Health and Religion: A Rhetorical Enquiry into the Role of Pentecostal Christianity in the Health of Black African Women.

A Thesis Presented for the

Master of Arts

Degree

The University of Tennessee, Knoxville

Stefania Grant

August 2025

Acknowledgement

I would first of all thank Jesus Christ, the great shepherd and keeper of my soul, for bringing me this far. I thank my mother, Ms. Margaret Eshun, and my grandmother, Madam Florence Sowah, for their immense support throughout my education. My immediate family, Mr. Ernest Arku, Mrs. Theodora Barkers, and Mr. Henry Arku, for their constant support in the course of my Master's program. My lecturers from the Kwame Nkrumah University of Science and Technology's department of English are not exempt from my gratitude, as they were very helpful and supportive in directing my next steps after my undergraduate degree. I thank the very brilliant, humble, and extremely dedicated professors I met in the course of my graduate program, including Dr. Jeffrey Ringer, Dr. Alexander Jamal-Jared, Dr. Lisa King, Dr. Tanita Saenkhum, Dr. Anne Lagendorfer, Dr. Danara Wallace, and Dr. Rima Elabdali. Their intellectual ability and unwavering support during my studies will always be a mark on my heart and a value worth emulating. I thank my peers who were always accommodating with my numerous questions on academic matters and textual resources. I also thank the International House, which includes the institutional and religious wing, for their guidance in my first year of transitioning into the Master's program. Finally, I say thank you to all my research participants who were willing to participate in the interviews and shared their valuable experiences with me.

Abstract

This study explores how Black Pentecostal Christian women in the United States and primarily Ghana perceive their health and healthcare experiences, with a particular focus on the relationship between Christianity and health through the lens of faith healing and positive emotions. Grounded in a constructionist and interpretivist framework, the research employs phenomenological interviewing to capture participants' lived experiences. A convenience and snowball sampling approach was used to recruit participants, with interviews conducted via Zoom and transcribed using Otter.ai. This project contributes to ongoing discussions in the Rhetoric of Religion and Health and religious approaches to healthcare. It highlights how Black Pentecostal women in Ghana and the U.S. use faith-based narratives as central rhetorical resources for making meaning of illness and healthcare decisions. Drawing from the broader Rhetoric of Health and Medicine, the study aligns with scholarship emphasizing patient narratives, spiritual agency, and culturally informed care (Attard et al. 2020; Hamilton 2020). The World Health Organization (WHO) estimates that around 80% of the population in developing countries rely on Traditional and Faith Healing (TAFH) due to disparities in access to orthodox medical care. Some scholars also assert that prayer, meditation, and collective worship foster positive emotions, which enhance social connections, increase psychological resilience, and may even alleviate symptoms of illness. By examining the intersection of faith, healthcare, and well-being, this research highlights how spirituality influences health perceptions and decision-making among Black Pentecostal women. It also provides insight into how religious beliefs shape healthcare engagement in contexts where faith healing is an integral part of health-seeking behaviors.

Keywords: Black Pentecostal women, Pentecostalism, faith healing, positive emotions, religion and health, healthcare disparities, Traditional healing, qualitative research, phenomenology, constructionism, Ghana, United States

Table of Contents

Chapter One: Introduction	1
Chapter Two: Literature Review	**Error! Bookmark not defined.**
Chapter Three: Methodology	32
Chapter Four: Results/Findings	55
Chapter Five: Discussion	70
Chapter Six: Conclusion	83
References	89
Appendices	93
Vita	103

Chapter One: Introduction

My inquiry into the intersection of faith, healing, and rhetoric began with a personal story that stems from my family's health and religious journey. My religious background has transitioned through several episodes of joy, confusion, fear, acceptance, and hope. This journey has shaped not only my personal faith but also my academic interests. For example, my early experiences with Christianity were shaped by Methodism, as I attended a Methodist church with my grandmother. Growing up, I came to understand and define faith through historical figures. To me, Methodism was synonymous with John Wesley, whose teachings emphasized personal devotion, holiness, and structured worship. My grandmother exemplified this devotion. She faithfully paid tithes, attended Sunday services, and sang hymns with reverence. Christianity, in this sense, represented stability, duty, and spiritual solace.

By the time I reached fourth grade, I experienced a significant shift in our Christian denomination. My mother, who had been working overseas, returned home unexpectedly. What I thought would be a brief visit became a turning point in our spiritual journey. She had been battling a series of illnesses, and when doctors abroad advised her to undergo surgery, she panicked, fearing an unsuccessful procedure, and chose to return home instead. This moment marked a new direction in our faith, one centered more on healing and spiritual intervention. What followed was a whirlwind of religious transitions. Our once-familiar Methodist faith was left behind as my mother sought divine healing in different church spaces. Over the next fifteen years, we moved from Methodism to Charismatic Christianity and eventually to Pentecostalism, each transition shaped by her pursuit of healing and spiritual comfort. This period felt unstable and disorienting due to the rapid movement from one church to another. During this time, I came to associate Pentecostalism with James McKeown, the founder of the Church of Pentecost in

Ghana. His movement emphasized miracles, prophecy, and divine healing. Pentecostalism, as a form of Christianity, highlights the experience of the Holy Spirit, including spiritual gifts such as speaking in tongues, healing, prophecy, and miracles (Meyer, 2004). In Ghana, Pentecostalism is known for its dynamic worship, strong belief in faith healing, and a focus on personal transformation through the power of God (Wyllie, 1974).

My mother and grandmother fully embraced this new faith, engaging in deliverance services, prophetic declarations, and faith-based healing practices. I became both an observer and a witness to the ways faith and health intertwined, often in ways that seemed contradictory. For example, I saw flashy, wealthy pastors in exorbitantly expensive shoes leading congregations made up mostly of women who poured their time, energy, and finances into these churches. My mother and grandmother became deeply immersed in this cycle of faith-based healing, often prioritizing church gatherings, anointing oils, and prophetic encounters over medical interventions. My mother's health, however, did not improve. Instead, I watched as her condition deteriorated over time, along with our family's finances. More money was spent on church offerings, spiritual consultations, and sacred objects than on the few hospitals we had visited. I began to question why my mother had still not received her healing, as neither the church gatherings nor the hospital medications yielded any results.

I asked myself: Was faith enough? Were the spiritual practices failing her, or was there something more complex at play? How did others reconcile their faith with the harsh realities of illness? I observed a tension between hope and despair, frustration and the application of faith in health dilemmas. These questions, and the lived contradictions I witnessed, became the inspiration behind this thesis, leading me to explore how the Ghanaian Black Pentecostal women

living in the U.S and primarily Ghana, talk about their sense of health and faith healing and also how they engage with these two avenues of healing.

However, this research is not an attempt to negate or dismiss faith. Religious beliefs and spiritual practices play a crucial role in shaping health-related behaviors, particularly among Ghanaian communities. Many individuals in these populations integrate faith-based approaches into their healthcare decisions, often viewing spiritual well-being as an essential component of overall health (Dessio et al. 2014). My mother's experience does not serve as a critique of Christianity, Pentecostalism, or faith-based healing practices. Rather, it has inspired me to ask deeper questions about how the faith of Christian women intersects with their health and well-being. While I saw the challenges and financial strains that faith-based healing placed on my family, I also witnessed the comfort, strength, and hope it provided. Many women like my mother turn to faith not simply out of desperation, but because they genuinely believe in its power to heal, sustain, and guide them.

This realization led me to frame my research around the intersection of faith, health, and rhetoric, particularly in the lives of Black Pentecostal Christian women in Ghana. Their stories do not necessarily reflect the same reliance on divine intervention as my mother's, but instead reveal an openness to the possibilities of divine healing. Within the field of Rhetoric of Health and Medicine (RHM), some scholars have increasingly turned their attention to non-biomedical frameworks of care, including faith-based and traditional healing. Rhetoric of Health and Medicine is a field of study that examines how words, symbols, and communication strategies affect medical decisions and patient experiences. Authors such as Scott et al. explain that the Rhetoric of Health and Medicine (RHM) started as a branch of the rhetoric of science, but it has since developed into its own field. This shift means that RHM does not just study how scientists

communicate but how doctors and patients interact with each other. The field also studies how people use language to understand their own health experiences. This focus on lived, embodied narratives aligns with Alexander and Edenfield's concept of tactical folk medicine (Alexander and Edenfield), especially in instances where patients may have unsatisfactory interactions with the healthcare system. Alexander and Edenfield's work demonstrates how marginalized communities develop and maintain alternative health practices in response to systemic exclusions and institutional failures in mainstream medicine. These practices are not simply cultural artifacts; they are acts of rhetorical agency that challenge dominant biomedical paradigms while asserting survival and livelihood.

In my study, the participants' narratives on their religious backgrounds and faith healing clearly reflect this concept. For example, some women recounted how their early religious upbringing, praying mothers, scripture-based discipline, church attendance, and religious fellowships formed a foundation for later faith-based health decisions. When formal healthcare systems failed to meet their needs or were inaccessible, they often turned to what Alexander and Edenfield, in their 2021 article, call tactical folk medicine: marginalized groups' deliberate use of alternative healing practices as acts of survival and care, in response to systemic failures in institutional healthcare. These include spiritual remedies, prophetic encounters, and communal rituals rooted in their Pentecostal knowledge and experiences. These practices, embedded in personal and collective memory, served not only as responses to illness but also as affirmations of faith, self-determination, and religious continuity. A key distinction between Alexander and Edenfield's framework of Tactical Folk Medicine (TFM) and the findings in this research lies in the source of healing power each centers. Alexander and Edenfield describe TFM as a tactical practice rooted in practical knowledge and community-based improvisation in response to

systemic healthcare exclusion. In contrast, the women interviewed in this study may often approach healing through a theology of divine possibility where prayer, prophetic utterance, and deliverance are not simply tools of resistance, but active channels for supernatural intervention. Their belief systems do not rest solely on adapting to the absence of biomedicine; they are grounded in the expectation that divine healing is real and accessible.

This study addresses a gap in RHM by focusing on the voices of Black Pentecostal women in two distinct yet parallel contexts. While RHM has engaged with cultural rhetorics and patient narratives, it has not sufficiently explored the rhetorical strategies of faith-based healing within global Black Pentecostal traditions. I will discuss more of these instances in the literature review section. Some of the research questions that guide this study are:

1. How do Ghanaian Black Pentecostal Christian women talk about religion and spirituality and its influence on their health choices?
2. How do these Ghanaian Black Pentecostal Christian women view the benefits and limitations of faith healing?

To answer these questions, I interviewed ten Black Pentecostal Christian women born and bred in Ghana using Seidman's phenomenological method of interviewing, capturing their lived experiences and rhetorical expressions related to faith and health. Across African and American contexts, individuals of African descent face similar healthcare challenges, including limited access, high costs, and uneven care quality. Despite different systems, both regions reflect deep-rooted inequities shaped by history and race. Their experiences reveal how faith-based healing serves not only as a response to local healthcare gaps but also as part of a broader, transnational pattern of resilience in the face of systemic health imbalance.

My research is not just an academic endeavor. It is also a personal exploration of questions that have lingered in my mind for some time. I realize that my mother's experiences may share similarities with those of my participants. These women shared experiences in both private and public hospitals and reflected on how their faith influenced their decision-making and healing outcomes. Some participants reported positive outcomes that they attributed to faith, while others faced dead ends. Even so, the findings from this study revealed that their faith and healthcare experiences are not opposing forces, but coexisting frameworks that help them make sense of their health journeys, often blending prayer, wisdom, and medical action.

The findings align with Alexander and Edenfield's assertion that such faith-based health narratives function as tactical, not incidental, practices that offer rhetorical agency and resistance. Participants' stories show how early religious formation and faith traditions become the basis for engaging with illness, especially when institutional medicine falls short. Their narratives reinforce how faith, far from being irrational or desperate, is a dynamic and embodied response to lived health experiences. Historically, the Black Church has served as more than just a spiritual refuge. As Eric Lincoln and Lawrence Mamiya (1990) argue in *The Black Church in the African American Experience*, the church has long played an integral role in the economic, political, spiritual, and health-related lives of Black communities. Similarly, in both African American and Ghanaian contexts, the church often functions as a responder in times of illness, offering not only prayer but community support and a rhetorical framework through which to understand suffering and recovery. In sum, my thesis examines how Black Pentecostal women draw on faith not only as belief but as practice, where faith serves as a way to endure, make sense of, and at times rise above the limitations and disappointments of the healthcare system. They navigate illness, seek healing, and assert spiritual agency through the language, rituals, and

memories shaped by their religious upbringing. My personal narrative, shaped by childhood bouts of illness, family reliance on preventive medicine, and experiences with both hospitals and prayer camps, forms the backbone of this inquiry. I hope this research not only contributes to RHM scholarship but also honors the journeys of the women who entrusted me with their stories.

