious objectors") acknowledge visiting modern health facilities before praying or without the consent or knowledge of their spiritual leaders.

The findings also indicated that the majority of the Johanne Masowe subgroups do not allow polygamy, wife inheritance or child pledging while the ultra-conservative/fundamentalist segments do allow these socio-cultural practices, and justify them biblically or on the basis of the church's foundational doctrine. However, in some instances, some followers have polygamous unions prior to joining the church, and are allowed to maintain the unions without marrying additional wives. The majority of the Apostolic members interviewed in this study strongly indicated that faithfulness is one of the key doctrines of the Apostolic churches, and men are generally encouraged to commit to one partner or their married wives. However, the assumption or belief that all members are faithful may increase risk to HIV infection or act as a hindrance to HIV testing since it presupposes that the members are HIV free.

Paul Mwazha

Paul Mwazha's African Apostolic Church has increasingly become semi-conservative and liberal in some respects since it publicly accepts the use of modern (including maternal and child) healthcare services in addition to encouraging faith healing. Members of African Apostolic Church (Paul Mwazha) claimed to have their children vaccinated and use modern health facilities. They attribute this liberal position, unlike the religious objectors, to the positive shift in the leaders' attitude towards access to modern health services. The interviewees highlighted that Paul Mwazha, the founder, personally encourages his followers to use modern health services and go for HIV testing and AIDS treatment (such ARVs) while believing for faith healing. Hence, respondents from this Apostolic subgroup expressed willingness to get tested for HIV as well as take ARVs if HIV positive. Despite the permissible use of modern medical services, a significant proportion of the respondents from Paul Mwazha's African Apostolic Church stated that they were inclined to using spiritual healing methods concurrently with modern health services. These

footnotes

13 Shamiso Yikoniko (2011) "Marange polygamy a health risk", The Sunday Mail, February 20-26, 2011, p. D7.

14 Kudakwashe Gwabanayi (2011) "Apostolic changing times: Bishops embrace circumcision, urged to practise safe sex", The Sunday Mail, February 6-12, 2011, D5.

findings speak to the availability of plurality of healthworlds[15] in Africa, notwithstanding the church's forbiddance of traditional healing. The findings also pointed that Paul Mwazha African Apostolic Church's doctrine and teaching forbid polygamy, wife inheritance or child pledging. Whilst modern treatment methods are permissible, it also seems that most will also use spiritual healing methods concurrently with use of ARV's, and there is a level of uncertainty over the use of ARV's at first instance.

Other Apostolic Groups

The survey highlighted the variability of teaching, practices, doctrine, and regulation among the "other" Apostolic groups mentioned above. However, similarly to *Marange, Masowe,* and *Mwazha* Apostolic groups, these other groups strongly believe in faith healing, Mweya (Holy Spirit), and primacy of trusting God for healing instead of putting one's faith in the medical system. Consequently, some groups use faith healing concurrently with modern medical services. Interesting, the majority of the respondents who use both healthworlds (faith healing rituals and modern medical services and biomedicines) explained that their faith was low, and hence the need to utilize modern health services. The findings also pointed that almost the majority of the Apostolic groups represented in the sample have church midwives and elderly women with the responsibility of delivering pregnant women and providing both antenatal and postnatal care.

Ultra-Conservative Groups: Religious Philosophy and Socio-Cultural Barriers

The beliefs of the dominant ultra-conservative Apostolic groups (e.g., Johanne Marange, Johanne Masowe, and Madhidha) are largely centered on the teachings of the founders of the religious groups, and minimally embedded in the biblical text. The respondents emphasized the prophetic revelation given to the founders through the Holy Spirit (Mweya), which is perceived to guide Apostolic practices, teachings and prophesy. For example, Johanne Marange claimed to have received his church's charter, its rules and practices through the Holy Spirit, and hence Johanne Marange Apostolic church emphasize the work of the Holy Spirit (Bourdillon 1987). Johanne Marange and the Madhidha Apostolic groups also emphasize the centrality of the Holy Spirit in the lives of the Apostolic faith believers. According to one Apostolic woman operating an Apostolic informal maternity home:

> "There are no complications here. I am told by the Holy Spirit when a woman is going to have problems. I can even tell that a prospective mother is HIV-positive because the Spirit enlightens me" (Chimuka and Cheru-Mpambawashe 2011).

The Holy Spirit works through prophets and Apostolic members with special gifts and anointing of the Spirit, and they are able to detect sin not confessed, individuals practicing witchcraft or committing adultery or those seeking modern medical assistance and medicines contrary to church doctrine.

Table 4 provides a clear picture on Apostolic groups' beliefs about disease, which often attribute diseases to sin by individuals or parents. Consequently, sicknesses is deemed to have a spiritual root cause, and thus merely a "manifestation of a spiritual rather than biological pathology" (Campbell 2010:18). It is therefore not surprising that, in cases of child illness or obstetric complications, the child's parents are expected to confess their sins to ward off disease or affliction given the perceived correlation between physical illness and spiritual sin. Often, the responsibility is placed on women to confess their sins.

When the researcher visited the places of worship of the ultra-conservative Apostolic groups, he observed that men occupied leadership and clergy positions, and whenever the members sought counsel of *Mweya*, they went to consult males. As prophets, men are highly valued since they are the received the word of God or prophesy from the Holy Spirit. In addition, whenever issues of measles-related death among children were discussed, the issues of adultery, witchcraft and sin were largely linked to women. Therefore, women seem to shoulder the burden and most sermons centered on them, and they are expected to confess sins of adultery and witchcraft (Reverend Mujinga Mwamba Kora n.d.).

In most instances, the respondents expressed that church doctrine and practice would not change unless Mweya confirms to the church members about that change. However, they noted that *Mweya* categorically objects to the use of modern medicines and medical services since it gave that prophetic instruction to the founding church leaders, and advised them to use consecrated water (holy water) for healing purposes, laying hands on the sick, and praying for

footnotes

13 Germond, P & Cochrane, JR (n.d) "Healthworlds: Conceptualizing the Human and Society in the Nexus of Religion and Health", Unpublished paper.

their recovery[16]. The Apostolic members strongly believe in faith healing, and the ultra-conservative Apostolic groups' strict moral proscriptions against modern medicines and medical services even at the brink of death as a demonstration of faith or "test" of faith. One's belief in faith healing in times of illness, no matter how severe, reflects trust or faith in God's power to heal. However, when a member accesses modern medical treatment, it is a sign of insufficient faith or trust in God's healing intervention as well as "weak faith".

The focus on faith healing is a religious belief and conviction, which often reduces the need for medical treatment even for life-threatening ailments and obstetric complications. During fieldwork, we heard anecdotes about women who were refused medical treatment despite having obstetric complications, and some women failing to deliver normally or experience breach were beaten up while in labor and forced to confess their sin or adultery. Sin was viewed as the source of illness or complications, and hence confession was a prerequisite for healing and normal delivery to occur. Ironically, Apostolic religious fundamentalism that prevents members from turning to modern medicine and medical services is rooted in unwavering religious beliefs and strict adherence to church doctrine that views recourse to modern medicine as a "sign of rebellion and infidelity towards God" (Campbell 2010:17).

Consequently, some people shun modern medicine and medical services even when facing the prospect of preventable death for fear of "the sin of loss of faith, or transfer of faith to medical professionals that should be reserved for God alone" (Campbell 2010:16). This religious philosophy relies on faith, prayer, anointing rituals, and Apostolic community's conviction of God's and *Mweya's* sovereignty over healing power. Therefore, God or *Mweya* has the authority to heal and bestow this authority on prophets, church leaders, elders, and individuals within the Apostolic community. The findings clearly indicate the ultra-conservative Apostolic groups' religious-based objections to medicines and modern medical services, and the their core religious beliefs affirm medical avoidance (*Chimuka* and *Cheru-Mpambawashe* 2011) as well as reinforce the view that biomedicines and medicalization increase the medical professional prowess and consequently making God less important or undermining His Sovereignty (for a detailed discussion of the theologies and theodicies of faith healing, please refer to Campbell 2010).

A critical analysis of ultra-conservative Apostolic philosophy on faith healing reveals that its unquestionable acceptance and submission to it may have disastrous consequences for women and children needing medical assistance. The tragic and unnecessary deaths of women and child due to religious beliefs and parental behavior that are anti-modern medical services cannot be ignored[17]. We cannot ignore the unfortunate, pervasive anecdotes and sad stories of preventable child deaths in communities, and the lack of knowledge of child diseases that could be easily prevented by vaccines as well as risks to non-treatment of children.

The "artificial" dichotomy between faith healing communities and modern medical communities requires re-examination in light of these stories, and engagement is required between these communities of practice and a common ground built that nurtures central commitments to the interests and welfare of women and children. What is important is increasing the Apostolic community's capacity to problem solve health challenges and reduce rates of morbidity and mortality through adaptive theology, doctrinal arguments, and social teachings. This can be achieved through "engaged theology" and constructive platforms that enable Apostolic groups to learn and change as well as foster ties with formal health providers (Blanchard et al. 2008; Chitando 2007). The reformation process has to be triggered by active Apostolic participation and development of social influence paradigms that focus on nurturing progressive thinking and change among the Apostolic youth members and instilling new values on religion and health. It is important therefore to build network ties of Apostolic women, youth, and leaders to enable internal conversations about health and socio-cultural underpinnings of Apostolic faith traditions.

footnotes

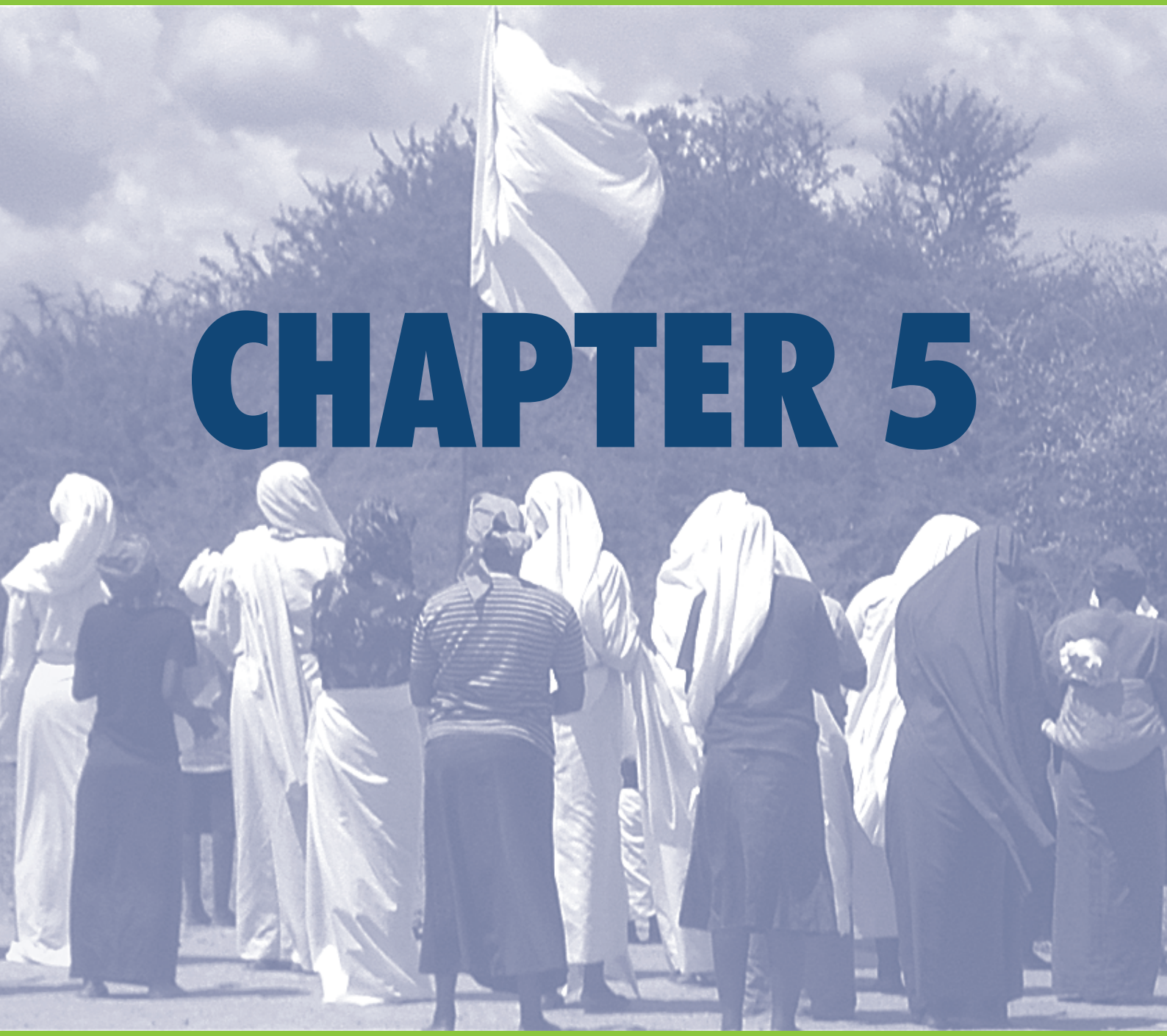
16 See the Bible, the Epistle of James 5:14-15: "Is any among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven."

Mark 16:18: "…they will lay hands on the sick, and they will recover."

2 Chronicles 16:12: "…Asa became diseased in his feet, and his malady was severe; yet in his disease he did not seek the LORD, but the physicians."

Luke 8:43-48: quoted to prove the perceived ineffectiveness of physicians in healing a person of their affliction.

17 See the editorial article by Muchaneta Chimuka and Monica Cheru-Mpambawashe (2011) "Bush camp delivers death, not children", *The Herald,* 5 July 2011.



CHAPTER 5

5 Discussion

This discussion section provides a nuanced analysis of the findings of the study, and unpacks Apostolic religious influence on health-seeking behavior, utilization of modern health services (primarily maternal and child health services), and health outcomes. It examines the findings within the analytical frameworks previously discussed as well as highlighting their utility and limitations in explaining Apostolic religion and health within the context of Zimbabwe. It is important that the reader bears in mind that these findings are limited to the Apostolic groups covered in this research, and never intended to be representative of the Apostolic community in Zimbabwe. Therefore, our findings and analysis may be biased towards Johanne Marange, Johanne Masowe, and Paul Mwazha's Apostolic groups given the relatively high proportion of interviewees from these groups represented in this study. The issues of health and objection to vaccination and uptake of modern health services are sensitive, and any research involving these issues and other controversial socio-cultural and religious practices tends to attract suspicion. Given these realities, we spend a lot of time building rapport and trust among the relevant stakeholders and ensuring that Apostolic interviewees appreciated the value of this study and their "fears" addressed.

Apostolic Religion and Health Seeking

The findings confirm previous observations that members of the ultra-conservative Apostolic groups ("religious objectors") were more likely not to use modern health services (including MCH services) than members of liberal or semi-conservative Apostolic groups and other religions. The ultra-conservative Apostolic groups (e.g. Johanne Marange, Madhidha, conservative subgroups within Johanne Masowe) have strict religious proscriptions and doctrines that demonize modern health services and biomedicines. These views are embedded in the founding philosophy of the church (spiritual) leaders, who claimed to have received divine revelation against the use of biomedicines and medical services. They also place emphasis on faith healing, and equivocally regard modern health services and biomedicines as "heathen" or "devilish" since they elevate human ingenuity (man) above God. In addition, these Apostolic groups tend to over-spiritualize illnesses/diseases by associating them with the works of evil and ancestral spirits. The teachings reiterate that sin results in illness/disease and death, and therefore physical illness has spiritual undercurrents. Therefore, spiritual consultation and faith healing rituals (prayers of faith, holy water, special religious concoctions) offer recovery and cleansing of evil spirits that cause illness. In view of this religious position, it is not surprising that Apostolic leaders of the ultra-conservative groups do not subscribe to use of modern health services and actively promote and "teach faith-healing and regard sickness as itself and use of medical services (traditional or modern) as signs of weakness of faith" (Gregson et al. 1999:188). In explaining why one does not seek any medical professional assistance, one respondent (41 year old married female) stated,

> "We do not do so because it is against the tenets of our faith. This corrupts our holy bodies and also shows great signs of lack of faith in God".

Consequently, the ultra-conservative Apostolic groups believe in "faith-healing" and members with "special anointing and gifts" of the Holy Spirit *(Mweya)* perform "healing rituals", which serve as part of the Apostolic healthcare system. The Apostolic "health system" is embedded in religious beliefs that the Spirit (Mweya) has endowed the church with healing powers and spiritual gifts, and the church has internal capacity (elderly women) with anointing for delivery and addressing child-related health problems. In addition, Mweya is believed to foretell disease outbreaks, pregnancy complications, and possible demonic attacks, and deemed to protect, heal, and deliver people from these conditions (Bwititi 2011; Gregson et al. 1999; Mukonyora 1998; Ranger 1999).

The belief in *Mweya* has an overriding influence in health seeking behavior of the most Apostolic groups, and strongly shape their attitude and behavior. The findings revealed that members of the Apostolic groups interviewed in this study overwhelmingly believed that *Mweya* can foretell disease outbreaks, illness, and infections, and thus significantly shaping their perceptions of susceptibility to diseases as well as whether the illness or pregnancy complications would be severe. The Health Belief Model (Glanz et al. 2002) provides elements that explain one's opinion of chances of getting a condition (perceived susceptibility) or how serious a condition and its consequences are (perceived severity). Our findings highlight that ultra-conservative Apostolic groups' attitudes and behaviors are strongly mediated by their strong convictions about works of *Mweya* and perceived role in protecting one from diseases. Therefore, beliefs about *Mweya* are central to explaining and

predicting the behavior of members of the Apostolic groups since Mweya is deemed to mitigate the perceived threat, and influence one's action and assessment of whether the condition will be serious or not since it foretells.

However, the actions taken in addressing a health challenge among the ultra-conservative Apostolic groups ("religious objectors") tend to favor Apostolic healthcare system which is embedded in church beliefs, values and doctrine. In this context, it is imperative that we understand how the Apostolic "alternative healthcare system" is structured and reinforces its efficacy and relevance to the conservative Apostolic groups. It has strong appeal to its members and acts counter to formal medical services (antenatal and postnatal care services, institutional delivery, general care etc.). Therefore, there is need to develop deliberate health education and training programs to target the Apostolic alternative healthcare system, particularly those elements dealing with birth attendance, antenatal and postnatal care, and children's general health given non-utilization of modern medical services.

Hove et al. (1999:31) notes a ""syndrome" of non-use of medical services, whether ANC, PNC or place of delivery, which is likely related to religious affiliation with churches that encourage prayer and faith as methods for treating disease and maintaining health". We need to recognize that non-attendance at modern medical services is a function of religious beliefs and doctrine. This religious dynamic is critical in shaping health seeking behavior and determining where to seek support. Instead of "throwing the baby out with the bath water", it is imperative to develop greater collaboration between "religious objectors'" alternative healthcare system and health service providers in training and capacity building in order to close the gaps within Apostolic health delivery system as well as bridge the gaps between the two cultures (Hove et al. 1999). By building collaborations, strengthening capacity of Apostolic health delivery system through training Apostolic birth attendants, and educating Apostolic members on "methods for treating diseases and maintaining health on PNC services, which do not contradict their religious beliefs" (Hove et al. 1999:31), it is possible to mitigate the negative consequences of non-use of MCH services, and reverse the trend of poor utilization of MCH services and high maternal and child morbidity and mortality among Apostolic religious objectors.

The findings also pointed that the majority of the Apostolic respondents had primary and secondary education, and only a very small proportion had 'A' level and tertiary education. This has implications on the socio-economic status of the Apostolic groups, and equally raises questions about the influence of maternal education on maternal and child health outcomes. The cross-tabulation maternal education and perspectives on MCH and utilization of modern health services indicated that the key driver of health seeking was religious beliefs. Even women from liberal and semi-conservative Apostolic groups, placed value in religious beliefs related to faith healing, prayer and adherence to church values and teaching. Consequently, the health-seeking behavior of these women tended to flow from religious teaching and church regulations (Gregson et al. 1999) of Apostolic religious objectors. However, this should not be taken to imply that the Apostolic women in this study lacked agency; in some situations, they acted in defiance of church teaching and regulation to seek modern maternal and child healthcare services in spite of attracting resentment from their husbands and church leaders and socially labeled as having weak faith or lacking faith. Others accessed medical services secretly while some took advantage of the compulsory vaccinations and outreach initiatives to obtain biomedicines and medical services.

These findings reinforce the Religio-cultural thesis on the overriding influence of religion and cultural processes on health seeking behavior as well as the power of religious/spiritual attributions of sickness and disease (Fourn et al. 2009; Gregson et al. 1999; Gyimah et al 2006). This spiritualization of diseases/sicknesses influences people's attitude and behavior, primarily driven by their belief that sickness has a spiritual undertone and often requires a religious response. The findings clearly highlight how religious beliefs incline one to particular health behaviors. In our case, the beliefs of ultra-conservative Apostolic groups ("religious objectors") predispose their women and children to vaccine-preventable diseases and unnecessary, avoidable maternal and child deaths given their reticence towards use of biomedicines and modern healthcare services. In addition, health behavior and outcomes among the religious objectors are largely shaped by religious beliefs (particularly *Mweya* and faith healing rituals) and capacity of the "Apostolic healthcare system" to deliver appropriate services and minimizing maternal and child mortality.

Contrary to previous studies that largely explain health-seeking and service utilization behavior on family characteristics, this study unpacks the pervasiveness of the "Apostolic healthcare system" of faith-healing as the dominant one and purely embedded in a religious belief system. Therefore, it provides answers to why there is poor uptake of modern healthcare services among the Apostolic community, which regards the modern medical health system as the alternative healthcare system. The Apostolic "healthcare system" is premised on religious beliefs and values about the will of God, the role of the Holy Spirit, and

faith-healing, which inherently reinforce particular health-seeking behaviors and decisions on non-use of modern health services with the objective of de-secularizing health delivery systems.

Earlier, we argued that modern healthcare services and biomedicines are deemed "heathen", "of the devil" and secular. Hence, use of modern medical services among the ultra-conservative Apostolic "religious objectors" are perceived as of "weak faith", defiled (kun'ora) and elevating the medical fraternity above God and thus taking away God's glory. The results revealed that "faith" assessment plays an important part in determining courses of action and whether one seeks modern health services or not as well as situational valuing of faith-healing. It appears that modern health services were sought as secondary options to faith healing and spiritual (Mweya) consultation.

Interestingly, this study sheds light on the need to explore what factors trigger people to shift from the dominant Apostolic healthcare system (faith-healing) to modern medical services – creating utilization of medical services a viable proposition. Understanding the perceived benefits of taking action and overcoming the barriers requires seeing limitations imposed by restrictive religious beliefs that contribute to negative health outcomes, particularly among women and children as well as challenging unfounded myths about biomedicines and modern medical services. One key informant from an Apostolic religious body expressed the myth among some Apostolic groups that biomedicines, primarily drugs/tablets, are literally made from human brains and/or pork as ingredients:

> "We do not know what is in the injections and tablets; maybe it is something that our church forbids like pork" (29 year old female, Johanne Marange).

This was corroborated by other Apostolic interviewees. This distrust of biomedicines and medical services based on misinformation has to be addressed through targeted information, education and communication (IEC) interventions.