In the next chapter, which is the second chapter of this study, I will delve into the key literature, which I divided into themes that inform this research. The third chapter will outline the research methodology, detailing the qualitative approach, participant selection, and ethical considerations that shaped this study. The fourth chapter will present the findings, highlighting their religious upbringing, ways Black Pentecostal Christian women construct and embody healing through faith, and their concerns of the healthcare spaces they experienced. The fifth chapter will discuss the implications of these findings for healthcare policy and rhetorical scholarship, especially in relation to faith-based healing, medical mistrust, and culturally responsive care. The final chapter will offer concluding reflections, summarizing key insights of the study.

Chapter Two: Literature Review

In this chapter, I will explore themes such as health and healthcare in both the American and Ghanaian contexts, the role of religion and spirituality in health, the influence of Pentecostalism in Ghana, and the ongoing strides and gaps in the rhetoric of health and medicine when it comes to religious rhetorics and patient narratives. These themes are important because they help us understand how Black Pentecostal Christian women make meaning of their health experiences. While the primary focus of this study centers on the lived experiences of Ghanaian Pentecostal women, it is important to note that the participants I interviewed include women residing in Ghana, the United States, and one Ghanaian woman living in Italy due to limitations in recruitment hence some convenience sampling involved. Despite their current geographic locations, all participants shared narratives primarily rooted in the Ghanaian sociocultural and religious context. Most of the women, although currently living in the United States, expressed that they did not have much direct experience with the American healthcare system. However, I found it important to include references to the American context in the literature review for two reasons: first, because half of the women I interviewed now live in the U.S. and are inevitably influenced by its health culture and systems; and second, because some scholarly texts such Braxton's "No Pain No Gain" which I encountered during my master's program here in the U.S. contributed to shaping this study and they emerge from African American health discourse. Moreover, themes such as chronic illness, mistrust in healthcare systems, and the role of faith-based alternatives are concerns that cut across both Ghanaian and African American communities. While the study remains grounded in Ghanaian experience, engaging with American literature provides a comparative rhetorical lens and allows more understanding of

how Black Pentecostal women interpret and articulate healing across different but interconnected healthcare systems.

Health and healthcare in the African and American contexts are connected in several important ways, especially when considering the experiences of people of African descent. Both Ghana and the U.S face challenges related to access, affordability, and the quality of healthcare services, particularly among marginalized groups. In the United States, African Americans often struggle with chronic illnesses, mental health issues, and healthcare disparities rooted in systemic racism and socioeconomic inequality. Similarly, in Ghana, people face limited access to medical facilities, shortages of healthcare professionals, and financial barriers to care. Despite the differences in setting and resources, both contexts reveal how social, economic, and cultural factors shape health outcomes. In addition, people in both countries often turn to religion and spirituality as key sources of comfort, guidance, and healing (Peprah et al.; Dessio et al.). These shared experiences make it meaningful to study African and African American health contexts together, as they highlight the relevance of faith in navigating healthcare systems and coping with illness.

Currently, health expertise is in high demand on a global scale as a result of the increase in stressful health conditions among individuals (Benavidez et al.). Individuals with diseases such as hypertension or even a common headache could end up in states of emergency. This is often due to fast-paced lifestyles, economic pressures, and limited access to consistent healthcare. Benavidez et al. in their 2024 article on chronic disease prevalence in the US, state that “An estimated 129 million people in the US have at least 1 major chronic disease (eg, heart disease, cancer, diabetes, obesity, hypertension) as defined by the US Department of Health and Human Services “ (p.1). Despite the fact, chronic diseases may be a result of the non-helpful

health practices of individuals, they are influenced by the social determinants of health (SDOH), which include socio-economic and environmental factors such as affordable healthcare and physical access to it.

In light of this, Malkowski, Scott, and Keränen (2016) argue that rhetorical approaches to health call attention to the ways in which health is socially constructed and culturally mediated, showing that health is not merely a result of biological predisposition or individual choices. They bring to light this idea by insisting that health discourse, how individuals talk about illness, wellness, care, and responsibility, is deeply embedded in power dynamics and systems of inequality. The narratives around who deserves care, who gets blamed for illness, and how illness is portrayed in public rhetoric often mirror broader societal biases related to race, class, gender, and citizenship. Understanding health through a rhetorical lens allows scholars and practitioners to interrogate how structures of privilege and marginalization influence who receives timely, effective healthcare and who is left behind. In the same vein, the narratives of Ghanaian Pentecostal Christian women I interviewed, both in Ghana, the U.S, and one Ghanaian currently living in Italy, highlight how dominant health systems shaped by racial, economic, and gendered inequities often overlook or marginalize the experiences of women.

Health and Healthcare in the Ghanaian Context

In Ghana, health and healthcare expenses remain a critical concern, particularly as the cost of medical services continues to rise amid economic challenges. While the National Health Insurance Scheme (NHIS) was introduced to increase access to affordable healthcare, many Ghanaians still pay out-of-pocket for essential services due to gaps in coverage, drug shortages, and limited healthcare infrastructure. This aligns with broader research in the Ghanaian context, where out-of-pocket expenses continue to be a significant obstacle to accessing healthcare

(Aikins et al.). The financial burden often leads individuals to delay treatment or seek alternative forms of care, including traditional or faith-based healing. As a result, preventable and manageable conditions can escalate, contributing to higher long-term costs and increased strain on both families and the healthcare system.

Faced with limited access and unaffordable costs, many individuals engage in what Alexander and Edenfield describe as “tactical folk medicine,” which refers to strategic choices by marginalized groups who navigate gaps in formal medical systems by turning to alternative frameworks such as spiritual healing, herbal remedies, or communal care. Alexander and Edenfield further define tactical folk medicine as the improvised, strategic use of traditional or culturally-rooted healing practices by marginalized communities in response to systemic neglect or exclusion from institutional healthcare systems. They explore how Black communities develop alternative modes of care, such as folk practices and complementary medicine as acts of survival, resistance, and rhetorical agency. These practices are not merely “folk” in a nostalgic or primitive sense, but tactical. They are adaptive, responsive, and rooted in both cultural memory and lived necessity. Specifically, tactical in Alexander and Edenfield draws from Michel de Certeau's 1984 concept of tactics as everyday acts of resistance by people who lack institutional power. Tactical folk medicine thus becomes a response to exclusion, or inaccessibility, and a rhetorical practice which communicates values, asserts dignity, and challenges dominant narratives about health and legitimacy. Although Alexander and Edenfield’s work is situated in the Black American context, the concept of tactical folk medicine resonates in the Ghanaian context too, through how Ghanaians resort to religious and traditional remedies when they cannot afford healthcare. There are also other concerns that reflect broader systemic challenges

in Ghana's healthcare system, such as staff shortages, limited resources, and uneven training, all of which affect patient experiences and outcomes.

The health landscape in Ghana is shaped by a combination of disease prevalence, healthcare access, and socio-economic disparities. Cardiovascular diseases (CVDs) and other chronic non-communicable diseases (CNCDs) pose significant health challenges, while access to healthcare services remains inequitable, particularly for marginalized groups. A meta-analysis conducted by Doku et al. revealed a concerning prevalence of CVD in Ghana, estimated at 10.34%. The study found that hospital-based settings recorded a significantly higher prevalence (10.74%) compared to community-based settings (5.04%), indicating that many individuals may not seek medical attention until conditions become severe (Doku et al.). In other words, key risk factors for CVD include male gender, older age, unemployment, diabetes, and hypertension. These findings show the need for increased preventive care and early intervention, particularly in community settings where the prevalence of CVD is lower, potentially due to underreporting or lack of healthcare access.

Beyond cardiovascular diseases CVD, chronic non-communicable diseases more broadly account for approximately 43% of all deaths in Ghana, as found by Tuoyire et al. The study identified several factors negatively impacting health-related quality of life (HRQoL), such as older age, unemployment, and the presence of multiple chronic conditions (Tuoyire et al., 2017). This aligns with the findings on cardiovascular diseases, where similar socio-economic vulnerabilities contribute to poor health outcomes. The overlap in risk factors hints that improving economic conditions and expanding employment opportunities could indirectly enhance public health outcomes. This hints at why faith-based healing becomes an important alternative for many Black Christian women in living in Ghana, the U.S., and even abroad. When

women face economic hardship or unemployment, they are more likely to encounter challenges in accessing consistent, quality healthcare. This reality shapes how they talk about religion and spirituality in relation to their health because faith becomes not only a spiritual anchor but also a practical resource when formal medical options are limited or unaffordable. As Derkatch (2018) puts it, “wellness discourse relies on a language that is “self-generating”, meaning that individuals can claim authority over their own health through alternative narratives and practices outside of institutional medicine (p.132).

Healthcare utilization in Ghana further reflects disparities based on socio-economic status, wealth, and insurance coverage. Tuoyire’s analysis of the 2017 Ghana Living Standard Survey (GLSS) found that individuals in the “highest wealth quintiles” utilized healthcare services 22% more than those in the lowest wealth quintiles. Moreover, those with valid health insurance were 77% more likely to seek healthcare than uninsured individuals (Tuoyire, 2017). The gap in healthcare access extends to disease severity as patients with severe illnesses were 65% more likely to seek medical care compared to those with acute conditions. These patterns suggest that financial security and insurance coverage play a crucial role in healthcare utilization, reinforcing the need for policies that expand insurance access and reduce out-of-pocket expenses for low-income populations.

Spatial disparities further compound healthcare inequities in Ghanaian cities. Dumedah et al. analyzed access to health services in urban areas, finding that the number of physicians per 10,000 people was as low as 1.78 in some locations, falling far below the World Health Organization’s recommended threshold (Dumedah et al., 2021). The study also noted that economically disadvantaged populations endured longer travel distances to access healthcare, exacerbating inequities. When combined with Tuoyire et al.’s findings on healthcare utilization,

it becomes evident that financial constraints and geographical barriers collectively hinder access to quality medical care.

The intersection of healthcare access, economic status, and health outcomes is also reflected in the rhetorical dynamics between patients and physicians. Segal (2008) explains the role of credibility in medical encounters, emphasizing that a patient's ability to communicate effectively with a physician can influence the quality of care received. In Ghana's context, where disparities exist in access and utilization, factors such as literacy, health education, and socioeconomic background likely influence how patients navigate the healthcare system. Those with limited education or lower socio-economic status may struggle to advocate for themselves effectively, potentially leading to suboptimal care. This claim connects to Pentecostalism in Ghana by highlighting why many people, especially those with limited education or lower socioeconomic status, are drawn to Pentecostal churches as alternative spaces for health, empowerment, and care. In contexts where navigating the formal healthcare system is difficult due to low literacy, lack of health education, expensive healthcare, or economic hardship, Pentecostalism offers an accessible and culturally resonant alternative. Many Pentecostal churches provide spiritual explanations for illness, promote divine healing through prayer and deliverance, and foster supportive communities where believers feel seen and heard. It is the rhetoric coming out of these churches that shapes the rhetorical practices of women when seeking remedies for healthcare. This can be especially important for those who feel overlooked or mistreated in medical settings. Additionally, Pentecostal teachings often emphasize personal agency through faith, which can feel empowering to individuals who may not have the resources to influence outcomes in medical spaces. Faith becomes a way to reclaim control over one's health and well-being. Rachel Monroe (2017) observes in her exploration of essential oil use in

the U.S., such wellness practices often "offer the illusion of control in a chaotic world," suggesting a transnational parallel in how health practices rooted in belief can provide psychological relief and a sense of empowerment. Rachel Monroe also asserts that in times of uncertainty and emotional strain, people often turn to "natural" or spiritual remedies not simply for their perceived healing properties but because these remedies offer comfort, control, and a sense of meaning in an otherwise overwhelming healthcare landscape. For Ghanaian Pentecostal Christian women both in Ghana and in the US, the church and its healing practices fulfill a similar role, offering emotional reassurance, spiritual clarity, and a community-based system of care when biomedicine feels inaccessible or unresponsive.

Collectively, these studies reveal persistent structural problems within Ghana's healthcare system. Disparities in healthcare access remain widespread, with physician shortages limiting timely medical attention, especially in rural and underserved areas. Health insurance coverage is often insufficient, leaving many individuals to bear high out-of-pocket expenses. Additionally, inadequate healthcare infrastructure in economically disadvantaged and geographically isolated regions further restricts access to quality care, exacerbating health inequities across the country. In the next section, I will discuss health and healthcare in the African American context as it shares similar limitations with the Ghanaian healthcare system.