Maternal Health

The findings of this study clearly demonstrated that Apostolic religion is a major predictor of use of maternal healthcare services, and use or non-use depends on one's affiliation to a particular Apostolic group (ultra conservative, semi-conservative or liberal). The primary religious objectors (Johanne Marange, Madhidha, and conservative subgroups of Johanne Masowe) dictate that their pregnant women use church-related services and support offered by church midwives and spiritual leaders rather than professionally-assisted antenatal and delivery-care services.

Some respondents from the Apostolic "religious objectors" commented:

> "The help is not from hospitals but from the church. We have church midwives who stand with you from pregnancy to delivery. We do not use hospitals" (39 year old female, Johanne Marange).

> "Women are not allowed to give birth in hospitals. We have midwives within the church who assist these pregnant women to give birth naturally. We believe in the Holy Spirit who heals and ensures safe birth to the pregnant woman" (45 year old male, Johanne Marange).

> "Pregnant women are not allowed to go to antenatal clinics. They are encouraged to get help from the midwives within the church. Prophets also help by giving holy water and prayers to pregnant women so that they deliver their babies safely" (46 year old widow, Johanne Marange).

> "They encourage pregnant women to seek help as quickly as possible if they realize that there is a problem pertaining to their pregnancy. The help must be sought from those other women who deal with matters of health but within the church" (28 year old female, Johanne Marange).

> "Once a pregnant woman goes to the clinic, it shows that one does not have faith in God" (27 year old male, Johanne Marange).

> "Our pregnant women make use of our maternal services and we do not use any modern health facilities… We stand by God and the Bible during and after the pregnancy. Our neighbor, an Apostolic church member, delivered her baby safely in her home" (41 year old married female, Madhidha).

These views were commonly shared by males and females from among the Apostolic religious objectors, and across the educational spectrum. There was a strong sentiment that this was "the norm and we abide by it" (53 year old married female, Madhidha). However, males tended to reiterate adherence to church regulations and normative prescriptions of their Apostolic religion emphasizing natural delivery not tainted by secular assistance:

> "People are just like animals. Animals can give birth without any assistance. So this issue of specialist medical personnel is not necessary. Birth is a natural process

within one can do even alone" (27 year old married male, Johanne Marange).

"If there are any problems arising related to the pregnancy, God will inform us and then pray and everything will be in order before it is late. People don't have to waste their wealth on hospital and medication" (39 year old male, Johanne Marange).

Despite the relative consensus between male and female respondents regarding interventions by God/Holy Spirit in ensuring and restoring the health of pregnant women, mothers and babies, the findings indicated that women were generally more inclined to seeking medical services in cases of pregnancy complications and emergency situations. They reiterated the importance of referring serious cases from Apostolic health system to medical facilities. Interestingly, quite a significant number of the female respondents from among religious objectors felt that they were not in a position to "question but the church says we not to seek medical attention from healthcare providers" (15 year old female, Johanne Marange), and it is church doctrine. However, some individuals recognized that there are "some other things that can't be done at the church like operations and treating other complications... Before we go to the hospital, we are first helped at church and that is where we are told to go to the hospital or not" (19 year old female, Johanne Masowe Nguwo Tsvuku).

Based on our cross-tabulation of marital status, education, and gender on issues of maternal health, our findings did not show any significant evidence that marital status, gender, and education have profound positive influence on primary preference for utilizing modern maternal health services among religious objectors. What was clearly visible was the influence of religious teaching and doctrine in determining non-use of maternal health services. Therefore, any interventions to promote uptake of modern maternal healthcare services has to pay very close attention to religious factors and socio-cultural aspects that are reinforced by religious beliefs and Apostolic doctrine. This "religious disadvantage" translates into religiously imposed limitations on women, whether in terms of educational opportunities, child-bearing responsibilities, denied access to contraception and modern health services, and limited economic opportunities.

Contrary to other studies on the relationship between maternal education and utilization of health services, our findings indicate that maternal education is not a major factor determining the use of maternal health services but rather religion is the major determinant, which mediates either use or non-use of maternal health services and women's opportunities to pursue education. Therefore, we caution the view that "use of antenatal care linearly increased with education" (Mekonnen and Mekonnen 2003:376). Instead, our findings concur with others (Gyimah, Takyi and Addai 2006; Hove et al. 1999; Iyaniwura and Yussuf 2009; Mekonnen and Mekonnen 2003) who reiterate the profound constraining influence of religion in utilization of maternal health services. Our findings merely show that the influence of maternal education and wealth on use of maternal health services has to be understood in the context of religious influence, which largely determines perceptions and explanations of events, sources of consultation, and place of delivery. Table 5 below summarizes findings related to maternal health, and their implications on health seeking are previously discussed. It should be noted that the efficacy of faith-healing and Apostolic concoctions (special healing regimens) were beyond the scope of this study, and therefore we are not in a position to make normative judgments.

Since church doctrine of ultra-conservative Apostolic groups forbid members from seeking modern medical services, pregnant women resort to Apostolic makeshift or "bush maternity" centers for delivery where they are assisted by untrained fellow women who are deemed to have special anointing, healing powers, and divine appointment. Therefore, the women give birth without proper medical care, and no HIV testing is done prior to giving birth to ensure that pregnant women receive medication (Nevirapine and appropriate ARV regime) to prevent mother-to-child transmission of HIV. At the makeshift Apostolic maternity centers, women live in unhygienic environments that may increase risks to communicable diseases and still encouraged to rely on prayer to get through pregnancy challenges and obstetric complications. The women are not exposed to modern knowledge about HIV prevention, child killer diseases, and immunization (Chimuka and Cheru-Mpambawashe 2011).

Table 5: Summarized Findings on Maternal Health

Maternal Health	Restrictive Beliefs & Barriers	Methods of Care and Prevention
• Religious objectors only promote use of Apostolic health system (church midwives, faith healing rituals etc.) • Liberals and semi-conservative allow use of maternal health services but emphasize seeking spiritual counsel and support from the church • Some severe pregnancy complications referred to modern medical services	• Birth as a natural process so women can do it without hospitals • Hospitals viewed as elevating medicines and health professionals above God • Beliefs that *Mweya* forewarns about any pregnancy challenges • Limited financial resources to pay for medical services even when one is willing to defer strict regulations against use of medical services • Mixing with ' unbelievers' or heathens • Attitudes of health workers towards apostolic sect members	• Special Apostolic concoctions for pregnant women - honey, lemons and sanctified eggs believed to prevent a sunken fontanel *(nhova)* on child upon birth • Mother should not 'sin' • Induced vomiting to deal with obstructed placenta • Stretching birth canal in preparation of birth, using soap, warm water and/or inserting fist • Not engaging in sexual intercourse when pregnant. • Don't eat leftover food, but eat fresh and hot food always • Use clean water and boiled water for drinking • Live in clean environments

Child Health

The findings reconfirmed previous studies[18] that indicated reticence towards vaccination and uptake of child health services among religious objectors, primarily Johanne Marange, Madhidha and the conservative religious subgroups within Johanne Masowe. The religious objectors' beliefs, practices and principles reinforce intolerance towards vaccination and medical services for children (see Table 6 below). Consequently, members of Apostolic religious objectors (groups) are largely missed by the Expanded Program on Immunization (EPI), routine immunization, and even outreach programs.

Fourn et al. (2006) provide a compelling analysis of factors that drive religious reticence towards vaccination and use of child health services in West Africa. However, their analysis has clear relevance for this study since it also highlights the constraining influence of religious beliefs on positive uptake of child health services. Despite the global recognition that child vaccination is an effective strategy against epidemics (Biellik et al. 2002), the poor coverage among religious objectors remains a cause of concern especially when religious beliefs demonize vaccination and child health medical services or reinforce perceptions that Apostolic children are not prone to contracting major diseases common among children under-five or if they get the disease, only God can cure them. These views were largely prevalent among the Apostolic religious objectors:

> "There is very little chance for our kids to contract the diseases like other kids of non-believers. Our prayers protect them from all sorts of problems on this earth" (39 year old married male, Johanne Marange)

> "Our children have low chances of contracting child illnesses because the Spirit (Mweya) reveals the onset of a disease outbreak, and our children are given holy water to protect them. Our children don't get immunized" (Johanne Marange member)

footnotes

[18] See the "Report on Evaluation of Zimbabwe Post Measles Vaccination and Vitamin A Supplementation Campaign (24 May – 2 June 2010)", Ministry of Health & Child Welfare, WHO, European Commission, UNICEF and Helen Keller International.

"Even in the Bible, people got sick. So yes, our children can get diseases but like I told you, diseases are caused by demons and evil spirits. There is no need to go to the clinic because there is no disease that God cannot cure" (28 year old male, Johanne Marange)

"Whether children get sick or not is purely not our concern as parents. Look we don't even bother ourselves… We just believe God takes care of them. Nonetheless, they have equal chances of getting diseases like measles, and when they get attacked we know how to deal with them. We just pray while we as parents abstain from sex, and make sure that the children are isolated from others" (41 year old married female, Madhidha).

Notwithstanding the constraining influence of these strong religious beliefs among the ultra-conservative Apostolic groups, the women were able to negotiate this complex religious terrain by secretly vaccinating their children and rationalizing vaccination:

"I take my children to the clinic for immunization but this is an individual choice… Children do get sick but some are taken to the hospital by their parents and some are not depending on the faith of the parents. If they believe that the Holy Spirit will heal their children, then they will not take them to the clinic" (27 year old female, Paul Mwazha African Apostolic Church)

"Our church does not allow us to have children immunized. Health workers just force us by immunizing our children at school. After immunization, we always pray for the children and given them holy water to cleanse off the involuntary immunization" (46 year old female, Johanne Marange)

"My child can be immunized only when we are forced during the disease outbreak" (25 year old married female, Johanne Marange)

"One of my wives immunizes my children secretly, and you hear the kids saying it, and my wife is in trouble but only that God hates divorce" (39 year old male, Johanne Marange).

Table 6: Summarized Findings on Child Health

CHILD HEALTH	
Religious Beliefs and Practices	Preventive and Promotive Measures
• Faith healing rituals - prayer and sanctified water etc. • Children bathed with sanctified water for cleansing evil spirits and restoring health • Children to drink holy water to treat child-related diseases • Parents to avoid sexual contact when child has measles • *Mweya* forewarns potential illnesses and disease outbreaks targeting children, and hence able to protect children against the diseases through measures advised by *Mweya*	• Prayer • Sanctified water and faith healing rituals • Induced vomiting • Eat hot food and fresh food • Hygiene and cleanliness • Clean water sources and boiling drinking water • Clean living environments • Use of ash to sanitize environment • Special concoctions to treat child-related illnesses

Clearly, from these statements, it is apparent that the Apostolic religious objectors invoke church doctrine, biblical text, prayer and tenets of their faith to justify their attitude toward child health services. The hardcore conservatives, faithful to church doctrine strongly deplore compulsory vaccination and coercive actions of law enforcement and healthcare providers in enforcing public health interests:

> "My children would rather die rather than be vaccinated. I was never vaccinated and neither do my children need to be vaccinated. Besides, they get serious reactions to these drugs as some of the develop allergies to the biomedicines…The vaccinators and police use force, and they don't respect our differences with them" (41 year old female, Madhidha)

> "I have terrible experiences as my child was forced to be immunized and up to now he no longer likes to go to school. He is now traumatized" (53 year old female, Madhidha)

> "Vaccination of children and use of maternal health services should never be mandatory. You see forcing these on us is like rape. You take our helpless children at school, while they are crying for help, you force yourselves on them. We, Apostolic groups, are being raped" (a member of the Madhidha Apostolic group).

This imagery or analogy of rape associated with forced vaccination presented by a member in one of the ultra-conservative Apostolic groups (religious objectors) speaks to the strong moral sentiment against vaccination. Unless, one fully understands the depth of "the religious dimension that underlies reticence toward all child vaccination" (Fourn et al. 2009), it will be difficult to design effective interventions that take into account these religious beliefs and perceptions of immunization programs. As previously stated, it is religion more than the behavior of health care providers (officials) that act as deterrent to vaccination and uptake of modern child health services.

Our findings generally highlighted a significant favorable attitude towards healthcare providers among Apostolic groups that subscribe to the use of medical services while the religious objectors merely disqualified the importance of modern medical services and professionals in their lives. The negative perceptions toward vaccinators were mainly associated with the act of coercion rather than the character and service behavior of the vaccinators; thus dislike the process not the professional behavior. Our findings highlight the negative attitude of religious objectors towards vaccination and compulsory child health service interventions, which is largely linked to their religious stance. Interestingly, some women within the ultra-conservative Apostolic groups expressed appreciation of compulsory vaccination and special outreach interventions since they enabled them to have their children vaccinated under "official compliance" while other secretly/privately accessed modern healthcare services. The opportunities presented by these conditions cannot be underestimated since they speak to agency and willingness to take action to seek medical assistance even within a restrictive religion.

Strategies for Promoting Effective Uptake of MCH Services

The key informants, almost overwhelmingly, lamented the low uptake of modern health services and poor immunization coverage among Apostolic groups, and primarily the pervasiveness of religious beliefs that openly discourage use of biomedicines and MCH services among religious objectors such as Johanne Marange, Madhidha and conservative segments of Johanne Masowe. They indicated that religious objectors' beliefs have had disastrous consequences for women and children, and often resulted in avoidable deaths among these groups. In addition, the prioritization of faith-healing over modern medical treatment and socio-cultural practices in situations of illness or complications among women and children have contributed to difficulties in containing disease outbreaks, case management, and delivering effective responses against vaccine preventable diseases. Therefore, they called for the development of mandatory immunization and Public Health responses that protect the rights of women and children:

> "Vaccination and use of professionally-assisted maternal services should be mandatory as we have experienced lots of child deaths in our communities from preventable diseases. The Madhidha sect has a high mortality rate because they sometimes get away with their anti-vaccination stance" (School teacher, with experience on the Madhidha group)

> "It should be made law. If not enforced, a lot of lives will be lost. Law should hold parents accountable for deaths deemed to be a result of negligence by depriving anyone, including their children, of health care services. For example, children died because they were not

immunized. A good number of women had pregnancy complications and died during child birth. Steps should be taken to reduce infant and maternal mortality in light of the high number of deaths. Everyone has the right to access health and also the freedom to worship but that freedom should not cause the death of anyone due to perceived negligence. It is necessary to make it law" (Assistant District Administrator)

"If we are saying 'Health for All by 2012', it should be mandatory for child vaccination and maternal health service utilization" (a nurse at Mpilo Hospital)

"We are saying it must be mandatory regardless of religion because the seven killer diseases are the major causes of mortality and morbidity, and hence the reason to make use of MCH services mandatory" (District Health Promotion Practitioner, Ministry of Health and Child Welfare).

The consideration of mandatory use of MCH services regardless of religious beliefs raises fundamental questions about rights, and national debate on these issues is required. This has constitutional implications, and points to competing tensions between rights and freedom as well as the need to engender fundamental rights – whether rights to health, religion and worship, right of government to enforce public health etc. These questions become apparent especially when faith-healing fails or there is death of children from parental decision to rely on faith-healing rather than medical treatment[19] (Campbell 2010).

The expert interviewees also highlighted the "power of persuasion", primarily through engaging Apostolic leadership, "first wives", and church midwives (traditional birth attendants) in dialogue and program design aimed at improving the Apostolic health delivery system. They emphasized social mobilization, communication strategies, and capacity building (health educational training, logistical support and distribution of basic materials required for acceptable minimum standards in delivery and care of pregnant women and children) while nurturing shifts in values:

"Women should be invited to workshops on health matters so that they are made aware of the benefits of using modern health services… Women of the Marange sect are virtually prisoners who have no say on health matters. These summits or workshops can empower these women so that they can claim their rights to healthcare services" (Public Health Specialist).

"We have to involve the Apostolic groups in our planning and health programs especially the leaders because they are the ones who influence. This also requires a change in beliefs, and it will take time. If it is possible to offer some services for free to Apostolic members as well as capacitate health care providers to offer training to nurses working with Apostolic members"

These statements point to the need for capacity building, training, education, and collaborative engagement with the Apostolic religious group as well as innovations that respond to the religious realities of Apostolic groups. These can be in the form of:

"Mobile clinic program actually worked well since we went to them (Apostolic members). We took the vaccines to them" (Sister in Charge, Ministry of Health and Child Welfare official)

"The program where health promoters went door-to-door raising awareness was an effective mobilization effort as well as the school campaigns where children were asked to bring their health cards. We were then able to identify those without or never had vaccinations, and we wrote to their parents so that they come to us without fear of being arrested" (Community Health Worker, Ministry of Health and Child Welfare official).

Other key experts reiterated that health officials should make an effort to go to areas of worship and advice Apostolic groups on the benefits of using modern health services and medicines while fully cognizant of the religious beliefs of the respective Apostolic group to ensure that their advice is relevant to them:

"We have to encourage others to go to clinic and hospitals because there are certain illnesses that do not require spiritual healing… and some things need the attention of the clinics, and should be dealt with by those health care providers" (Community leader).

footnotes

[19] Refer to Campbell (2010) discussion on "What More in the Name of God? Theologies and Theodicies of Faith Healing."

These observations concur with Hove et al (1999:31), who recommended educating " persons belonging to churches that encourage prayer and faith as methods for treating diseases and maintaining health on PNC services, which does not contradict their religious beliefs" as well as explaining that no all services provided by medical facilities require taking biomedicines. Notwithstanding the competing views between Apostolic members and key experts and healthcare providers interviewed in this study regarding the mandatory use of MCH services and legal enforcement of public health-related intervention, there was expressed commitment from both sides to explore effective ways of collaboration and building bridges across the gap between these two cultures. The following section discusses the proposed options of building optimal collaboration and learning from previous experiences. The discussion will focus on illuminating and appreciatively highlighting the positive elements within the Apostolic community and previous engagements.

Strengthening Elements within the Apostolic Community

The key objective of the study was deeper understanding of the determinants of behavior that lead to acceptance of rejection of preventive and promotive health and social practices among Apostolic religious objectors, and this inevitably pointed to examining the "problems" within the Apostolic community, especially factors that hinder uptake of biomedicines and medical services. However, the Terms of Reference (ToRs) clearly stated the need for appreciative inquiry, and we deliberately sought stories from among Apostolic members that highlighted the positive elements and internal capacities that could be leverage for change and improvement of health outcomes among Apostolic members. In discovering positive attributes or "stories" focusing on successful elements of Apostolic experiences, this study creates opportunities for stimulating core positive change as well as present problems in ways that enable further analysis, and therefore allow critical questioning of transferability of successful stories in similar and different situations. From the "stories", we learnt about Apostolic experiences with health promotion initiatives as well as areas they believed offered opportunities for optimal collaboration.

One of the key areas was to understand the contributions that the Apostolic churches deemed to make to health improvement of their membership. When asked key experts to provide their assessment of Apostolic churches' contribution to health improvement among their members. Interestingly, the views diametrically opposed. Apostolic leaders and members interviewed in this study focused primarily on spirituality and health:

> "Evangelists pray for me and they give me holy water to improve my health when I am not feeling well" (32 year old married female, Paul Mwazha African Apostolic Church)

> "Firstly, you go to the prophet so that you get holy water and prayed for *(munamato)*, and go through a healing ritual. Thereafter, you can go to the clinic. Your healing will be faster at the clinic or hospital if you had gone through spiritual healing and consulted the Holy Spirit" (43 year old married female, Johanne Masowe yeVadzidzi)

> "There are times that even doctors would not be able to diagnose the nature of the illness, but at our shrines, the prophet can easily be shown by the Holy Spirit what the condition is" (57 year old widow, Johanne Masowe Chishanu)

The Apostolic members focused on the benefits of spirituality on health. This association between spirituality and health has attracted growing interest (Lee et al 2008; Wallace & Forman 1998; Freedman et al 2002). In view of this body of literature that is increasing highlighting the positive connection between spirituality and health, it may be useful to explore appreciatively how the Apostolic religion contributes to health outcomes. Seeking an understanding of Apostolic positive qualities and strengths enables healthcare providers to build on the positive elements and stimulate dialogue between them in order to promote change and learning. This study noted that a large proportion of the Apostolic religious groups, with the exceptions of the ultra-conservative groups like Johanne Marange, Madhidha and conservative segment of Johanne Masowe, has shifted away from polygamy, wife inheritance and pledging young girls to marriage (non-consensual) to progressive socio-cultural practices. They also emphasize monogamous relationships, strongly preach against divorce, pre-marital and extra-marital sex, and encourage HIV testing for their members. Some of the groups encourage male circumcision and education for children. By focusing purely on the problems within Apostolic groups, one can easily miss these important shifts and positive attributes, which can be built upon to reinforce positive health outcomes.

Gregson et al. (1999) argue that the restrictive moral proscriptions and teachings could minimize the risk exposure of some Apostolic members to the HIV epidemic since they accelerate moves towards behavior codes that are protective against HIV infection, and thereby limit the long term mortality impact of the epidemic. However, this trend does not apply to all Apostolic groups given their variability in terms of teachings and practices related to sexuality. What the findings of this study show, similarly to Gregson et al. (1999), is that differences in the content of religious teaching, practices and levels of adherence to church teaching fundamentally influence healthcare seeking and behavior of the Apostolic members.

In addition, the iniquitousness of Apostolic traditional birth attendants (church midwives) and healing system as a dominant health system cannot be overlook. It operates outside and sometimes complementary to the modern healthcare system. Therefore, it role in providing service to pregnant women and children, and people with various illness has to be examined, and where gaps exist closed through capacity building and logistical support. Skilling Apostolic birth attendants and elderly Apostolic women with spiritual mandate over maternal and child health required breaking barriers and bridging the gaps between Apostolic health system and modern healthcare providers. The support can be in the form of training and continuous education of Apostolic "midwives" (traditional birth attendants), provision of materials or strategic resourcing, assessing places of delivery, upgrading facilities, promoting women's empowerment and maternal education etc. According to the Apostolic women, these are some of practical responses that will positively impact them rather than trying to force a change towards use of modern health services:

> "Nothing pleased me because the health professionals do not respect our church values and doctrine. They are not supposed to force us to do things we do not believe in. We believe in different things. However, they are supposed to teach us the advantages of following what they believe in and we decide what we want to do but not forcing us" (30 year old married female, Johanne Masowe)

In terms of the best collaborative experience, the majority of the Apostolic interviewees referred to the 2008-09 cholera outbreak responses and 2009-10 measles outreach initiatives. They praised the effective IEC strategy and logistical support of the health care providers:

> "We got buckets, clean water, and aqua tabs, and our houses were sprayed. They taught us how to look after ourselves properly" (33 year old married female, Johanne Masowe Chishanu Nguwo Chena)

> "They came and sunk boreholes so that we have clean and safe water to drink and for cooking. We were given buckets and aqua tabs to use when drinking water by UNICEF" (35 year old married female, Zimbabwe Apostolic Faith Church)

> "I was impressed with how health people worked 24 hours a day to try and save people who had been affected by cholera, spraying their households and teaching them what to do" (47 year old male, Paul Mwazha African Apostolic Church).

> "They reacted quickly by establishing satellite clinics, and community health workers would go do-to-door educating people and making assessments on area cleanliness" (23 year old female, Johanne Masowe Chishanu)

> "During the immunization outreach, we were very grateful working with health providers. They thoroughly educated us about the importance of immunization to the well-being of our children. We also saw the benefits of immunization as our children who had been vaccinated were not affected by measles like those of our counterparts that had refused to immunize their children" (28 year old married female, Johanne Masowe yeSabata).