Health disparities among African Americans in the United States remain a critical concern, with chronic diseases disproportionately affecting this population. Research suggests that socio-economic factors, mental health, and spirituality all play significant roles in shaping health outcomes (Braxton et al.; Robinson et al.). Also, chronic pain among older African American patients is not merely a biomedical issue. It is a rhetorical and emotional experience shaped by cultural context and a long history of mistrust in medical institutions. These patients

often face a healthcare system that questions or diminishes their accounts of suffering, forcing them to navigate complex dynamics of disbelief and misinterpretation (Braxton et al.). Patients out of medical distrust may resort to non-compliance in the form of refusing to take medication or delaying the need to seek treatment. Here, the refusal to seek care may be out of a history of medical neglect.

Robinson et al.'s study on hopelessness and chronic disease among African Americans highlights the psychological toll of chronic illness. Using data from the National Survey of American Life, the study found that 13.14% of respondents reported high levels of hopelessness, while 31.5% reported moderate levels. Additionally, 19% of respondents had experienced chronic disease, and those with chronic illness reported significantly higher hopelessness scores than those without. These findings reinforce previous research on the link between psychological distress and poor health outcomes within Black communities. In exploring the lived experiences behind these statistics, Braxton et al. (2023) provide a narrative analysis of how older African American patients articulate their experiences with chronic pain management. Their findings highlight that pain is not just a biomedical issue, but a rhetorical and emotional one, often shaped by patients' cultural contexts and historical mistrust of medical institutions. As the authors note, "patients' accounts of pain are saturated with the complexities of navigating a healthcare system that often disbelieves, misinterprets, or minimizes their suffering" (Braxton et al. 2023). These narratives show the importance of listening to how patients talk about pain, not just how it is clinically measured, emphasizing the need for more culturally sensitive approaches to chronic illness.

The broader demographic trends in the U.S. indicate a growing African American and Caribbean Black population, which is expected to increase from 12.3% of the total U.S. population to 17.9% by 2060 (U.S. Census 2015). Likewise, the Black immigrant population has quadrupled since 1980, with approximately half of these individuals coming from the Caribbean (Anderson, 2015). Despite this growth, health disparities persist. African Americans and Caribbean Blacks continue to experience worse health outcomes than non-Hispanic Whites. Existing literature on these populations remains scarce, and few national studies have explored how these groups cope with chronic disease.

Research indicates that optimism and pessimism influence health outcomes, with individuals exhibiting greater pessimism being more prone to illness. Robinson's study extends this understanding by examining hopelessness as a psychological determinant of chronic disease, reinforcing the need for interventions that address both mental and physical health. Given that chronic diseases may be among the leading causes of death in the U.S., with nearly half of adults living with at least one chronic condition (Ward et al. 2012; CDC 2016), addressing these disparities is crucial. Moreover, chronic diseases account for seven out of ten deaths annually and 86% of all healthcare expenditures in the U.S. (CDC 2016).

One significant finding in Robinson et al.'s study is the inverse relationship between spirituality and hopelessness. Individuals with higher levels of spirituality exhibited lower levels of hopelessness, which aligns with previous research indicating that Black men and women in the US report higher levels of spirituality compared to White populations. Spirituality in Robinson et al.'s, is portrayed as a directional tool with tangible potential for mental health and wellbeing, pointing to strategies clinicians can leverage to better support patients navigating chronic illness. This connection aligns closely with my participants' understanding of faith in

Ghanaian Pentecostal contexts, where spirituality is not simply a personal belief but a source of emotional resilience. Faith-based organizations, particularly Black churches, have long served as essential sources of emotional and social support within Black communities (Lincoln and Mamiya 1990). This suggests that spirituality may function as a rhetorical attitude that spirituality and faith traditions make possible. Understanding spirituality as a rhetorical attitude, a way of seeing, interpreting, and responding to the world helps reveal how religious frameworks and spirituality shape not only belief systems but also material actions related to health and healing.

Religion and Spirituality

Religious beliefs and spiritual practices play a crucial role in shaping health-related behaviors, particularly among African American and Ghanaian communities. Studies have shown that African American women frequently turn to religion and spirituality for health-related reasons (Dessio et al.). According to Dessio et al., approximately 43% of African American women reported using religion or spirituality as a coping mechanism for managing serious health conditions such as cancer, heart disease, and depression (190). The reliance on spirituality as a source of healing and also a coping mechanism reflects a broader trend in Black communities where religious institutions, particularly churches, serve as central pillars of support and guidance (Hamilton 338).

Research sheds light on the view that spirituality and religious traditions significantly affect therapeutic approaches for African American women. Therapeutic approaches are connected to religion and spirituality for African American women in that many view their faith not just as a belief system, but as a key part of how they cope with emotional, psychological, and even physical challenges. Frame et al. discuss how emotional solitude and self-reliance are

common themes in the experiences of African American women seeking counseling. Spirituality serves as a framework through which these individuals process emotional and psychological distress (182). Counseling that incorporates religious and spiritual dimensions often resonates deeply with African American women, underlying the need for culturally sensitive therapeutic interventions.

Similarly, faith healing is a prominent practice in Ghanaian communities. Peprah et al. note that faith healing services are increasingly sought after for both curative and preventive healthcare, particularly in sub-Saharan Africa. Although Peprah et al. do not explicitly define faith healing, they characterize it as a practice rooted in Ghanaian society involving the diagnosis, prevention, and treatment of various health issues through spiritual means. Many individuals turn to faith healers who may be affiliated with mission churches, African independent churches, or traditional spiritual practices, believing that their illnesses have spiritual origins and require divine intervention (Peprah et al., 2018). Mission churches are those established by foreign missionaries, bringing traditional Christian teachings to the region, and are often more structured in their worship practices. On the other hand, African independent churches are local churches founded by Africans, blending Christian beliefs with African cultural practices, such as incorporating music, dance, and rituals into their worship. Meanwhile, traditional spiritual practices involve indigenous beliefs, including rituals and ceremonies that honor spirits, ancestors, and natural forces, often coexisting with Christian faith in some communities. This turn toward faith-based care can also be read as a critique of and response to the limitations of biomedicine in addressing the full reality of Black health experiences. As Segal (2008) argues, medicine is not just a science but a “rhetoric” that “responds to the social order

and helps to sustain it" (Segal, 2008, p. 5). This framing highlights how medical knowledge and practices are shaped by, and in turn shape, broader social, cultural, and political structures.

Within Black communities, this rhetorical nature of medicine becomes especially apparent. Biomedical frameworks often emphasize objectivity, standardization, and physical symptoms, but they frequently overlook the cultural, spiritual, and emotional realities that many patients bring to their healing journeys. In response to these limitations, faith and church spaces within Black communities operate as alternative sites of care and resistance. These spiritual spaces do not merely supplement biomedical care. They challenge its boundaries by centering lived experience, collective memory, and spiritual authority. In doing so, they offer a more holistic approach to health that affirms the interconnectedness of body, mind, and spirit, and provides culturally resonant forms of healing that the dominant medical system often neglects or dismisses.

Faith healers utilize prayer, anointing oils, and holy water, practices that many believers perceive as effective in treating ailments ranging from mental health conditions to infectious diseases. This preference for faith healing is often linked to its accessibility, affordability, and cultural relevance, particularly in contexts where biomedical healthcare services may be difficult to access (Peprah et al., 2018). As Monroe (2017) observes, alternative remedies appeal in part because they provide a feeling of ease, a sense of control, and purpose in a healthcare system that often feels confusing and stressful. This hints at why faith-based healing becomes an important alternative for many Ghanaian Black Pentecostal Christian women. When women face economic hardship or unemployment, they are more likely to encounter challenges in accessing consistent, quality healthcare (Benavidez et al.). This reality shapes how they talk about religion and spirituality in relation to their health because faith becomes not only a spiritual anchor but also a

practical resource when formal medical options are limited or unaffordable. Moreover, as Derkatch (2018) explains, the language of wellness and natural healing is "self-generating," giving authority to personal testimony over institutional expertise (p. 132). In other words, health narratives within these alternative frameworks often rely not on clinical trials or scientific validation, but on the lived experiences and stories of those who claim healing. These stories circulate within communities and gain power through repetition, creating a rhetorical system that reinforces belief and efficacy through personal and collective memory. This self-perpetuating dynamic allows individuals to validate and share healing experiences outside the bounds of biomedical legitimacy, privileging community knowledge over technocratic authority. Within the Ghanaian Pentecostal context, such testimonial knowledge aligns closely with religious values, where witnessing, testimony, and faith are already integral parts of the spiritual experience. As such, Derkatch's concept helps explain why many turn to spiritual healing even in the absence of medical endorsement. It offers not only potential relief but also social legitimacy and spiritual resonance rooted in shared belief.

Pentecostal traditions further illustrate the deep-rooted connection between faith and healing. Historically influenced by the North American Holiness movements, Pentecostal practices emphasize divine healing as a fundamental aspect of faith. This belief traces to figures such as A. B. Simpson (1890), who argued that if sickness resulted from the Fall, then healing must be included in Christ's atonement. This theological perspective led to the widespread Pentecostal belief that divine healing is an integral part of salvation, alongside spiritual redemption. Practices such as laying of hands, anointing with oil, and faith-based intercessory prayers are central to the Pentecostal approach to health and healing (Han 232). This Pentecostal approach made its way to Ghana through missionaries such as James McKeown and Ghanaian

Christian leaders such as Peter Anim. The arrival of Pentecostalism during colonial Christianity did not erase indigenous healing systems but became part of the spiritual landscape from which current practices draw. One example of an indigenous belief in Ghanaian healing systems is the practice of consulting a traditional healer or diviner (*ɔkomfo*) to diagnose and treat illnesses believed to be caused by spiritual forces, such as witchcraft, ancestral displeasure, or spirit possession. Pentecostal healing practices, while framed as purely Christian, often carry embedded traces of colonial influence as well as indigenous beliefs, making them hybrid forms of care. Although Alexander and Edenfield do not address Pentecostalism, their framework of TFM closely aligns with the healing logics present in Pentecostal faith healing. For example, TFM practices emerge from a mix of healing logics and experiences of exclusion and adaptation (Alexander and Edenfield). Similarly, Ghanaian Pentecostal women often navigate systemic healthcare failures by turning to spiritual alternatives such as deliverance, prophecy, and communal prayer that reflect both theological convictions and pragmatic survival strategies. In this way, Pentecostal healing can be read as a culturally situated, tactically improvised response to structural neglect, much like the broader TFM practices Alexander and Edenfield describe.

Despite the strong reliance on faith healing, scientific evaluations of its efficacy remain inconclusive. While many individuals attest to the effectiveness of spiritual healing methods, empirical evidence validating these claims is limited (Peprah, 2018). However, the persistence of faith-based healthcare practices highlights the cultural significance of spirituality in health decision-making. As Malkowski, Scott, and Keränen (2016) argue, rhetorical approaches to health challenge the assumption that science alone should dictate health behaviors. Instead, they stress that “rhetorical practices help shape how individuals and communities come to understand health, illness, and healing” (p. 4). Recognizing the interrelationship between religion and health

is thus essential for developing healthcare interventions that respect and incorporate patients' spiritual beliefs. Now this connection is evident in the context of Ghanaian Pentecostalism, where faith-based understandings of illness and healing help shape health-seeking behaviors and communal support systems.

Pentecostalism in the Ghanaian Context

Pentecostalism in Ghana is more than a religious tradition. It is a faith movement that continues to shape how many Ghanaians, particularly women, view healing, illness, and their healthcare choices, rooted in the spiritual revival movements of the early 20th century. Wyllie Robert in his 1974 article "Pioneers of Ghanaian Pentecostalism," gives a detailed explanation of how Pentecostalism began in Ghana. He highlights how Pentecostalism in Ghana grew through the pioneering work of leaders like Peter Anim and James McKeown. Anim, influenced by healing revival movements, emphasized divine healing and spiritual gifts, while McKeown, a Scottish missionary connected to the Apostolic Church, helped formalize and spread Pentecostal teachings in Ghana. Together, their influence laid the foundation for a theology that sees healing as both spiritual and physical, rooted in faith and the power of the Holy Spirit. Recent scholarship supports this view, showing that for many Ghanaian Christians, especially women, Pentecostalism offers not only spiritual comfort but also practical responses to illness, often in contexts where formal healthcare systems may be limited or inaccessible (Peprah et al.).

In 1937, James McKeown, an Irish missionary, was sent by the Apostolic Church in Bradford, UK, to Ghana to assist a group of believers in Asamankese, a town in southern Ghana, in the development of Pentecostal Christianity. His efforts led to the establishment of the Church of Pentecost in the 1950s, which has since become one of the largest Protestant denominations in Ghana. James McKeown played a key role in starting Pentecostalism in Ghana through a

movement that focused on the power of the Holy Spirit, healing, and holy living. His teachings encouraged people to pray, believe in miracles, and live a life worthy of emulation. McKeown also believed in raising local leaders, which helped the church grow quickly and become strong on its own. The church was not only a place for worship but also a close-knit community where members supported one another. In the beginning, the movement focused more on healing through prayer than medicine, which caused disagreements, especially when McKeown himself used medicine while sick. This dispute over faith healing and medicine created tensions in the movement. Even so, his teachings helped shape a strong, spirit-filled church that practiced revival-style worship with singing, drumming, and testimonies. His vision later spread to many countries, making the Church of Pentecost denomination one of the largest Pentecostal movements globally.

However, Pentecostalism in Ghana did not begin with the missionary McKeown alone. Peter Anim, another important pioneer and Ghanaian Christian leader who supported McKeown, also played a vital role. Anim had experienced healing from a guinea worm infection after trusting in God through faith, based on a scripture from 2 Chronicles 16:9, which explains how the eyes of the Lord search throughout the earth to strengthen those whose hearts are fully committed to him. This personal miracle led him to break away from the Basel Mission and settle in a small town in Ghana, where he promoted a faith-based healing message (Wyllie 1974). The Basel Mission was a Christian missionary society based in Switzerland that began work in what is now Ghana (then the Gold Coast). The mission was originally founded to spread Protestant Christianity and to engage in education, health care, and economic development. It played a significant role in shaping Christianity in Ghana by establishing schools, churches, and training centers. The Basel missionaries were known for their disciplined lifestyle and

commitment to Bible teaching and literacy, and they often combined religious instruction with vocational training. However, the Basel Mission emphasized a more European-style Christianity that was somewhat formal and did not always connect with the local spiritual experiences and needs of Ghanaians. This created a space for indigenous religious expression, which later helped fuel the growth of Pentecostalism, especially among those who felt that Western-style churches did not address their spiritual or healing needs.

The Basel missionaries were known for their disciplined lifestyle and commitment to Bible teaching and literacy, and they often combined religious instruction with vocational training. However, their version of Christianity was steeped in European customs characterized by rigid liturgy, subdued worship styles, and an emphasis on doctrinal conformity. This formal, structured approach did not always resonate with the lived spiritual realities of many Ghanaians, who had long-standing traditions of vibrant communal worship, spiritual healing, and ancestral reverence. The Basel Mission's reluctance to engage these local expressions of spirituality often left a cultural and spiritual gap. As a result, many Ghanaians found that the mission churches, while educational and morally instructive, lacked the emotional and spiritual immediacy that addressed their existential struggles, such as sickness, misfortune, or spiritual attacks. This disconnect fostered a desire for a more experiential and responsive faith. One that could speak directly to both the physical and spiritual dimensions of everyday life. In this context, different forms of Christianity, including Pentecostalism, began to flourish. Pentecostal churches embraced practices such as deliverance, prophecy, and divine healing elements that were not only familiar to Ghanaian spiritual traditions but also empowered believers to confront health crises through prayer, communal intercession, and faith-based rituals. These practices aligned more closely with local cultural norms and affirmed a holistic approach to healing that Western-

style churches had often overlooked or discouraged. This cultural misalignment between missionary Christianity, specifically Catholicism and Methodism, and indigenous spiritual needs thus played a significant role in paving the way for the rise of Pentecostalism as a more intense expression of faith. It provided a spiritual space where Ghanaians, especially women, could integrate their cultural understanding of healing, illness, and divine intervention into their Christian faith.

The relationship between Ghanaian cultural traditions and Pentecostalism is best understood as a blending of beliefs, which is a mix of local spiritual practices and Christian teachings, especially shaped by the Pentecostal movement. Rather than removing traditional ways of thinking, Pentecostalism in Ghana often takes them in, reshapes them, and presents them through a Christian lens. One area where they overlap is in their shared view that spiritual forces can cause illness or misfortune. For example, in the book written by Agyapong concerning witchcraft in Ghana, he mentions how in many Ghanaian traditional beliefs, health problems may be seen as the result of witchcraft, unhappy ancestors, or spiritual imbalance (Agyapong 2021). Pentecostalism does not completely reject these ideas; instead, it gives them new meaning. These problems are seen as caused by evil spirits, curses, or inherited sins and are issues that can be solved through prayer, fasting, and spiritual deliverance. This overlap helps Pentecostalism feel familiar to many people in Ghana. This may also explain why Ghanaians may have had a specific preference or approach to their health and spiritual needs.

However, when McKeown became seriously ill with malaria, he was taken to the European Hospital in Accra. This event disappointed many church members who believed that true faith in God should replace medical treatment. Although McKeown recovered and returned to work with Anim’s group, the tension over faith healing remained strong. Eventually,

McKeown moved his base to Winneba in 1938 to continue his ministry independently. This situation reflected a wider debate among Pentecostals in West Africa about the role of medicine and divine healing, as similar disagreements also happened in Nigeria (Wyllie, 1974). Conflicts arose in Nigeria, where Pentecostal communities debated whether faith healing alone was sufficient or if Christians could justifiably use hospitals and medications. Believers and leaders were also grappling with questions about whether seeking medical care showed a lack of faith or whether God could work through both doctors and miracles.

Wyllie (1974) notes that although McKeown eventually recovered and returned to collaborate with Anim's group, their disagreement over the role of medicine in Christian life was never fully resolved. McKeown believed that medical intervention could coexist with divine healing, while Anim maintained a stricter stance that true faith required complete reliance on God for healing. The teachings and experiences of both Peter Anim and James McKeown, along with contemporary scholarship, show that Pentecostalism in Ghana is not just a religion but a vibrant and personal faith movement. It may have helped shape how many Ghanaian Christians, especially women, understand healing, illness, and the role of faith in their healthcare choices.

In the broader African context, Pentecostalism has grown rapidly and taken on unique African expressions. Meyer (2004) notes that Pentecostalism in Africa has evolved into a highly dynamic and Africanized form of Christianity. African prophets and leaders of mega-churches promote messages about prosperity, healing, and personal encounters with God. Meyer notes that in many cases, the founder's family plays a big role in the leadership of the church. It is common for the succession, meaning who leads the church after the founder steps down or passes away, to stay within the founder's family, often passing to a spouse or child. This makes many Pentecostal Charismatic Churches (PCCs) look more like family-run ministries rather than

community-based churches where decisions are shared more broadly (Meyer, 2004; Anderson, 2002).

These churches are very energetic and focus a lot on spiritual gifts like healing, miracles, and prophecy. They are also very modern, using media like television, music, and big events to reach more people. According to Anderson (2002), PCCs include both "classical Pentecostal" movements and Charismatic churches that evolved out of mainline Protestant or Catholic denominations but now function independently and often with a strong emphasis on deliverance and prosperity theology. This is a growing phenomenon in Ghana's religious landscape. In addition to the rise of formal Charismatic churches, Ghana has also seen the emergence of a newer wave of independent prophetic ministries (IPCs), especially among local communities. These churches, as described by scholars like Anderson (2002) and Quayesi-Amakye, are typically informal, centered around the authority of a prophetic figure, and tend to emerge outside established denominational structures. Unlike the earlier Charismatic churches, these newer ministries that is Independent Prophetic Churches (IPCs) are less formal, often more rooted in local languages like Twi, and may not strongly identify with the Pentecostal-Charismatic Church (PCC) category, even though they share many similar beliefs such as healing, prophecy, and deliverance.

Many of these independent prophets and their churches focus primarily on practical spiritual needs such as healing from sickness, protection from spiritual attacks, and success in business or family life rather than publishing theological books or building international networks. Their sermons, prayers, and church services are usually conducted in local languages, making them more accessible to people from lower socio-economic backgrounds who may not be fluent in English. These distinctions between PCCs and Independent Prophetic Churches IPCs

are important to this inquiry because they illuminate how different religious frameworks shape health-seeking behaviors among Black Pentecostal Christian women in Ghana. While both traditions emphasize spiritual gifts such as healing and deliverance, IPCs tend to operate more informally and are deeply embedded in local languages, cultural practices, and community-level struggles with poverty and healthcare inaccessibility. This makes IPCs especially relevant in contexts where formal biomedical services are limited or unaffordable, positioning them as central sites of spiritual and physical care. PCCs, on the other hand, often cater to more urban or middle-class populations and may offer a more institutionalized approach to healing that blends spiritual authority with broader teachings on prosperity, moral discipline, and personal development. Understanding the theological, linguistic, and socio-economic nuances between these church traditions helps clarify why some women turn to IPCs whose rhetoric are embedded in the Pentecostal tradition. It becomes their primary source of healing and hope, and highlights the role of spiritual spaces as culturally resonant alternatives to dominant healthcare models.

Contributions and Gaps of Rhetoric of Health and Medicine (RHM)

The field of Rhetoric of Health and Medicine (RHM) has made significant strides in exploring cultural rhetorics and patient narratives, yet it has not fully engaged with the rhetorical strategies employed within global Black Pentecostal traditions, particularly those related to faith-based healing. This oversight is significant, given the profound influence of Pentecostalism on health perceptions and practices among Black communities worldwide. Within these communities, health and illness are often interpreted through a spiritual lens, where divine intervention is central to healing, challenging the biomedical model that tends to isolate physical health from spiritual well-being. Practices such as prayer, fasting, deliverance, and testimony are not supplementary but foundational to health maintenance and recovery. As Derkatch (2018)

argues, wellness discourses often draw upon moral, spiritual, and natural logics to legitimize alternative healing practices and frameworks that resonate with Pentecostal healing narratives. These practices function as sophisticated rhetorical strategies that assert agency and resist dominant biomedical paradigms. Building on this, Johnson and Quinlan's (2018) concept of affective labor highlights the emotional work patients perform to navigate healthcare systems. In Black Pentecostal contexts, this labor is embodied through expressions of faith, communal support, and spiritual resilience, which serve not only as coping mechanisms but also as deliberate rhetorical acts of resistance and identity affirmation.

While RHM scholars such as Alexander and Edenfield have made important contributions in exploring how race, gender, and culture shape health narratives, there remains a great opportunity to extend this work by engaging more with faith healing as a unique rhetorical system that serves as a way through which some populations respond to health inequities. Within Black Pentecostal traditions, rhetorical forms such as sermons, prophecy, ritual, and testimony function not only as expressions of belief but as powerful strategies for meaning-making, health maintenance, and communal resilience. Exploring these modes can greatly enrich RHM's understanding of how health is lived, communicated, and transformed in spiritually grounded communities, particularly in contexts where healthcare may be difficult to access by marginalized communities, as expressed by Alexander and Edenfield.

Rather than signaling a limitation, RHM's current focus on Western, secular frameworks opens the door to an expansion. One that embraces intersectional, transnational, and spiritually rooted perspectives. Black Pentecostal healing practices, far from being peripheral, offer dynamic responses to historical trauma, systemic inequities, and healthcare barriers. Their rhetorical strategies, such as prophetic framing, collective prayer, and ritual embodiment, invite

scholars to rethink how healing is understood and practiced across cultural and spiritual contexts. For example, the experiences of Ghanaian Pentecostal women navigating spiritual, economic, and political landscapes demonstrate the importance of culturally attuned approaches that honor both faith and agency. By turning greater scholarly attention to these traditions, RHM has the opportunity to grow into a more inclusive and resonant field. One that values spiritual epistemologies alongside clinical and policy discourse. Engaging Black Pentecostal healing rhetorics encourages us all to imagine new possibilities for care, connection, and transformation across boundaries of belief, culture, and geography. Given the many threads explored in this study, including tactical folk medicine, postcolonial religious landscapes, spiritual healing practices, and rhetorical power, what Rhetoric of Health and Medicine (RHM) needs is a study that asks: How do Black Pentecostal women talk about faith healing, its benefits, and even limitations? That is, in what ways do they frame spiritual practices like prayer, prophecy, and deliverance as legitimate responses to illness?