While the majority of liberal and semi-conservative Apostolic groups had positive experiences regarding collaboration with health providers, the ultra-conservative Apostolic groups (dominant religious objectors) had very strong mixed feelings; others deplored some of the initiatives by health providers while others greatly appreciated them:

> "There is nothing that excited us or excited us… at one point they forced our children to be vaccinated and those children fell ill. So is that exciting?" (27 year old male, Johanne Marange)

> "I was happy that the health providers considered our religious beliefs of not using medications. They taught us ways of eradicating some diseases without the use of medication. They encouraged us to use clean water, to keep the toilets clean, and to wash our hands after using the toilet" (31 year old single male, Johanne Marange)

> "By the time the immunization people came I was happy because the immunization benefitted innocent souls even though it was done forcefully" (35 year old male, Johanne Marange)
>
> "We have never had a smooth collaborative experience with health providers because often we are not given a chance to say our opinion on some compulsory programs" (53 year old female, Madhidha).

In taking an affirmative orientation, exemplified by application of appreciative model, we pragmatically believe that a focus on successful elements of previous experience of Apostolic groups (community), healthcare providers, and individuals unlock creative collaborative processes through strengths rather than weaknesses, opportunities rather than barriers, and solutions rather than problems. It also enables re-examination of problems from a solution-exploration angle and negotiation of interpretations and meanings. This deconstruction of problems facilitates understanding of Apostolic groups and individuals' experiences and meaning. This process of social negotiation of meaning recognizes that reality is socially constructed, and that there multiple socially constructed realities of health and worldviews.

The findings revealed the centrality of Mweya (Holy Spirit) in the Apostolic community, a supreme power which is deemed to give life, health and protection. This strong belief in the divine power, Mweya, and Apostolic members' relationship with Mweya, actively mold their attitude and behavior, and subsequently how one interprets faith, faith healing, and utilization of modern healthcare services. Unless we fully understand this meaning creation or the meaning Apostolic members give to their subjective experiences, health providers who fail to understand and negotiate these meanings miss the mark in their program design and programmatic interventions.

Therefore, this study has endeavored to decrypt the religious meanings and socially constructed realities of health and health-seeking among Apostolic groups, and through a process of textual analysis of the interview scripts, reflected the religious and cultural constructs, beliefs, teachings, church regulations, and social practices that influence healthcare-seeking behavior among Apostolic members. The religious beliefs and practices mold attitudes and behaviors of Apostolic members in profound ways, and hence shifts in behavior have been driven by IEC, dialogue, positive engagement, and reinforcing new patterns of beliefs and practices driven by Apostolic bodies.

Health Belief Model (HBM) Constructs, Apostolic Faith, and Health Seeking

The Health Belief Model (HBM) has great utility in understanding the preventive and promotive health, behavior and social practices of Apostolic groups. The HBM suggests that in order for an individual to take action to avoid a disease, one needs to believe that he or she is susceptible to the disease *(perceived susceptibility)*; the disease could have severe impact on one's health *(perceived severity)*; certain behaviors beneficially reduce one's perceived susceptibility or severity in case of affliction with the illness/disease *(perceived benefits)*; and these behaviors would not be impeded by cost, socio-cultural restrictions, and physical pain *(perceived barriers)*. HBM proponents argue that HBM is useful in predicting health-related behavior, care-seeking decisions, and sexual behaviors in the context of HIV and AIDS (Lin, Simoni and Zemon 2005). Recognizing the utility of this model in explaining health behavior, we felt that it was imperative to explore its applicability in a cultural context taking into account the diversity and subgroups within the Apostolic community, which may create differences in prevention and promotive health behaviors. The results indicated variation of health beliefs among Apostolic groups.

Our findings revealed that Apostolic religious beliefs strongly mediated beliefs about health, particularly perceptions of susceptibility to diseases. The majority of the respondents, while admitting the possibility of contracting diseases, they also strongly stated that the Holy Spirit would forewarn them about disease outbreaks or threat to their health in order to reduce chances of getting ill. The ultra-conservative members interviewed in this study forcefully argued that having multiple sexual partners within their polygamous relationship was not a risk factor since the Holy Spirit can tell if one is HIV positive or not, including whether a partner is having an extra-marital sexual relationship. Therefore, according to the Apostolic interviewees, the Holy Spirit significantly reduces susceptibility to diseases among adults and children by forewarning and advising how to overcome contracting illness/disease. In terms of perceived severity, the majority of respondents believed that faith in God/Mweya and faith healing severely reduce the severity of any disease/illness, and the Apostolic healing rituals (prayer, holy water, and special concoctions) work as protective gear against illness caused by evil spirits.

However, when one has committed sin or has weak faith, the impact of illness will be severe and even cause death;

with death deemed as a will of God. The interview guide for individual Apostolic members explored perceived benefits of taking action to reduce the disease threat. We assumed that when Apostolic individual members would opt for modern medical assistance when "sufficiently-threatened" (Janz and Becker 1984:2) by a serious illness or disease outbreak. Interestingly, the results revealed that Apostolic religious beliefs largely predisposed Apostolic members to faith healing, healing rituals, prayer and spiritual counseling as effective courses of action to reduce the disease threat.

Despite acknowledging modern medical assistance as the recommended health action for certain medical condition, the Apostolic members perceived faith healing and church assistance as efficacious. As previously stated, the prioritization of faith healing over modern medical assistance is not surprising given Apostolic religious beliefs and doctrine. This is largely influenced by beliefs about the effectiveness of faith-oriented action. Earlier discussions highlighted how Apostolic religious beliefs about disease influence Apostolic members' preventive health behaviors and willingness to obtain vaccination against diseases. Our results demonstrate that religiously-constructed health beliefs regarding susceptibility, severity, and efficacy are important factors in Apostolic members' utilization of modern healthcare services and vaccination. The perceived barriers were often associated with the religious sanctions and moral dilemmas associated with using modern healthcare services especially when it is forbidden by church doctrine and teaching. We highlighted earlier the perceived costs of acting defiantly against church norms and values as well as the implications of faith assessment (whether one perceives to have strong or weak faith) in undertaking medically recommended preventive health behaviors. While the recommended medical action may be beneficial, the religious beliefs and perceptions may work against the recommended behavior and weaken the cues to action driven even by powerful health IEC and health providers.

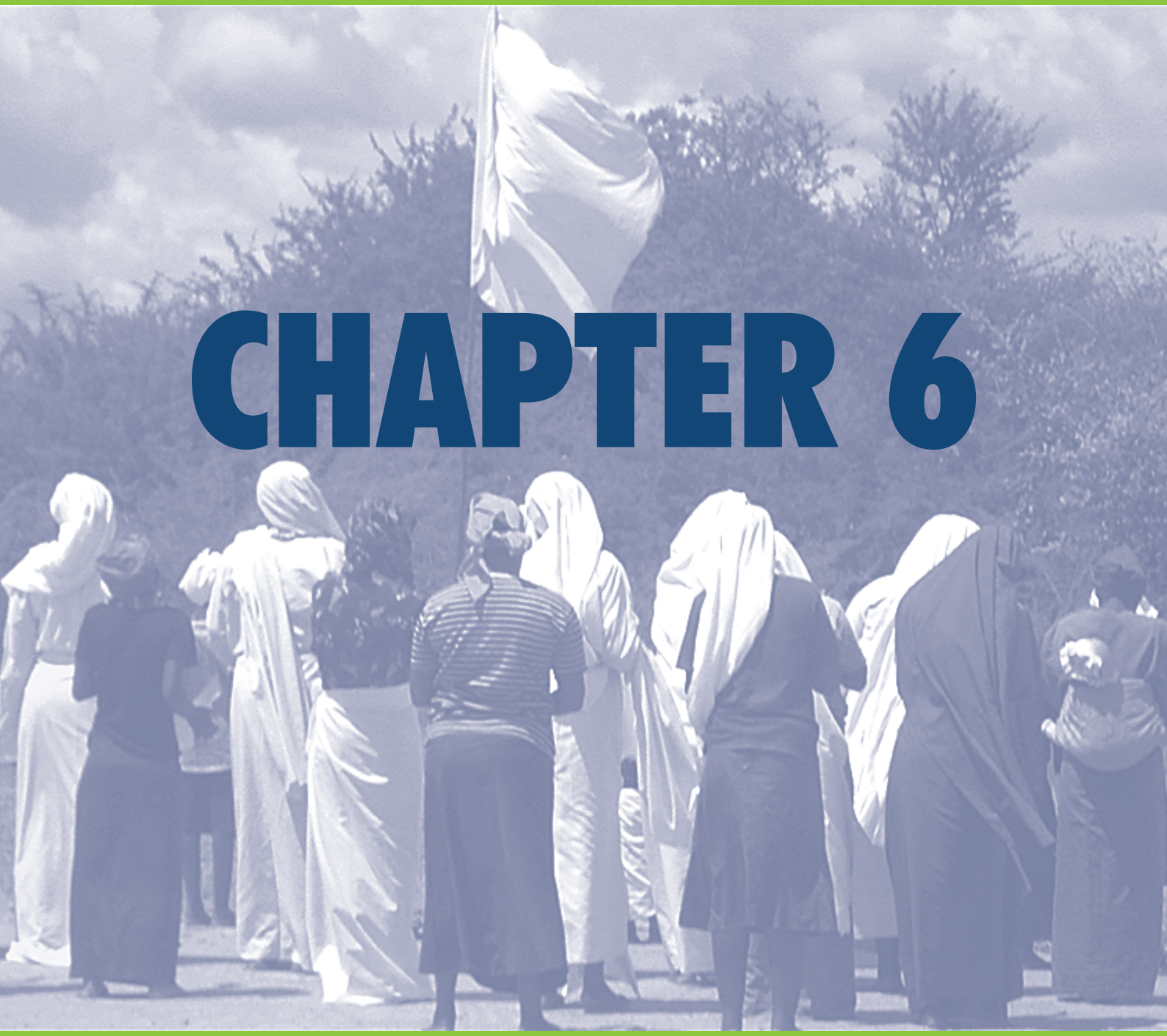
Based our results, we argue that religious beliefs or Apostolic religion fundamentally influence health beliefs and perceptions about "susceptibility", "severity", "benefits", "barriers", and "cues to action" among Apostolic members. Unless we understand religiously-constituted or socially constructed health beliefs, we can easily make erroneous conclusions about health actions of Apostolic members and fail to account fully for the critical determinants of behavior that lead to acceptance or rejection of preventive and promotive health and social practices among Apostolic groups, primarily religious objectors. Literature is replete with studies on religion and health, and the discussions focus on both the beneficial effects of religion and its negative side primarily its propensity to increase the risk of sickness or death (Brown 2000; Cau, Sevoyan and Agadjanian 2010; Dupre, Franzese and Parrado 2006; Ellison and Levin 1998; Freedman et al. 2002; Gonnerman Jr et al. 2008; Jarvis and Northcott 1987; Kennedy, Brown and Gust 2005; Lee and Newberg 2005; Levin, Chatters and Taylor 2005; Levin 1996; Obaid 2005).

The detailed discussion of the effects of religion on maternal and child morbidity and mortality is beyond the scope of this study given the methodological difficulties and challenges in conclusively linking religion and health. However, we focused on qualitatively understanding the association between Apostolic religion and health practices and health-related behaviors by studying Apostolic teachings, doctrine, rituals and beliefs influencing Apostolic members' attitude and uptake of modern healthcare services. The findings clearly demonstrated that the ultra-conservative Apostolic religions may risk the risk of certain illnesses or death among their members by discouraging actions which may be health promoting (i.e., taking modern medication, getting medical assistance or use maternal and health services). Such proscriptions, by discouraging acceptance of medical treatment or acceptance of public health principles, may increase risks to diseases and deaths which could easily be avoided through uptake of modern medical services. However, there are some aspects of the Apostolic religion which may promote positive health outcomes and reduce the risk of some sicknesses or death. This emerges from prescribing behavior which prevents illness or assists in treatment of sickness. Without placing moral judgment on the efficacy of Apostolic healing rituals and special concoctions or "tips" on health, as previous highlighted, it seems most of the "healing rituals and concoctions" are premised on encouraging people to drink lots of water, avoid left-over foods, and hygienic behaviors.