Chapter Three: Methodology

This chapter highlights the research design and methodological choices used to explore how Black Pentecostal Christian women from Ghana and the U.S construct and experience health and healthcare through the lens of their faith. Guided by a constructionist epistemology and a phenomenological interviewing approach, the study sought to capture the lived experiences of women whose understandings of health are connected with their spiritual identities. Drawing on the three-part interview structure proposed by Seidman (2006), this research employed in-depth, open-ended conversations as its primary mode of data collection, allowing participants to reflect on their religious background, health encounters, and the connections between faith and healing. This chapter provides a detailed discussion of the epistemological stance, theoretical grounding, and qualitative methods that informed this study, from participant recruitment to data collection, participants' background, and analysis.

Constructionism as a Theoretical Framework

In the context of this study, constructionism serves as the epistemological foundation for understanding how Black Pentecostal Christian women make sense of their health experiences through the lens of faith. The study was grounded in constructionism, which is a way of thinking about knowledge that sees it as something people build together through their experiences and interactions with the world. As Crotty (1998) explains, constructionism holds that "all knowledge, and therefore all meaningful reality, is contingent upon human practices" (p. 42). In other words, people do not just find knowledge; they create it by making sense of their experiences within their cultural and social contexts. For the women in this study, their understanding of health and faith was shaped not only by personal encounters with illness and healing but also by their religious beliefs, church teachings, and shared practices in Pentecostal

communities. Although the women I interviewed may not belong to the same age group as my mother, they are Ghanaians who share valid experiences within the Pentecostal Christian faith. Their stories show how faith and health are not separate ideas but are deeply connected in the ways they talk, act, and think. Using a constructionist lens allowed the study to focus on how these women actively construct meaning from their lived experiences, rather than treating health beliefs as fixed or universal. Constructionism also posits that meaning is not objectively discovered but rather socially constructed, meaning that individuals interpret and assign significance to their experiences based on their cultural, religious, and social contexts. It invites us to view the world, meaning, and phenomena as socially created rather than fixed or objective. It recognizes that people interpret their world based on their interactions, cultural contexts, and shared understandings.

In this study, participants' views on health, healing, and religion were seen as shaped by their Pentecostal faith, Ghanaian identity, and social environments. Given their commitment to their Pentecostal Christian faith, the participants would likely respond to the constructionist framing with a mix of openness and caution. On one hand, they might appreciate the idea that meaning is shaped through social and cultural experiences, as their own understanding of health and healing is rooted in their religious community and shared faith practices. Their testimonies may often reflect the influence of church teachings, communal prayer, and spiritual and medical interpretations of illness and recovery. On the other hand, because their faith may be grounded in the belief that certain truths are divinely revealed and absolute, some participants might find it challenging to fully embrace the idea that all meaning is socially constructed. For them, certain aspects of health, healing, and religious experience are not just shaped by culture but are guided by a higher, unchanging spiritual reality. Interestingly, none of the participants rejected or

pushed back against the constructionist framing during the interview process. This non-reaction could suggest several possibilities. Perhaps the questions were framed in a way that invited reflection rather than confrontation, allowing participants to share their experiences without feeling that their beliefs were being questioned. It may also be that, in practice, these women are already navigating the blurred lines between spiritual conviction and social experience by recognizing how faith is lived and shaped in context. Even if they do not name it in theoretical terms. Their lived theology may hold space for both divine revelation and social embeddedness without perceiving a conflict.

The Relevance and Pitfalls of Constructionism in the Study

For this study, constructionism is particularly relevant because it acknowledges that different individuals may experience the same health-related events, such as illness, healing, or medical treatment, but construct meaning around them in diverse ways. A health complication, for example, may be viewed by one participant as a test of faith, by another as a call to deeper spiritual devotion, and by yet another as an opportunity to embrace both faith and medical science. Even within the shared socio-religious framework of Pentecostalism, with the mention of sub-traditions such as IPCs and PCCs, participants' interpretations of healing, prayer, and medical interventions may vary based on personal experiences, theological teachings, and social influences.

One epistemological pitfall of this constructionist approach, however, is the risk of fragmenting participants' narratives and treating theological claims as merely cultural expressions or psychological mechanisms rather than as real and meaningful knowledge claims within their own epistemological frameworks. To avoid this, I adopted an approach that honors both the social construction of meaning and the participants' spiritual convictions. In other

words, I foregrounded their testimonies as valid theological claims, and I worked to ensure that their beliefs were not simply retranslated into secular terms but understood as real and meaningful within their own epistemological frameworks. This balancing act was essential for respecting participants' interpretive authority and for representing their health narratives in a way that expresses both their lived realities and their faith-based criteria. For instance, when I asked Alice about her views on health and healthcare, she responded, "I believe that every profession in this life is ordained by God, and that we cannot underestimate the works of doctors and then all the other professions, even though there are times that there are certain medical conditions that are just way beyond them, I believe that when you are sick, yes, even though we pray, go to the hospital and do checkup and then still pray, because I've come into contact with some doctors that still believe that, yes, it is God that does the final work for them, and some of them even refer you to go and pray." Rather than interpreting this statement as a cultural coping mechanism or symbolic ritual, I approached it as a theological truth claim within her own framework. One that reflects a spiritual logic integrating divine authority with medical expertise. This approach avoided epistemological fragmentation by recognizing her statement as a valid expression of lived theology, not simply as a psychological or cultural adaptation.

In viewing the study from a constructionist lens, the distinction between religion and culture becomes critically important. While religion can be expressed through culture, shaping language, rituals, food, and ethics, such as those seen in Ghanaian Pentecostal communities, it also transcends culture for many believers. Religion is not merely a social product but is often understood as divinely revealed truth from a higher source. As Hamilton (2020) notes, "religion and spirituality, while culturally inflected, also serve as ontological anchors for many African American and diasporic communities in understanding illness and healing" (p. 338). In my

experience, this is also true of Ghanaian Pentecostalism. For many Ghanaian Pentecostals, prayer, prophecy, and divine healing are not symbolic gestures but active responses to real suffering. Health challenges are often understood as spiritual battles or moral tests, and healing is pursued not only through hospitals but also through fasting, anointing, and communal intercession. Recognizing this boundary and overlap prevents the epistemological error of collapsing religious meaning into mere social function.

Phenomenology as a Theoretical Framework

I used a phenomenological interviewing approach to explore these experiences in depth, enabling participants to articulate their perspectives freely while minimizing researcher bias. Seidman (2006) argues that "interviewing provides access to the context of people's behavior and thereby provides a way for researchers to understand the meaning of that behavior" (p. 10). Seidman also explains that the goal of phenomenology is to have the participant reconstruct his or her experience within the topic under study. When an interview participant reconstructs their experience within the study, they may go through several mental processes that shape their narrative. First, they may engage in memory retrieval, recalling past health-related experiences such as medical encounters, church teachings, or personal health decisions. They may also try to make sense of their memories of health and evoke feelings of gratitude, frustration, fear, or hope. Seidman's approach is phenomenological in that it centers the lived experience of the participant as the primary source of meaning. Rather than imposing external analytical frameworks from the outset, this method seeks to allow the participant's voice to emerge authentically through reflection. By guiding participants to reconstruct their experiences in their own words, Seidman's model aligns with the phenomenological aim of accessing consciousness as it is lived and interpreted. Seidman's phenomenological interviewing method, which emphasizes participants'

meaning-making through lived experience, aligns closely with Crotty's constructionist view that knowledge is shaped through social and cultural contexts. Together, they support my use of phenomenological interviews as a fitting method for exploring how Black Pentecostal women construct understandings of health within their faith communities and as a tool to uncover how they understand health.

To complete the study, I conducted online interviews through the Zoom application with a group of Ghanaian Black Pentecostal Christian women from Ghana; some who live in Ghana and others who live in the U.S. Online interviews were selected due to their flexibility and accessibility, allowing participants across different time zones and geographic locations to share their experiences. This method also created a comfortable setting for participants to speak openly about sensitive topics related to health, faith, and personal narratives. The interviews, being my main source of information, was helpful in gaining new perspectives on the rhetoric of health and religion and the rhetoric of health and medicine (RHM). In the course of conducting the interviews, I paid close attention to participants' views on their health and healthcare experiences and the connections that fell in line with each and every narrative. The open-ended nature of the questions encouraged candid and unfiltered responses, such as: "How comfortable are you discussing your health experiences with medical professionals?" or "Can you share a story about your faith journey?". As Seidman (2006) notes, when people tell stories, they select details of their experience from their stream of consciousness (p. 7). This meaning-making was particularly vivid in this study, as participants reflected on past experiences and present beliefs, bringing together narratives in which illness, prayer, medical care, and divine agency were interconnected.

I received approval from the Institutional Review Board (IRB) at the University of Tennessee, Knoxville, in early Fall 2024, and began participant recruitment in the late fall of the same year. The next sections provide more details about my recruitment, interviews, participants, data collection, and analysis.

Recruitment and Participant Selection

To recruit participants for the interviews, I first created recruitment scripts that were initially intended to be delivered via email and by snowballing. As the nature of my targeted participant population had a more popular mode of communication prior to their Ghanaian socio-cultural background, I used the WhatsApp application with its version as 25.2.83: WhatsApp is one of the most used social media platform in Ghana. I used the scripts in the form of WhatsApp messages to participants. In the messages, participants were made aware that the interview was intended to help complete my thesis research for my Master's program in the University of Tennessee, Knoxville, and to help discover how Black Pentecostal women talk about the faith on their health. In efforts to be considerate of their availability and time schedules, I stated and assured them that it was going to be a three-part interview session of no more than 60 minutes, and they will be recorded via the Zoom application. Initially, it was meant to be a three-part interview series with each section lasting for at least sixty minutes. However, I combined all three series into a one-time sixty-minute interview session due to a few constraints, which I will explain further in the interviews section. I also indicated in the messages and before the start of all the interviews that pseudonyms would be used to mask the identity of each participant. I also attached consent forms (Appendix A) as a Word document, for which verbal consent was obtained before every single interview commenced.

The study focused on Black Pentecostal Christian women who had had in-depth experience with the Pentecostal faith; some belonged to PCCs and a few others to IPCs. All ten women interviewed were Ghanaians; some live in Ghana, while others live in the U.S., and one Ghanaian lives in Italy due to recruitment availability. By situating the study within a constructionist epistemology, I acknowledged that participants' knowledge claims, particularly those regarding divine healing, spiritual authority, and medical decisions, are shaped by both their social realities and theological worldviews. Recognizing that knowledge emerges from lived experience, community interpretation, and divine revelation, this approach aimed to honor the different ways Pentecostal women come to know health and healing within their faith tradition. This population was chosen based on my positionality as a Black Christian woman with a Pentecostal background and an interest in faith healing, a common concept in Pentecostalism. My positionality also follows from my experiences as I watched my grandmother rely on prayer and church for healing, and how my mother faced challenges in the healthcare system that made her turn even more toward her faith. These experiences shaped how I see the connection between religion and health, especially for women.

It is important to note that my familiarity with the Pentecostal tradition might make me less likely to probe what seems "obvious" to both myself and the participant (Seidman, 2006, p. 42). This echoes with Seidman's assertions on the downsides of interviewing friends as a result of convenience sampling. This could result in missed opportunities to unpack key meanings or practices that warrant further analysis. Saldana (2013) emphasizes the importance of remaining critically self-reflective throughout the research process to avoid the trap of assumed understanding (p. 41). I did this by note taking during each interview, reflecting along the way to make connections from one interview to the next, allowing me to come up with follow-up

questions to what was said during the interview. Thus, while my positionality created a bridge of mutual recognition and trust, it also demanded a heightened level of reflexivity. I had to avoid over-identification, ensuring that I remained open to the particularities of each woman's story, rather than interpreting them through the lens of my own. For instance, during my interview with Mandy, she recounts how she was born in a Christian family and so "developed some fundamental values which are rooted in Christianity". As a researcher who shares a Pentecostal background, it might feel natural to nod in agreement and move on, assuming shared understanding. However, instead of taking the statement at face value, I responded, " Do you mind telling me what some of the fundamental values are?"

Studying a specific denomination allowed for a more focused exploration of shared beliefs and health-related practices. The intended participant pool was age 23 to 40, a range selected to align with my existing network and to identify potential patterns within this demographic. The ages of the participants willing to partake in the study were between 23 to 26. The outcome of the participant list was a result of my proximity as a researcher who is within the same age range. Hence, it attracted participants of a similar age range. Sampling was conducted using a combination of convenience and snowball sampling; four participants were recruited through convenience sampling, while six participants were referred through snowball sampling. The study aimed to recruit up to 10 participants, with an initial sample of five. Due to participants' limited availability and difficulty in scheduling multiple sessions, the original three-session interview format was adapted into a single session to maximize participation and ensure that they could still share their experiences meaningfully. The first four participants were individuals I had personal relationships with for close to seven years through high school and college education back in Ghana. Seidman (2006) notes that the closer we are to our participants,

the more we must interrogate the assumptions we bring to the research. He goes on to explain how "interviewers and the participants who are friends usually assume that they understand each other"(p. 42). One of the key dangers of this kind of insider identification is the potential to project my own experiences onto those of my participants, thereby blurring the lines between their voices and mine. However, Saldana (2013) acknowledges that while researchers have limitations in fully understanding others, comprehension is still possible through careful interpretation of their actions and expressions.

After conducting interviews with the first four, the snowball method was followed as they referred me to six similar participants in total who fit the study criteria. These six participants appealed to me as appropriate fits for the study as they were all Black Pentecostal Christian women from Ghana who had significant experience in the Pentecostal faith. The referral was done by entreating the participants I had already interviewed to send recruitment scripts (Appendix D) to their colleagues. The recruitment script for referral had the details of who was considered eligible to be part of the study, which is preferably a Black Christian woman who has an in-depth experience in the Pentecostal faith. The referred participants, based on the recruitment scripts shared by my initial participants, reached out to me offering to participate, and I confirmed their background to ensure they were Ghanaian Christian women who had an in-depth experience with the Pentecostal faith. I then sent them the consent forms and scheduled a time that would be convenient for them.

Interviews

The study employed qualitative interviews as the primary data collection method. I employed Seidman's (2006) interview model. Seidman's interview model is a qualitative research method focused on understanding people's lived experiences through their own stories.

The model involves three separate, in-depth interviews with each participant, usually conducted over time. However, in order to make the time convenient for participants due to their busy schedules, the interviews were structured as a one-time session, covering three key themes: (1) life history, (2) details of experiences in health and the healthcare system, and (3) the reflection on experiences. This falls into Seidman's three-fold model of focused life history, details of experiences, and a reflection on past experiences shared. The first part of the interview included three questions focused on participants' faith journeys, allowing them to narrate their religious upbringing, spiritual milestones, and their engagement with Pentecostal beliefs. This structure was an indirect imitation of Seidman's three interview structure, which cuts into three parts: mainly history and background, in-depth details of experiences, with the last part presenting itself as a reflection.

In this study, I chose to conduct a one-session interview with timings of interviews that ended up ranging from fifteen minutes to an hour and a half, rather than a three-session structure, which consists of sixty minutes per session. This is mainly because of the nature of my sampling approach and the practical realities of working with participants who live in Ghana; six are currently studying in the US, one is studying in Italy, and three other participants are studying in Ghana. Using convenience and snowball sampling meant that the participants were primarily individuals within my existing network or referred through close contacts. Although the original plan followed Seidman's (2006) three-fold interview model, it became clear that participants' availability was limited, and most could only spare time for a single session. In reaching out to participants, most expressed that their time schedules may not favor the three-fold model of sixty minutes per session. I had to compromise the sixty-minute per session plan into sixty minutes for the whole interview instead. To respect their schedules while still gathering meaningful data, I

adapted the interviews into one comprehensive meeting. This decision also matched the demographic characteristics of the sample, as participants shared similar cultural and religious backgrounds.

To guide the discussion, I developed a total of 12 open-ended questions, structured in a way that would allow participants to share their experiences. The first part consisted of three questions that helped them narrate their life history and religious background. The second part, comprising six questions, explored their interactions with healthcare systems, their perceptions of medical professionals, and their experiences seeking treatment both within Ghana and, for some, abroad. The final set comprising of three questions encouraged deeper reflection by asking participants to analyze how their faith influenced their health decisions, and whether they would have done things differently if they were to go back in time. Their similar religious and social backgrounds made the conversations more straightforward because they all had a common understanding, which helped clear themes to emerge. Additionally, my positionality as a Ghanaian Pentecostal Christian woman allowed me to engage participants with culturally relevant follow-up questions, fostering a deeper sense of trust and openness. The shared cultural and religious background helped create a conversational atmosphere where participants felt comfortable sharing personal and sometimes sensitive health experiences. This is important from a constructionist perspective because it shows that knowledge is built through relationships, shared experiences, and the specific context in which people are speaking. This rapport was evident in instances where participants voluntarily expanded on their responses, reflecting on their health complications and pondering whether their healing resulted from medical intervention, faith practices, or a combination of both. In such moments, I was able to probe further, asking questions that encouraged introspection, such as, “How do you interpret your

healing experience in light of your faith?" or "Did your faith shape how you sought medical care?"

Participants

All participants were Ghanaian Christian women whose faith was rooted in Pentecostalism, with three residing in Ghana, one studying in Europe, and six studying in the U.S. Participants had diverse backgrounds and varying experiences with Pentecostal churches in Ghana. Some participants expressed that while they were in Ghana, they were active members of their Pentecostal churches, but moving to study in the US and abroad had led to a form of religious hiatus. Similarly, most expressed that they have more experience to share about the healthcare system in Ghana than in the U.S. As explained in Chapter 2 of the study (Literature Review), Pentecostal-Charismatic Churches are newer Christian movements that combine Pentecostal beliefs with some ideas from charismatic movements. PCCs are often founded by a single charismatic leader, usually a pastor, prophet, or apostle, who is seen as specially anointed by God. This leader typically has strong personal authority over the church, and the church community is often built around their teachings, gifts, and personality. As a result, the church is more like a private organization than a community-owned institution.

While earlier Charismatic churches often adopted a Westernized model (such as using English names like "International" or "Global," and emphasizing leadership development and prosperity theology), these newer movements (IPCs) tend to stay more community-based and culturally embedded. The strong use of Twi and other local languages reflects both educational differences and economic realities, suggesting that these churches serve a different social group than the more "elite" charismatic congregations in places like Accra. Many participants admitted to the widespread use of these various categories of the Pentecostal faith and how they interacted

with them. Not only did they recount their interaction with these churches, but also how they saw their family members and members of their community engage with these churches.

This shows how Pentecostal and Charismatic Christianity in Ghana continues to adapt to different social, economic, and cultural contexts, creating new forms of religious life that are both modern and local.

Participants' Background

To help readers better understand the participants and the experiences they shared, I include background information about each participant. Sharing their backgrounds gives context to their views on health, faith, and healthcare. To protect their privacy, I have used pseudonyms instead of their real names throughout this study. This background information is based on my prior knowledge of them as individuals and stories they have shared with me.

Suzzy

Suzzy is a twenty-five-year-old Ghanaian woman who was born and raised in a Christian family. She is currently living in the United States as she pursues her Master's degree. She has maintained her faith throughout her life and credits it with shaping her values and approach to challenges. According to her interview, her Christian beliefs play a significant role in her understanding of health and healing, as she relies on both prayer and medical interventions when dealing with illness.

Alice

Alice grew up in Accra, Ghana, and has spent most of her life there, but currently lives in the US. During her interview, twenty- five year old Alice shared with me how she attended the University of Ghana, where she deepened her understanding of Christianity and developed a personal relationship with God. Coming from a pastoral family, she was raised in a Christian

environment, but it was during her time at university that she truly grasped the essence of being a believer. She also shared with me that through church fellowship, she became involved in various church activities, including singing, ushering, and organizing.

Mandy

Mandy is a twenty-year-old devoted Christian currently living in the US. She was born into a Christian family in Ghana and raised in the church. Mandy shared during her interview how her faith has significantly shaped her values, choices, and life path. From childhood, her religious upbringing involved regular church attendance, prayer, and spiritual guidance from her parents. However, she describes a pivotal moment in her teenage years when she made a personal decision to commit to her faith, transitioning from merely following her parents' beliefs to embracing Christianity as her own. Mandy expressed in the interview that faith plays a crucial role in her daily life, influencing her relationships, interests, and even her academic and professional decisions.

Constance

Constance is a twenty-six-year-old Ghanaian woman who currently lives in the US and is also pursuing her Master’s degree. Constance grew up in a family where Christianity was not a central part of daily life. Although her parents acknowledged God's existence, they did not actively practice religion. Despite this, Constance's interest in church grew, initially influenced by her involvement in a choreography group at her aunt's place. She later reconnected with God during high school, becoming “born again” as mentioned in her interview and realizing the importance of seeking God's guidance in her life. This spiritual renewal helped her see God's hand in everything she did, and she started to “prioritize His will over her own,” as she said in her interview.

Debra

Debra is a twenty-five-year-old Ghanaian woman who currently lives in Ghana and works in an environmental organisation. Debra was raised in a Christian household, where her mother was more religious, and her father held a more flexible view on religion, not identifying with a particular denomination. She recounts in the interview that while her father acknowledged God, he did not limit himself to a specific religious group. Debra also explains that she primarily followed her mother's lead when it came to attending church, growing up in Christian teachings through Sunday school, youth classes, and adult classes. Debra's Christian faith has been a part of her life, although she does not describe it as having moments of intense transformation. She acknowledged to me in her interview the importance of her foundation and the spiritual practices that have been part of her upbringing.

Tracy

Twenty-four-year-old Tracy recently moved to Italy to pursue her Master's degree in nutrition. Tracy was born into a Christian household in Ghana and was familiar with God from an early age. In my interview with her, she narrates how her personal faith journey began when she felt the need to encounter God for herself, beyond simply hearing about Him from others. She realized that knowing God personally was vital for her spiritual growth, and through this pursuit, she came to understand the importance of encountering God's love and truth directly. She shared in the interview how a significant turning point in her spiritual journey occurred when she struggled with low self-esteem and feelings of inadequacy. She also recounts to me in her interview how, during this time, reading the Bible helped her discover God's thoughts toward her and realize that she was created beautifully and wonderfully in His image. This realization empowered her to appreciate herself more deeply and trust in God's purpose for her life.

Linda

Linda is a twenty-four-year-old student living in the US. Linda was born into a Christian family, where her mother regularly attended church, though her father did not. Linda narrated how, due to frequent moves, the family changed churches often, attending places such as Apostolic and ICGC, before settling at a Baptist church. Initially, their church attendance was inconsistent, but things began to change when Linda's mother became more spiritually committed, especially after meeting a prophetess who spoke about serious family matters. This led to more consistent church attendance and prayer meetings. Linda expressed that her faith journey deepened during her time at university. It was there that she became more grounded in her Christian identity. In the interview, she noted that she joined the Baptist Students Union, where she became a cell leader. This role exposed her to greater spiritual responsibility and helped her grow in her relationship with God. Through these experiences, Linda began to know Christ personally and experienced a connection to her faith as said in her interview.

Flora

Flora is a twenty-six-year-old woman currently studying in the US. During the interview, Flora expressed that her Christian journey began in a family where church attendance was part of their routine. While initially feeling as though she was being forced to follow her parents' Christian practices, Flora later realized the personal benefits of her faith. She was actively involved in Sunday services, Sunday school, and volunteered in children's activities. Though she did not attend the women's fellowship meetings due to her age, she participated in youth meetings and evening services. As her faith matured, Flora recounted in the interview how she began to experience a connection with God through prayer, especially in learning to hear the

voice of the Holy Spirit. Though she occasionally doubts whether what she hears is truly from God, her belief in His reality continues to shape her spiritual journey.

Rita

Rita is a twenty-three-year-old woman currently living in Ghana. Rita grew up in a Christian household, where her knowledge of God began in her early years. However, it was during secondary school and university that her curiosity about God intensified. In university, she became more involved in church activities, joining a technical department where she was part of a close-knit Christian community. She regularly attended prayer meetings and Bible studies, which deepened her faith. In the interview, Rita stated that one key turning point in her journey was meeting a leader who encouraged her to read the Bible daily and attend church meetings. This mentorship, along with her Christian friends, played a major role in shaping her faith.

Gail

Gail is a twenty-four-year-old woman who lives in Ghana and recently completed her National Service, a one-year mandatory program for all Ghanaian graduates. She was raised in a religious household where Christianity was not just a personal belief but a family tradition passed down through generations. In her interview, she stated that her parents and grandparents are all Christians. They encouraged her to read the Bible, join groups in church, and partake in religious activities, which she noted laid a foundation for her spiritual development. She also shared that the choice of friends she made at church and at the workplace helped build her faith. She further expressed in her interview that the support from her family background and friends has played a key role in shaping who she is and where she is in life today.