In addition, some of the Apostolic groups proscribe unhealthy behaviors including the prohibitions against the use of alcohol and tobacco, and discourage "immoral" or "sinful" practices such as having sexual partners, pre-marital sex, and promiscuity. Notwithstanding the emerging evidence on Apostolic religion and mortality and HIV, as well as media reports singling out the Apostolic religion for attention (often painted in a negative light and sensationally), there is need for systematic analysis of the

mortality effects of Apostolic proscriptions of certain activities. In addition, we know very little about what the Apostolic religion prescribes. What are the benefits of religiously-driven social support linked to caring for others and easing burden during difficult times? How does the Apostolic position on eating fresh foods, personal hygiene, staying married, and prohibiting promiscuous sexual behavior contribute to better health and lowered mortality?

This study provides lenses through which we can better see and understand Apostolic religion and its effect on health behavior, health, and morbidity and mortality risks. As a qualitative study, it seeks to put the behavior of Apostolic groups in proper context and probes aspects of religious behavior and practices that are not captured by conventional quantitative research or Demographic and Health Surveys (Takyi 2003).



CHAPTER 6

6 Key Findings and Recommendations

The findings of this study clearly indicate that religion (religious beliefs, teaching, doctrine, regulation etc.) including its associated social structure (socio-cultural systems, organizational forms, education) is a key determinant of healthcare-seeking among Apostolic groups. The findings concur with previous research (Gregson et al. 1999; Hove et al. 1999) on the constraining influence of Apostolic religion on the use of modern healthcare services. However, this study unveiled the differences in health seeking among Apostolic groups by linking them to differences in Apostolic religious affiliation, whose differential teaching and regulations affect healthcare-seeking behavior. Our analysis revealed the importance of understanding the implications of Apostolic heterogeneity rather than treating the Apostolic community as a homogenous entity. Discerning these differences by Apostolic affiliation enables one to clearly see differential influence, impact and role of Apostolic religion in health-seeking behavior and health outcomes. It is erroneous to assume that Apostolic "theological homogeneity" (Gyimah et al. 2006:2935), and cluster the various Apostolic groups into a homogeneous unit without any theological differences. It is for this reason that our classification of the Apostolic groups revealed three distinctions: ultra-conservative, semi-conservative, and liberal Apostolic groups.

Our findings focused primarily on religious objectors, the ultra-conservative Apostolic groups that openly forbid their members from seeking modern medical services and biomedicines. The ultra-conservative Apostolic groups emphasize faith-healing and use of "church health services" rather than modern medical services, which they deem "heathen", evil, ungodly, and a contradiction to God's will. Unlike the ultra-conservative Apostolic groups, the semi-conservative and liberal Apostolic groups have an ambiguous position on use of modern healthcare services and are flexible to their members' willingness to use medical services. However, they encourage members to first seek spiritual counsel and faith-healing prior to utilizing medical services. They are similar to the ultra-conservative in emphasizing faith, and hence members of both ultra-conservative and semi-conservative/liberal Apostolic groups tended to speak about "faith" as a key determinant in deciding whether or not to use medical services. They both foster strong belief in faith/divine healing and trusting God for healing and health. However, they differ significantly in terms of the social control mechanisms executed to enforce adherence to church teaching and regulations; the ultra-conservative have a militaristic type approach whereas the semi-conservative and liberal Apostolic groups have a relatively soft approach and acknowledge personal choices and freedom within a religious framework.

Summarized Key Findings

Apostolic Religion and Health

The religious teaching, doctrine and regulations of the ultra-conservative Apostolic groups (e.g., Johanne Marange, Johanne Masowe Sabbath (ye Sabata), Madhidha), because of their emphases on faith healing and strict adherence to church beliefs and practices, tend to undermine modern health-seeking or use of modern health services. Violating church doctrine or regulations on use of modern healthcare services attracts social sanctions, which include confession, shaming (asked not to wear church regalia or *"kubvisiswa gamenzi"*, or re-baptism *(kujorodwa)*. Sometimes, militaristic-type discipline is invoked to instill strict adherence to the Apostolic group's norms, values, and leaders' instructions.

Semi-conservative and liberal Apostolic groups have ambiguous teachings and church doctrine related to use of modern healthcare services. Neither do they openly condemn or encourage use of modern health services but emphasize that their members first seek spiritual counsel and faith healing before utilizing modern healthcare services. Uptake of modern healthcare services is often secondary after initial spiritual consultation.

Holy Spirit *(Mweya)* is a central spiritual force in the beliefs and faith healing of the Apostolic religious communities, and is believed to foretell and forewarn about any impending disease outbreak, tragedy, complications as well as how to treat illnesses. The Holy Spirit works through prophets and church members, and endows them with special healing and prophetic powers.

The healing rituals and "spirit-filled members" with special healing powers and delivery skills (church midwives) within Apostolic churches constitute a dominant and/or alternative health system to conventional healthcare system. This "Apostolic healthcare system" has a religious basis, and often viewed as glorifying the work of God or the Holy Spirit. In contrast, the modern healthcare system is deemed worldly (heathen) and glorifies man above God. Faith healing and healing rituals entail the works of *Mweya*, prayers, sanctified (holy) water, sanctified stones *(matombo akayereswa)*, and use of "apostolic concoctions"; all these have the power to

heal or deliver healing, cleanse impurities or evil spirits, maintain good health or restore it during sickness, and ensure improved quality of life and health of members of Apostolic churches. In view of the spiritualization of illnesses and diseases, it is not surprising that those medical conditions are primarily referred to the church and spiritual leaders, and individuals encouraged to pursue faith-healing.

Consequently, the "Apostolic healthcare system" including faith-healing occupies a special place in the lives of the Apostolic members, and members expressed strong faith in it. The majority of female interviewees had strong convictions about the role of Apostolic women with "spiritual powers" to treat and care for pregnant women and deal with illnesses that affect children. Ignoring the pervasiveness of the "Apostolic healthcare system" is akin to burying one's head in sand and pretending that it does exist despite its attractiveness to the majority of Apostolic members. It depends on faith healing, healing rituals and special concoctions, serve as an alternative to modern medicines and medical services, and hence influencing the health-seeking behavior of Apostolic members as well as their attitudes toward modern medical assistance. Therefore, we can possibly answer the question why there is poor uptake of modern medical services by understanding the influence on "Apostolic healthcare system" and religious beliefs. In addition, we cannot underestimate the perceived role of Apostolic religious leaders and spiritually-ordained members in shaping health-seeking behavior and decisions of Apostolic members.

This study has demonstrated that Apostolic religion articulates certain religious and behavioral norms that fundamentally shape health outcomes[20] (Heaton 2010). The religious leaders and the Apostolic groups powerfully communicate Apostolic teachings, beliefs and doctrine to the members, and have means to enforce adherence to church teachings and practices. As stated earlier, the pervasiveness of the "Apostolic healthcare system" of faith-healing, healing rituals, and faith in Apostolic faith serve to build and reinforce attachment to it such that there is limited incentive to explore fully modern healthcare services. It is therefore not surprising that across all Apostolic groups with members interviewed in this study, there was a general consensus about faith and the interviewees clearly indicated that one's dependence on modern medical services reflected one's weak faith. The Apostolic religion generally emphasizes faith in their teachings, which ultimately influence decisions about health-seeking options.

Apostolic Religion and Rights and Health of Women and Children

The findings revealed the disproportionate challenges faced by women and children in ultra-conservative Apostolic groups, particularly among members of the Johanne Marange, Madhidha, and conservative variants of Johanne Masowe. Among Johanne Marange Apostolic members, the respondents indicated that the status of women and children is largely determined by dynamics associated with polygamy, religious beliefs and church doctrine that encourage multiple wives and numerous children[21] (Machingura 2011). The practice of polygamy poses risks to HIV and AIDS especially when one of the partner within the sexual network is infected. In addition, religious and socio-cultural practices on wife inheritance, pledging young girls to marriage with older men, and polygamy are nurtured within Johanne Marange, Johanne Masowe yeSabata, and Madhidha Apostolic groups, primarily through doctrinal views about marriages within the Apostolic group.

The ultra-conservative Apostolic groups' teachings emphasize marriage within the church, and discourage women from marrying outside the church. Given that women constitute the majority of Apostolic membership, it inevitably gives Apostolic males an opportunity to marry young girls and many women within the church. In marrying off young girls to older men under the guise of religion, the ultra-conservative Apostolic churches expose these young girls to early pregnancy, pregnancy complications, risks to HIV and AIDS in a multiple sexual network (polygamous relationship), and limit educational opportunities[22] and advancement of the young girls since they are likely to drop out of school. Some of the members of Johanne Marange interviewed in this study anecdotally shared their experiences of early marriages as well as narrated how some young pregnant girls (under the legal age) are wives of older males in the church. Therefore, the involvement of some Apostolic groups in "child marriages", contrary to existing legislation that protects the rights of children, poses fundamental questions about when the "right to religion and the right to

footnotes

20 Heaton (2010) provides a rich analysis of the influence of religion on reproductive behavior, and offers invaluable insights on understanding Apostolic religion and healthcare seeking.

21 Machingura, in his unpublished article on "A Diet of Wives as the Lifestyle of the Vapostori Sects: The Polygamy Debate in the Face of HIV and AIDS in Zimbabwe", sheds critical insights on these issues.

22 Restricting women's education has negative effects on women's status, economic opportunities, maternal health, and ability to make informed choices on health practices as well as access to health services.

childhood" conflict, and religious practices are akin to child abuse. Is it not a human tragedy when young girls are prematurely exposed to marriage, sexual intercourse, pregnancy, and child birth on religious grounds? These manifestations are denial of rights of children or the right to be a child. Similarly, is it not a denial of rights when pregnancy women and children of ultra-conservative religious groups are discouraged from seeking modern medical services on religious premises? This is "a tragedy we hear relatively little about."[23] (Obaid 2005:1161).

In encouraging Apostolic women and pregnant young girls to use "Apostolic health systems" or "makeshift maternity hospitals", the ultra-conservative Apostolic groups (religious objectors) expose them to sub-standard facilities, poor and inadequate medical care, serious pregnancy complications, and increase their risk to death due to birth complications without skilled birth attendants. In addition, without testing for HIV, the women risk transmitting HIV to their newborn babies since they would not have been administered within drug regimens to prevent mother-to-child HIV transmission. All these conditions are driven by theological rigidity (Chitando 2007), which fails to address drivers and co-determinants of maternal and child deaths, HIV and AIDS epidemic, and entrench gender insensitivities and the anti-modern healthcare stance. According to Chitando (2007), theological rigidity fuel stigma, discrimination, and reinforce superficial dichotomy between biomedicine and faith healing in ways that ignore their complementarity as healing systems. He argues that such theological rigidity can be overcome by affirming an action-oriented theology of child and gender rights and a theology of life that recognizes access to life-enhancing drugs while nurturing change in attitudes and beliefs. However, when theological rigidity sustains refusal to obtain medical treatment with serious health implications, and even deaths of Apostolic members, the question of human rights cannot be ignored and calls for analysis of conflict between right to religion and right to health. According to Chimuka and Cheru-Mpambawashe (2011:6), the "rights to health and life are very fundamental human rights and the provision of safe childbirth facilities for all means that there is a double benefit; to expectant mothers and to the infants."