Data Collection

As the study focused on Black Pentecostal Christian women with in-depth experience in Pentecostal faith traditions. All interviews were conducted via the Zoom application, which was used for both video conferencing and recording. The interviews lasted between fifteen minutes as the least record time and an hour and half minutes as the longest interview. Transcripts were generated using Otter.ai, a transcription tool, and were manually edited for accuracy. Pseudonyms were assigned to all participants to ensure their privacy.

Analysis

To analyze the data, I sought to recall the verbal tone and intensity of participants to better identify the emotions expressed during the interviews. Saldana's (2013) book titled *Coding Manual for Qualitative Researchers* guided the coding process. I used three of Saldana's coding methods, namely in vivo, descriptive, and thematic coding. This combination of in vivo, descriptive, and thematic coding was applied to ensure a comprehensive interpretation of the data: Nvivo coding preserved participants' voices, allowing their narratives to be recognized and tracked authentically. Descriptive coding helped categorize participant experiences, condensing their perspectives into concise codes. Thematic analysis is the main method I used, which is subordinated to narrative inquiry and embodiment theory. I included ideas from narrative inquiry and embodiment theory to support and add depth to the analysis. I will explain the analysis methods in the order of the thematic analysis, narrative inquiry, and embodiment theory in the upcoming sections.

Thematic coding facilitated the identification of overarching patterns by grouping related ideas into broader themes. The coding process followed a structured approach to ensure a thorough interpretation of the participants' narratives. First, I highlighted key words and

sentences that captured the core of each participant's thoughts, applying in vivo coding to preserve their exact expressions. One example of this method comes from Suzzy's interview. When I asked her to share the background of her Christian faith, she said, "My parents are Christians," "I was born into Christianity," and "I've not stopped worshiping God." These phrases were directly lifted from her response and used as in vivo codes to retain the authenticity of her voice. Next, I transitioned from Nvivo to descriptive coding by condensing these quotes into more succinct labels that summarized the essence of her statements. In Suzzy's case, the descriptive codes were inherited religious identity and faith as continuity rather than conversion. These codes helped to distill her experiences into manageable concepts. I then applied these codes to the other transcripts. Finally, I grouped these descriptive codes into overarching themes such as religious dedication and parental influence. These themes were then examined across all interviews to identify patterns, similarities, and variations in the experiences of these Black Pentecostal women. This structured coding process allowed me to stay close to participants' original language while also making their insights easier to analyze and interpret on a thematic level.

Throughout the coding and analysis process, I also paid close attention to emotionally charged expressions and linguistic features, and repetitions that conveyed emphasis and depth in participants' narratives. I did this to better understand the emotional weight of their experiences, particularly how their faith and health decisions were interconnected. For example, Debra's repetitive statement, "I decided not to visit the hospital again," stood out as particularly emotionally laden, signaling not only a strong personal conviction but also a possible underlying disappointment or distrust in the healthcare system. I also noticed her repeated use of intensifiers such as "very," which hinted at emotional tension. These features were not merely taken at face

value but were carefully noted as part of the interpretive process. Also, to ensure that these emotional interpretations were grounded in participants' actual intentions and not projected assumptions, I used follow-up questions during the interviews to clarify and expand on emotionally significant responses. For instance, after participants shared their religious background and faith journey, I often asked follow-up questions like, "Was there any particular experience or moment in your life that strengthened your faith in God or brought you closer to Him?" This helped elicit deeper reflections and personal stories, allowing an understanding of how their emotions were tied to their religious experiences and health decisions. Also, the language and framing of this follow-up question reflect my epistemological and theoretical stance, namely, a constructionist approach that values participants' interpretive authority and a phenomenological interest in how meaning is made through lived experience. By inviting participants to narrate significant spiritual moments in their own terms, I sought to honor their theological frameworks and knowledge rooted in their realities. These strategies ensured that my analysis remained faithful to the participants' lived realities while also capturing the subtle ways in which they expressed and processed their emotions through language.

In this study, thematic analysis serves as the primary methodological approach through which the interview data is organized and interpreted. Drawing from Saldana's (2013) *Coding Manual for Qualitative Researchers*, thematic analysis involves a process of identifying, analyzing, and reporting patterns or themes within data. Saldana emphasizes that a theme is not merely a category or topic, but "an extended phrase or sentence that identifies what a unit of data is about and/what it means" (Saldana, 2013, p. 175). This approach provides a systematic way to manage the large volume of qualitative data, enabling the researcher to condense narratives into meaningful and recurring themes such as "faith-based healing" and "medical mistrust".

Saldana (2013) notes, the progression from codes to categories to themes is not linear but instead requires cyclical and continuous engagement with the data. The process began with in vivo coding, where participants' statements such as “They did not do the kind of labs, I guess they were supposed to do,” or “I decided not to visit the hospital again” were highlighted as indicators of emotional or thematic significance. These were then translated into descriptive codes (e.g., low quality lab sessions, medical rejection) as mentioned earlier before being synthesized into broader interpretive themes (e.g., medical incompetence of practitioners, faith over medicine).

While thematic analysis structures the overall approach, it is supported by insights from narrative inquiry and embodiment theory, which serve as complementary, subordinated analyses. Narrative inquiry, rooted in interpretive phenomenological analysis and aligned with Irving Seidman’s emphasis on meaning-making through storytelling, allows the study to attend to how participants construct and articulate their life stories. According to Seidman (2006), “Telling stories is essentially a meaning-making process” (2006, p. 7). This lens helped uncover how women frame their health journeys in relation to their spiritual narratives, highlighting personal turning points, faith crises, or even moments of divine intervention. In this sense, narrative analysis does not simply describe what was said, but explores how it was said but how participants positioned themselves in their stories, and how they gave coherence to their lived experiences through religious language, metaphors, and scriptural references. The embodiment theory, meanwhile, offers a framework for interpreting how participants’ experiences of health, illness, and faith are lived out physically, emotionally, and spiritually. As Michael Crotty reminds us, all qualitative research is grounded in philosophical assumptions, and an interpretivist-constructivist paradigm “looks for culturally derived and historically situated

interpretations of the social world". (1998, p. 67). Embodiment theory aligns with this by emphasizing the lived, situated experience of the body in cultural and religious contexts. In this study, it helped unpack how prayer and avoidance of biomedical care were not only spiritual acts but may also be bodily experiences shaped by theological beliefs. Women's decisions not to seek hospital care or their expressions of feeling "spiritually stronger" during illness may illustrate how the body becomes a site of both suffering and sacredness. In the next chapter, I will be delving into the findings of the study, where I explain the patterns and overlapping themes that were identified.

Chapter Four: Results/Findings

In this chapter, I present the results that emerged from the interview. I will particularly show the patterns that emerged across most participants through the multiple lenses of interpretive phenomenological analysis, thematic analysis, narrative inquiry, and embodiment theory. Through these lenses, I not only describe what participants say; I also try to interpret the deeper meaning behind their words. For instance looked at their use of emotionally charged expressions and intensifiers such as “really’ and “very,” etc, to help me understand their narratives better. Thereafter, I look at the prominent patterns and themes that were repeatedly mentioned across all participant stories with the help of Saldana’s (2013) NVivo, descriptive, and thematic coding methods. The themes of parental influence on the faith lives of Ghanaian Christian women and fellowship and community as a way to engage in Christian faith are prominent in the data. The former theme highlights how participants’ faith journeys were shaped by their upbringing, particularly the religious beliefs and practices of their parents. Many women spoke about being introduced to Christianity through their families, especially their mothers, and continuing those practices into adulthood as part of their spiritual identity. Meanwhile, the latter theme reflects the importance of Christian community through church groups, friendships, and shared worship in sustaining faith. For many women, fellowship offered spiritual support, encouragement, and a sense of belonging, especially during personal struggles or while living abroad.

I explicate on these themes because they are connected to participants’ health experiences. Participants described how early teachings from parents and involvement in Christian communities built a strong faith foundation that later shaped their responses to health crises. Their concerns about the healthcare system, including experiences in both public and

private hospitals, also reveal how faith healing often provided hope, even when the medical system reached its limits. For some, faith healing led to positive health outcomes; for others, it brought emotional strength when treatments failed. However, although participants expressed strong belief in faith healing, they also showed an awareness that its effectiveness is not absolute. Some noted that faith healing did not always occur, and there were added financial burdens from offerings, the purchase of anointing oils, and other forms of giving tied to faith practices. Thus, faith healing was seen not simply as an automatic solution, but as a dual experience with both spiritual and material costs. This relationship echoes findings from Eric Lincoln and Lawrence Mamiya's The Black Church in the African American Experience, where faith healing is shown as historically central to the social, economic, and health lives of Black communities. In the upcoming sections, I discuss the themes of parental influence on the faith lives of Ghanaian Pentecostal Christian women, fellowship and community as a way to engage in Christian faith, and also the theme of participants' concerns about the healthcare system, which includes focus on the role of faith healing in their healthcare. These themes are interconnected because they each explore how faith is practiced, shaped, and experienced in the lives of Ghanaian Pentecostal Christian women, especially in relation to health.

Parental Influence on the Faith Lives of Ghanaian Pentecostal Christian Women

A consistent theme that emerged in the narratives of the women interviewed was the significant role their parents played in shaping their faith journeys. Nine out of ten participants attributed their Christian beliefs and practices to being raised in a Christian household, where faith was embedded in their daily lives from an early age. For some, Christianity was a natural and unquestioned part of life because their parents were devout believers. As Alice shared, "My dad is a pastor? So, yeah, so it came naturally that automatically you would be a Christian."

Similarly, Mandy reflected on how being raised in a Christian home shaped her identity and life decisions: "I have always been a Christian. I was born to Christian parents, and so from a very young age, I have always been in the church, what they call a church girl. So it kind of shaped a lot of the things that I have done, like even in the choice of school programs, life path."

For others, the influence of one parent was more dominant in their religious upbringing. Debra described how her mother's strong faith shaped the family's religious practices, even though her father did not subscribe to a specific Christian denomination: "So, my mom was more religious, my dad is not. So to say religious, I'll say he doesn't subscribe to say I want to be a Pentecostal, be a Baptist, or a Methodist. Let's say he acknowledges there is God; he's not an atheist. It's just that he doesn't put himself in a box. But my mom is religious, and we followed our mom most of the time when it comes to church stuff." This pattern of following the mother's religious commitment was also reflected in Linda's story: "I was born in a Christian family, I would say yes, so mostly my mom was going to church, so like we had to follow her to church, but my dad was not really going to church, so it was mostly my mom." Linda also shared how frequent relocations meant changing churches often, as her mother preferred attending nearby churches rather than traveling long distances. In some cases, faith was not just passed down through parents but also through extended family. Gail noted, "I was born into a Christian family and my grandparents and parents are all Christians." This suggests a multigenerational transmission of faith, where religious beliefs and practices were not only reinforced by parents but also by other family members. Similarly, Tracy also spoke of how she has emulated her grandmother's Christian religious beliefs and the influence of her grandmother's faith practices. She particularly noted how her grandmother prays over water when ill. In her interview, she stated, "As for my grandmother, any medication she has, you know, she prays on it. And if your

tummy is in pain, she will pray on water, then you drink it". Her statement demonstrates how she incorporates faith practices into her health lifestyle, just like her grandmother does.

While some women expressed a sense of natural continuity in their faith due to their upbringing, others highlighted a personal shift in their faith journeys, moving beyond what they had inherited from their families. Tracy, for instance, explained that while she grew up hearing about God, she later sought a personal encounter: "I knew or I heard about God from childhood, but then as I grew, I got to encounter him for myself and desired to know him more, because I know the importance of knowing God personally, and not just for what people say or the fear of other people's perspective." The narratives reveal that parental influence, from mothers and extended family, played a crucial role in shaping the early faith experiences of these Ghanaian Christian women. While many participants described their faith as a natural extension of their upbringing, others demonstrated a personal journey of moving beyond inherited beliefs to form a deeper, individual relationship with God.

Fellowship and community as a way to engage in Christian faith

Although all of the women were born into a Christian household, eight out of ten participants stressed that aside from the presence of religious parents, fellowship and community played a huge role in strengthening their Christian faith. It was one of the themes that showed up frequently in the conversations with these women. From childhood to adulthood, being part of a Christian community, whether through Sunday school, student fellowships, or church groups, deepened their faith and strengthened their commitment to God.