The Rights to Health and Religion: Human Rights Question

The majority of the key informants overwhelmingly stated the need for policy prescriptions and legal enforcement of compulsory immunization of children and use of professionally assisted delivery by pregnant women to address the risks associated with vaccine-preventable diseases and avoidable pregnancy related deaths and complications (Akpotor 2009; Birn 2005; Campbell 2010; Cau, Sevoyan and Agadjanian 2010; Obaid 2005; Stone, Gable and Gingerich 2009; Veerman and Sand 1999). The policy debate and legal studies on addressing the question about what happens when the right to health conflict with the right to religion are critical in view of the mixed feelings among Apostolic members regarding compulsory immunization initiatives undertaken by formal health providers. The ultra-conservative groups deplore these initiatives as a violation of their religious rights. However, some Apostolic members viewed compulsory vaccination positively as an opportunity to have children immunized despite religious objections. The findings also have implications for promoting public health, the rights of women and children, and the role of the State (or government) when religion and health conflict (Stone, Gable and Gingerich 2009; Veerman and Sand 1999).

Policy debate on religious opposition and exemption to immunization is needed in Zimbabwe given the recent cholera and measles outbreaks, and the growing number of the Apostolic community which objects uptake of modern medicines and medical services. There is evidence suggesting the poor uptake of vaccination in the Apostolic religion subjects children to an increased risk of disease outbreaks considering the decreased level of immunity that results from the increased number of non-immunized children in the Apostolic population. Interestingly, the Apostolic members interviewed in this study expressed that their children were less susceptible to diseases common among children because the Holy Spirit (Mweya), prayer, and sanctified water protects them or given them immunity. These religious beliefs strongly influence the Apostolic members' response to disease outbreaks and attitude towards immunization.

'Best Practice Situations': Lessons from the Cholera and Measles Outbreaks

The Apostolic members interviewed in this study acknowledged that the 2008-2009 cholera and 2009-2010 measles outbreaks resulted in many deaths among their membership because of their religious objection to use of modern healthcare services and medicines (Ministry of Health and Child Welfare 2010a; Ministry of Health and

footnotes

23 Thoraya Ahmed Obaid, executive director of the United Nations Population Fund, commenting on the relationship religion and reproductive health and rights.

Child Welfare 2010b). They noted that women and children were disproportionately and adversely affected by these outbreaks, and died while males secretly sought treatment. Notwithstanding this harsh reality, the Apostolic members interviewed lamented the loss of lives which would have been avoided through medical care and overcoming theological rigidity or fixed religious doctrine (Chitando 2007).

In addition, these experiences generated mixed views among the Apostolic respondents as some felt that they were discriminated against and stigmatized as Apostolic members by health workers (Tsoka and Ngwenya 2010) while others did not share those sentiments. The sense of discrimination and stigmatization was largely associated with the perceptions that health providers tend to treat the Apostolic community as homogeneous and hence ignoring its variability. The individual Apostolic members passionately discussed their differences, and deplored the failure by non-Apostolic members to recognize this diversity, which has serious implications on how they are approached as unique religious groups within the Apostolic religion(s). Therefore, they argued that achievement of optimal collaboration and success interventions is predicated on recognizing diversity within the Apostolic community and building bridges, strengthening dialogue and engagement primarily with religious leaders and ultra-conservative apostolic groups.

The massive immunization campaign undertaken by the Ministry of Health and Child Welfare in partnership with UNICEF Zimbabwe, World Health Organization (WHO) and other health providers and development partners from May to June 2010 was positively evaluated by key informants in terms of its ability to increase the routine immunization coverage among children aged 0-14 years. The key informants noted that political will and commitment to immunization, demonstrated by the involvement of parliamentarians (MPs) and government officials during the response to the measles outbreak, ensured effective organizational and social mobilization. The national Measles Taskforce organized meetings with various religious leaders and engaged Apostolic groups through comprehensive IEC to combat the spread of measles and unlock opportunities for Apostolic children to be vaccinated despite religious beliefs. While there were some pockets of resistance primarily from ultra-conservative Apostolic groups, the results of the campaign were overwhelmingly positive in terms of stimulating dialogue with the Apostolic community on the interface between Apostolic doctrine and the need for prevention rather than treatment. Parliamentarians and other local leaders campaigned for uptake of vaccination, which encouraged community participation and increase in the percentage coverage of children between 0-14 years immunized during the National Immunization Days (NIDS) and thus brought the measles outbreak under control.

Recommendations for Strategic Action and Programmatic Interventions

Based on the abovementioned findings, the study recommends:

Network Ties of Committed Apostolic Religious Leaders, Women and Youths

- Strengthen platforms and networks of Apostolic religious leaders who will promote dialogue and positive engagement, particularly focusing on ultra-conservative Apostolic communities (e.g., Johanne Marange, some variants of Johanne Masowe, Madhidha) or religious objectors with strong religious and socio-cultural views. This will create opportunities for nurturing positive responses to the call to action on HIV and AIDS, gender, and maternal and child health etc. Religious leaders and groups command significant influence and respect in the lives of the Apostolic members, and hence need to be "consulted in policy in policy formulation, education and implementation of health programs" (Gyimah et al. 2006:2942).
- Collaborate with religious bodies/ representatives such as UDACIZA in strengthening opportunities for positive change, overcoming theological rigidity, and capacity building. UDACIZA is strategically positioned as a potential partner in IEC activities and accessing the Apostolic membership as well as driving interventions targeting Apostolic youth.
- Strengthening voices of Apostolic women of faith, and promoting reproductive health and rights. A network of Apostolic Women and Girls of Faith will act as a vehicle for empowering Apostolic women and girls to respond to their health needs and constructively address religious and socio-cultural practices that weaken their status and reinforce vulnerabilities.

Policy, Legal Studies, Research

- Policy debates on legislating mandatory healthcare for children and pregnant women
- Research on the conflict between right to religion and right to health recognizing universal human rights analysis

- Research on Apostolic women and reproductive health and rights
- There is need for mapping Apostolic groups and establishing a relatively comprehensive database, which will enable local authorities and health providers to plan and locate other services (water and sanitation, designated places of worship), aimed to benefit the Apostolic communities.

Capacity Building

- Capacity assessment and building of Apostolic midwives to ensure that "acceptable minimum health standards" are practiced to minimize risks to mothers and children as well as the lives of the midwives themselves (Chimuka and Cheru-Mpambawashe 2011). This may require designing targeted training and effective IEC activities for Apostolic midwives since they are largely responsible for delivery among Apostolic women. However, there are policy implications, and this may require innovative thinking in terms of layering healthcare systems to take into account traditional and religious health systems. The Apostolic midwives and "spiritual churches can also be incorporated in some form in the health delivery system" (Gyimah et al. 2006:2942).
- Explore the possibility of setting up a pilot modern health clinic run by professional medical personnel who are members of the Apostolic religion as an experimental study to understand responsiveness and receptiveness to modern healthcare or medical assistance by Apostolic community to medical personnel of their faith.

Information, Education and Communication (IEC)

- Improved, targeted IEC and promotional events to address misinformation and lack of understanding on health matters among Apostolic youths, "midwives", women's faith groups, and leaders, particularly in the ultra-conservative Apostolic groups. The positive lessons from the anti-cholera campaign, particularly its IEC and relationship building strategy, can be replicated in other health promotion initiatives involving Apostolic communities since the majority of the respondents identified them as "best practice".

Conclusion

The real challenge we face today is balancing religion and health, and finding ways of achieving cooperation to improve health outcomes and uptake of modern healthcare services including maternal and child health services. We face pragmatic, yet morally loaded, questions and choices considering the relatively high maternal and child mortality in Africa compared to western countries, Asia and Latin America. Do we allow women and children to die from preventable conditions in our quest to advance African religions? Do we let ultra-conservative religious groups deny the rights of young girls to "childhood" as they are exposed to early marriages and pregnancy in the name of religion? Do we ignore Apostolic makeshift "maternity hospitals" to deliver babies and care for pregnant women "under the carpet" or explore innovative ways of layering the health delivery system so that it is hospitable to women and effectively promote positive health outcomes? What religious tenets and practices are antithetical to universal rights of women and children? In answering these questions, healthy debate, dialogue, and imagination are needed for engendering transformation and shifting religious and socio-cultural practices that stifle the rights of women and children.

This study has demonstrated that Apostolic religion is a key social structural factor influencing maternal and child health among Apostolic members, and affiliation to the ultra-conservative Apostolic groups (religious objectors) is strongly associated with poor or no uptake of modern health care services since these church principles forbid followers from seeking medical services. In such circumstances, ultra-conservative Apostolic groups' religious beliefs potentially result in negative health outcomes since they encourage negative attitudes towards modern maternal and child health services. We can deduce from the findings that members of the ultra-conservative Apostolic groups are at risks of vaccine preventable diseases and avoidable deaths because of their resistance to uptake of modern medicines. Others die silently under the conviction of faith, and resist medical treatment that could save life through appropriate preventive and curative health care provisions. The "choice to die" strictly adhering to Apostolic faith and proscriptions is troubling, and calls into question the overriding influence of ultra-conservative Apostolic religion on health seeking behavior and use of modern healthcare services. If Zimbabwe is to achieve its MDGs 4 and 5, it has to address social inequities in health generated and reinforced by religion and effectively tackle the conflict between the right to religion and the right to health. Religion should never be the vehicle for delivering death (Chimuka and Cheru-Mpambawashe) and undermining the rights of women and children.

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Appendix

Appendix 1: Individual In-depth Interview Guide

Introduction

Good morning / afternoon / evening. My name is _____. On behalf of our research organization (M-Consulting Group) and CCORE, I am conducting a survey on Apostolic Sects and health issues in Zimbabwe. This study seeks to learn from Apostolic Church members how they make decisions about their health and what they do in dealing with illness. The information gathered from this study will assist our nation in developing and improving health policies and interventions as well as making them acceptable to members of the community. The information will also help in highlighting various issues affecting the Apostolic Sect members. The information you share with us will be handled confidentially. Therefore, I sincerely request your cooperation in responding to the following questions, and the interview will take approximately up to an hour of your time (up to 60 minutes). However, at any time during the course of the interview, you are free to terminate the interview. May we proceed with the interview?

Yes: Proceed _____ No: Terminate the Interview _____

Agree to be interviewed: _____ Signature

Official Checks

Interviewer Code:	Venue:
Date:	Time: From _____ to _____
District & Name of Area:	

01. Respondent Code:	09. Household Monthly Income: US$
02. Name of Respondent (optional):	10. Normal Place of Residence:
03. Gender:	11. Name of Apostolic church:
04. Age:	12. Position in church: Leader_____ Follower_____
05. Marital Status:	13. Period in the church:
06. Level of Education:	14. Estimate number of church members:
07. Occupation:	15. Church services / meetings attended monthly:
08. Partner's Educational Level:	

General Questions about Individual Health

•101. What measures do you use to improve your health when you are ill? [Probe: prayers, *traditional healers, traditional medicine, household remedies, spiritual healing, 'holy water'*, etc.]

•102. Please tell me about the last time you fell ill. From whom did you seek advice or first time care? *[Probe: perceived cause of the illness / disease; what treatment was sought]*

•103. Do you seek any skilled, medical professional assistance to achieve health and well-being? *[Probe reasons for seeking or not seeking professional assistance]*

Religious Beliefs

•104. Who teaches about health in your church? What are the main teachings you have learned about health from your church? How are illnesses/ diseases explained in your church? *[Probe: what causes illness / sickness?]*

•105. What recommendations does your church have for protecting your children against ill-health?

•106. Does your church encourage the use of modern healthcare services? *[Probe: church's position on use or non-use of modern healthcare services. Explore church doctrine or theology and perspectives of church leadership on modern healthcare services and vaccination]*

•107. Does the teaching in your church encourage pregnant women to use maternal health services (e.g., antenatal care, postnatal care)? *[Probe reasons and church's position as well as preferred alternative places of deliver]*

Health Beliefs and Health Seeking Behavior

Perceived Susceptibility

•108. If you had a child aged under-five, what are his / her chances of getting diseases common among young children? [Probe: what would make children prone to contracting diseases common among young children? Would you get your children vaccinated against the major diseases affecting young children? *[Probe reasons]*

•109. What are your chances of contracting diseases such as cholera, HIV & AIDS? *[Probe: what conditions are likely to increase your susceptibility to diseases?]*

•110. What does your church recommend to pregnant women to promote their maternal health? *[Probe if the church encourages booking at clinics / hospitals for antenatal care or seek professional assistance to deal with complications/problems women experience in late pregnancy, labor, delivery, and the period immediately after birth. Find out if pregnancy complications are viewed as serious and what can happen to women with these types of problems?]*

•111. Is it necessary for pregnant women to deliver with assistance from health professionals at health centers? *[Probe reasons given and how pregnancy complications are dealt with. Explore the church's position on use health facilities for pregnant women in emergency and non-emergency situations. How are women in your church experiencing serious complications during pregnancy, delivery or after delivery assisted?]*

[Probe information on what steps are taken to deal with the complications and by whom, and what was the outcome]

Perceived Severity (Perceived Seriousness)

•112. In your view, are some health problems more serious than others? Can you name them? What would you do to prevent yourself or a member of your family from getting this condition? *[Probe if some of the conditions are listed below, and explore what the perceived causes are and how one protects against these conditions - Measles, Cholera, Pregnancy Complications, HIV and AIDS?]*

Perceived Barriers & Benefits

•113. What factors are likely to prevent you and your family from using health care services? *[Probe reasons and check if they are based on religious beliefs or other factors. How do these factors affect vaccination of children?]*

•114. Under what circumstances would you seek or not seek medical assistance even when you are ill?

•115. How are Apostolic members that get medical assistance viewed by others in your church?

•116. Under what circumstances would you get your child vaccinated or not vaccinated? *[Probe motivation]*

[Probe: perspectives on the quality and availability of care, difficulties in accessing appropriate care, transport, funds etc.]

Cues to Action & Health Seeking Behavior

•117. If there was a major disease outbreak in your community, from whom would you seek advice?

Whose advice would you be most likely to act on? Would you and your family adhere to modern health preventive measures in case of major disease outbreaks? Where would you seek assistance first? What would be your second option? *[Probe reasons given]*

•118. If a church / spiritual leader encouraged you to use health services, would you adhere to the call? *[Probe reasons for adherence or non-adherence]*

•119. Normally do people in your church agree to test for HIV? Would you get tested for HIV? What would influence you most to get tested for an illness [like HIV, Tuberculosis, or Malaria]? *[Probe reasons]*

•120. If a church member tested HIV positive, would you encourage them to use antiretroviral drugs (ARVs)? *[Ask the respondent to explain his/her response]*

General Health Practices

•121. In the past year, did you ever consult your spiritual leader because of a health problem? *[Probe: reasons given and explore form of assistance or advice one got]*

•122. Have you ever had a situation when you preferred to get health information / assistance outside the church? *[Probe reasons for preferring getting health information / assistance outside the church]*

Appreciative Inquiry –strengthening positive elements and sustaining optimal collaboration

•123. What are the major misunderstandings that your church (Apostolic Sects) experience among health professionals? *[Probe: perceptions of Apostolic members towards health professionals]*

•124. What has been the best experience your church (as Apostolic Sects) has had working with health care providers during disease outbreaks (such as measles / cholera) in your area? *[Probe – what qualifies it the best collaborative experience. Also find out if there has been an experience deemed the worst in working / interacting with healthcare providers]*

•125. What is your church's position on:

o Polygamy?

o Wife inheritance practice?

o Pledging a women or girl child for marriage without her consent?

[Probe: what changes are needed in religious/ social practices in order to reduce susceptibility to HIV and AIDS?]

•126. What needs to be done to ensure optimal collaboration between healthcare providers and Apostolic Church members? How can the relationship between healthcare providers and Apostolic Churches be strengthened?

SAY: Thank you for answering our questions about your experience and perspectives on Apostolic churches and health issues. In case there is anything else you might have left out, please feel free to tell me about it. THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK TO ME.

Appendix 2: Summary of Key Verbatim Responses on Issues and Solutions

Key Issues	Proposed Practical Recommendations by Respondents
Child Health and Challenges related to Major Diseases affecting Under-Five Children • "Our elders picked it up that through the Holy Spirit that there is going to be such and such a disease" (33 year old, married female, Johanne Masowe yeChishanu Nguwo Chena) • "Children not vaccinated by their mothers are prone to getting diseases" (32 year old, married female, Paul Mwazha African Apostolic Church) • "My children do not go for immunization because there is nothing good out of it but merely bring more problems, and those who get affected will be under the spell of the wicked one" (30 year old, married female, Johanne Masowe) • "Rarely does a child in our church get sick because of spiritual healing and prayer. During the rainy season, we continue worshipping in the open but we never catch flue because our spiritual leaders' powers protect us from illness" (32 year old, widow, Johanne Masowe yeChishanu) • "If you take your child to the clinic, you will be found out by the prophets at the church gate, and therefore you are supposed to confess and repent, and then cleansed in order to be accepted back into the church" (46 year old widow, Johanne Marange) • "We don't know what's in the injection, maybe it is something that our church prohibits us to use like pork" (29 year old, divorced female, Sungano Apostolic sect branch of Johanne Marange) • "I do not think that people in our church may want to go to hospitals because there is a binding agreement within our congregation that we should not change our ways" (46 year old, widow, Johanne Marange)	*Solutions* • "We pray for the children, then they go to the clinic to be vaccinated and treated" • "I take my children to the clinic for immunization but this is an individual choice…. Children do get sick but some are taken to the hospital by their parents and some are not depending on the faith of the parents. If they believe that the Holy Spirit will heal their children, then they will not take the children to the clinic" (27 year old, married female, Paul Mwazha African Apostolic Church) • "It is common that children get diseases. I have my children immunized secretly while I continue praying" (28 year old, married female, Johanne Masowe yeChishanu) • "…be hygienic and give children body-building foods to keep them healthy" • "teachings about nutrition and hygiene" • "follow the advice of health professionals" • "If our church elders tell us to go to the hospital, we will go because we obey instructions which are given by elders"…. "If the church leader pronounces it, I would go because the leader is the 'door'"
Maternal Health Challenges • "Every pregnant woman is supposed to seek help; the help is not from the hospitals but from the church. We have church midwives who stand with you from pregnancy to delivery. We do not use hospitals" (39 year old, married female, Johanne Marange)	*Solutions* • "It's necessary that for pregnant women to deliver with assistance of health professionals because they will be monitored for any problems" (32 year old, married female, Paul Mwazha African Apostolic Church)

- "…once a pregnant women goes to the clinic, it shows that she does not have faith in God" (27 year old, married female, Johanne Marange)
- "Our teachings say pregnant women should seek help from elderly women who are responsible for their care. We encourage the use of church midwives because they really know what is wanted by God"
- "…church preaches against use of hospitals and clinics". I do not seek medical assistance because our church does not allow us to take medical pills and consulting health professionals" (67)
- "I don't seek any professional medical assistance. I go to a spiritual healer in line with the church doctrine" (81)
- "We do not seek medical assistance because it is against the tenets of our faith. It [seeking medical assistance] corrupts our holy bodies and shows great signs of lack of faith in God" (89)
- "This problem of home-based deliveries will be difficult to end here in Epworth as mothers heavily rely on it…" (111)
- "It is not safe for pregnant women to give birth at home because if something goes wrong it is not possible to perform caesarian sections at home as they require a skilled surgeon to do that. It saves both the baby and the mother to give birth at the hospitals" (40 year old widow, Johanne Masowe)
- "…doctors are the ones that see how the baby is sitting and also test the mother for HIV" (4)
- "We do use modern medication but in most cases we start by consulting our prophets when we have health problems. The prophet would then recommend whether we seek medical healthcare facilities or not" (19)
- "I want to add that those Apostolic faith churches that do not allow their members to use health facilities should be force to do so by law. Eventually, they will see the advantages resulting in change and acceptance of modern medical services" (108)
- "I think the church elders should be given advice on health matters"
- "Maybe if they [health providers] took time to understand us as Apostolic churches without judging us, maybe there could be better relations" (83)

Barriers to Collaboration

- "…health professionals do not respect our doctrines. They are not supposed to force to do things we do not believe in" (103)
- "I did not see anything because we never worked with health providers when there was the cholera and measles outbreak. Church elders prayed for our children and were healed. Those who were in rural areas were forced to vaccinate their children, and this disturbed our children" (66)
- "I have terrible experiences as my child was forced to be immunized, and up to now he no longer likes going to school. He is now traumatized…" (90)
- "We have never had a smooth collaborative experience because often times we are not given a chance to say our opinion on some compulsory programs" (92)
- "Health professionals use medicines, which is against the laws of Johanne Marange. I do not see any chance of the two working together" (67)

Proposed Solutions

- "The fact that we believe in different things, they are supposed to teach us the advantages of following what they believe in and we decide what we want to do, not forcing us" (103)
- "Healthcare providers came and sunk boreholes so that we could have clean and safe water. We were given buckets and aqua tablets to use for purifying water" (12)
- "They [health providers] reacted quickly by establishing satellite clinics, and health community workers would go door-to-door educating people and making assessments on area cleanliness" (29)
- "…swift response of health professionals in the community"
- During the cholera outbreak, teachings were targeted at all community members and medication was accessible to all to prevent cholera" (74)
- "During the immunization outreach, we were grateful working with health providers. They thoroughly

- "Health providers and Apostolic members should not collaborate at all because church doctrine does not allow the use of medicine even though some members privately access medical services" (76)

educated us about the importance of immunization to the well-being of our children. We also saw the benefits of immunization as our children who were vaccinated were not affected by measles like those of our counterparts who refused to immunize their children" (87)

- "Health officials and church elders should work together so that we all get to know how to achieve better health"
- "Health professionals should be invited to church gatherings to address issues pertaining to health"
- "Whenever there are workshops on health, Apostolic members should be invited to participate so that they understand health issues. Health providers should organize meetings with Apostolic church leaders so that the leaders can build in new teachings and change church doctrine" (75)
- "…continue educating the church elders so that they allow their children and wives, and church embers to go to the clinics openly" (22)
- "The health people should try and understand our ways and not point fingers at us" (23)
- "Cooperation between our elders and health professionals is possible but the health providers should teach our elders how to treat diseases without using medication"

Health Providers' Views on Challenges in Mobilizing Apostolic Groups to Uptake Modern Health Services

- "Marange sect refused to vaccinate their children, and forbade children from receiving treatment despite lot of death of deaths of children in the area" (219)
- "Calling them whilst we are in the clinics doesn't work because they don't come" (224)
- "Campaigns didn't work, they simply ignored them"
- "What failed to work is to force them to take medication" (231)
- "We failed by forcing them last time. It was a big crime committed. We went with riot police…It is difficult for us to walk in the community because of that. This will never work" (233)
- "During the National Immunization Days (2010) targeting measles elimination, we did our mobilization

Recommendations

- "Talk to church elders concerning health"
- "Mobile clinics work well"
- "Promote area health meetings with leaders and stakeholders"
- "When other nurses who are members of the Apostolic churches asked for permission from church leaders to assist, it worked well because they were speaking the same language"
- "Knowing when and where there could be church gatherings, and approach the leaders for time slots to conduct health promotion and awareness...Dissemination of information during general church gatherings may assist"
- "Selective use of police force during immunization and cholera campaigns worked in some areas"

very well but by the time we went to their [Apostolic members] houses unfortunately there were only older people and no children in the houses since they had all ran away" (235) • "Any awareness with a clinical bias including family planning methods, some Apostolic members will not accept but there are some that will privately consult health professionals" (240)	• "Promote basic education and access to secondary education for girl child" • "Apostolic Summit on Child Health and Immunization" • "There is need to keep educating them intensively until they understand" • "…sit down and talk to elders of Apostolic sects. This should yield results because they [members] respect their elders and normally would do what they will tell them" • "Legislate compulsory vaccination and use of maternal and child health services"