For some, their introduction to faith was through structured religious activities in church. Suzzy recalls how, as a child, "we went to church, and they had a place that was basically for children. So we go there, and then we have leaders, like grown-ups, that will come and then take

up or teach us and play with us, teach us some children's songs." These early experiences in the Christian community laid a strong foundation for their faith, shaping their understanding of God. Mandy similarly emphasizes the importance of communal worship, stating, "As a little child, I would go to church every Saturday, Sunday, and we would pray at home." The routine of attending church services and engaging in communal prayer became a core part of her faith journey. For some women, their faith grew stronger in school settings, where Christian fellowships created an environment of spiritual learning and support. Suzzy also shares how joining a church fellowship on campus helped her understand her faith better: "You know how school is, you get a lot of preachers coming in every single time to educate you about the word. So you now tend to appreciate God more and get the understanding." Similarly, Tracy, who was a small group leader in school, recalls organizing weekly religious meetings: "My colleagues and I used to call our cell members. Some of them would come. Some would say, 'I am coming, but never show up. But we kept pushing. Every week, we either invited someone from the main church to preach, or one of us would take up the role, just to involve everyone and make them anticipate and come for the small group meeting."

Linda's experience in the Church Students' Union also solidified her Christian beliefs. "I joined the Church Students' Union. I was there, I became a small group leader, and all that. So that exposed me to be more grounded in the faith," she says. Likewise, Rita reflects on how joining church groups during secondary and university years deepened her faith: "I started to join a church in secondary school, but in university, it intensified. My knowledge of my Christian faith became better." Participation in various church roles also played a significant part in shaping these women's Christian lives. Flora recalls volunteering in church activities, following in her father's footsteps: "My dad volunteered, you know, teaching them, so I also volunteered

teaching them." Similarly, Constance's faith was influenced by her involvement in a choreography group at her aunt's church: "That largely influenced my going to church. And then in high school, I sort of reconnected to God and reaffirmed my faith, became born again, and that is where it actually started."

Beyond structured church activities, friendships and peer relationships also played a role in nurturing their faith. Gail acknowledges the impact of Christian friendships: "I did whatever I knew in order to get closer to God, such as reading the Bible, joining groups in church, and associating with like-minded friends who would contribute to my Christian life from senior high school to tertiary and even in my workplace. I am proud of the friends I had in my Christian life." Debra summarizes how faith is nurtured through communal experiences: "We grew up in Sunday school, youth class, secondary school, and now we're in the adult class. So it is mostly building up from childhood, building on whatever you are taught." Her words capture how faith is a continuous journey, strengthened by the bonds of fellowship at different stages of life. Through these experiences, it is evident that faith is not just a personal journey but one deeply embedded in the collective Christian community. The presence of mentors, friends, and religious activities created an environment where faith could grow, be tested, and be reaffirmed. These women's stories bring to light the significant role of Christian fellowship in fostering a lifelong commitment to God. However, this sense of community and support extends beyond spiritual matters and touches on their concerns about the healthcare system. Several participants expressed frustration with the international and primarily Ghanaian healthcare systems, citing experiences that eroded their trust in hospitals and doctors. As a result, many of them began to rely more on their judgment, prayers, and alternative health solutions, illustrating the intersection of faith and healthcare in their lives. In the next theme, I will be discussing the concerns of the

healthcare system and why their religious background relates to their healthcare and health practices.

Concerns of the Healthcare System

Some participants expressed their concern for the healthcare system and shared some of their experiences, which depict the need for a better healthcare system.

Many of the participants expressed doubts and frustrations about the healthcare system, both in Ghana and beyond. Their experiences often led them to lose confidence in hospitals and doctors, choosing instead to rely on their judgment, prayers, or alternative solutions, and they all admitted the cost of medical care. Debra, for instance, expressed how some private hospitals she visited, although efficient, were expensive as compared to public hospitals. Debra stated, “The health system has its downforce. So that's that one, but I think that it also depends on the hospital, public or private, and the facility you are accessing. You cannot really compare Corpus Memorial Hospital to a hospital in your neighborhood”. In Ghana, public hospitals usually owned and operated by the government, are generally more cost-effective and accessible, especially for low-income individuals, but they are often perceived as less efficient due to issues like long wait times, overcrowding, and limited resources. In contrast, private hospitals are typically owned by a group of individuals or a medical doctor with years of expertise in their field. They tend to offer quicker and more reliable care, but at a significantly higher cost, making them less accessible to many. This reveals the socio-economic stance and hospital efficiency when it comes to private hospitals and public/government hospitals in both rural and urban areas. Suzzy shared how her experience at a hospital in her hometown left her feeling uncertain about the quality of care she received. "They didn't do the kind of labs, I guess they were supposed to do," she explained. Despite taking the prescribed medicine, she remained unwell and eventually

decided to stop seeking hospital treatment. "I decided not to go to the hospital again," she said, believing it was not helping her condition. For Mandy, her struggle with painful menstrual cramps highlighted the inconsistency of medical treatments. "I have taken different medications, and they have also prescribed different procedures... sometimes it works for a while, and then it resets back, and sometimes it doesn't even work at all." Her experience left her frustrated, as she had tried many different treatments without lasting relief. Constance spoke about her lack of trust in hospitals, particularly in Ghana. "Hospitals in Ghana do 'Nyame bɛyɛ,'" she said, using the Twi phrase meaning "God will do it." By saying "hospitals in Ghana do 'Nyame bɛyɛ,'" Constance is not just expressing personal frustration; she is offering a critique of the biomedical system itself, suggesting it lacks the technical certainty and professional rigor expected of modern healthcare. Instead of confidence in medicine, the system reflects a spiritualized uncertainty, which, for many Pentecostals and other Christian denominations, reinforces the appeal of faith healing and divine intervention. She described the healthcare system as operating on trial and error, recalling instances where family members had passed away from avoidable circumstances. She also emphasized that "women in general are not paid much attention when it comes to healthcare," and negligence often worsens their conditions, highlighting women's health issues.

Debra also voiced her frustration with the repetitive nature of hospital visits. "You go to the hospital, every time they say, 'Oh, go and do this. Go and do that. Do this lab, do that.' You do all that, and it's still the same thing." The high cost of medication and the stress of endless tests made her question whether it was worth continuing to seek medical care. "The cost is what even pushed me to say, 'I'm not even going to the hospital again.'" Tracy highlighted the poor conditions of public healthcare facilities, particularly for women and mothers. "Except if you can

afford private medical care in Ghana, it is not really good. Even during childbirth, some women will be on the floor. Their babies will be on the floor." She also described how family members who care for sick relatives often suffer as well, saying, "If you don't take care, you end up getting worse than the person who is sick." Linda pointed out that many people avoid hospitals not because they don't want care, but because they cannot afford it. "The problem is that there's no free healthcare. So sometimes people don't go, not because they don't want to, but because they can't pay." Flora was particularly frustrated by the lack of proper diagnoses in hospitals. "They didn't even try searching it online! With just a simple search, I found the answer. At that moment, I thought I could do a better job than all the doctors there because they could not even diagnose my brother." These experiences reflect a deep distrust in the healthcare system, shaped by inefficiency, high costs, misdiagnoses, and inadequate medical attention, particularly for women. However, all participants expressed that these experiences in the healthcare systems do not negate the benefits of going to the hospital. They expressed the need to visit healthcare facilities for diagnosis and a check-up. Even though most of the women shared their worries and disappointments with healthcare, they all still believed that going to the hospital and getting medical help is important. Many of them showed that their Christian faith does not stop them from using health services. They believe in doing both: praying and seeking medical help when needed. Suzzy said, "I think when you are not feeling well, it is advisable for you to go to the hospital to be checked... and if there's something wrong with you, it can be well done." This shows her trust in the hospital system and the belief that early checks can help. Alice also said something similar: "I, as a believer, don't take the doctors' work for granted. When I am sick, I go to the hospital." For her, trusting doctors does not mean she has less faith in God. It means using the knowledge and help that God has given to doctors.

All participants shared how prayer and medical care can work hand in hand. Participants such as Mandy expressed that while her family believes in the power of prayer, it does not stop them from getting medical help. “My family prays about everything. It does not stop us from seeking health.” Constance also made a point about regular checkups. She explained how people sometimes wait too long before finding out they have serious health problems like kidney disease. “People have kidney issues until it's too late, and it’s all because they don’t do regular checkups.” She stated that she is lucky to have health insurance through her job, so she tries to get tests and checks whenever she can. Debra pointed out the importance of quality care and shared her experience with a trusted private hospital in Accra. “There is this hospital... It is a private one, they are very, very good.” Her words show that at least she perceives that some hospitals do provide good care, and it is worth finding and using those services. Tracy, while saying she does not often go to the hospital because she rarely falls sick, still acknowledged that good care is possible, especially if you can afford private services. “From what I hear, sometimes it is not really good except you can afford private medical care in Ghana.” Linda simply said, “I think healthcare is important. As human beings, we fall sick and we need to go to the hospitals… even just to get advice.” Her statement reminds us that healthcare is not just about treating sickness, but also about learning how to stay healthy. Finally, Rita shared that: “Well, I’ll say if I am ill, I will definitely go to the hospital.” Her response shows that seeking care when sick is a basic and accepted step in taking care of oneself. Participants admitted concerns with healthcare services, their pros and cons, and how they include their faith. However, the healthcare costs were not the only obstacle in their attempts to achieve wellness. Some participants also revealed the role of the presence of Pentecostal Charismatic Churches (PCCs) and the Independent Prophetic Churches(IPCs), which took much after the Pentecostal faith. Attending these churches

and not receiving healing created some exasperation. Debra, for instance, recounts her experience where she visits a church but receives no healing, and she questions, “Okay, what is it? What is the issue? Is it that we do not believe, and I know we believe, right? And so what is it that we are not going to get our healing? “ Here, the question of faith healing becomes one of imbalance between what is expected and what is experienced. This imbalance highlights the discrepancy between theological belief and lived reality, where faith is present, yet the desired outcome of healing does not manifest. It suggests a struggle with questions of worthiness, divine will, and the limits of faith-based healing. For many, such experiences may provoke inner doubt, feelings of abandonment, or confusion about the efficacy of spiritual practices, especially when healing is taught as a guaranteed outcome of true belief.

Mandy shared that it is not right for individuals to categorize a religious patient’s faith as inadequate when they do not receive healing. Moreover, some participants had doubts about the efficacy of faith healing through these churches, and others were more concerned about the costs that are involved in faith healing through these Independent Prophetic Churches (Amakye, 2004). In the interview data, Flora, for instance, said, “So, well, for my family, we do not believe in having someone say a pastor or going somewhere to pray because we believe that we are children of God”. Constance also raised a theological concern on faith healing in churches as she states “I don't believe that God will heal you based on your faith. Well, because if someone cannot walk, how do you know that he does not want to walk more than you are praying for him to walk?”. Her reflection points to a stance suggesting that attributing healing solely to faith may overlook the complex realities of individual struggles and physical conditions.

A few participants, such as Tracy, Debra, Flora, and Constance, were also skeptical of the authenticity of the healing testimonies proclaimed by the churches. Tracy, for instance, said,

“Generally, in our part of the world, when you see Africans or Ghanaians, when you go to a church, you may even see that there is a wide difference. And even when you see videos of these one-man churches, where there are so many miracles and all that stuff, there are so many women that you only find a handful of men. So you will see that women, I think, I don't know whether to say that they are vulnerable. Independent Prophetic Churches are popularly referred to as one-man churches in Ghana, just as Tracy stated in her conversation. As discussed earlier in Chapter 2 (Literature Review) of the study, these churches typically revolve around a single central figure, usually a male pastor or prophet who exercises considerable spiritual, emotional, and even financial authority over the congregation. This model not only reflects concerns about a lack of institutional accountability and authenticity, but also brings gender-related issues to focus. Although these congregations are often predominantly composed of women, the leadership and prophetic authority are overwhelmingly male. This creates a stark power imbalance in which women’s spiritual expressions and roles are mediated through male authority, limiting opportunities for female leadership or theological agency. Furthermore, the heavy reliance on a single male leader may reinforce patriarchal structures, where women's bodies, testimonies, and health concerns are interpreted and responded to through male-centered doctrines. As a result, these churches can become spaces where women are spiritually active but structurally and theologically marginalized, reflecting societal patterns of gender hierarchy masked under the language of faith and prophecy.

Some participants also referenced how some of their family members tried several IPC and PCC churches but their family members still passed away. Constance, for instance, said, “ It becomes a very slippery slope when you try to ask God why, so a lot of it, you just take it in stride. And if he says, okay, you need to be saved. You need it, as I said, if it is in his will, there

is nothing you could do that will change His mind". Constance's statement reflects a form of resigned fatalism, where health outcomes are perceived as entirely subject to God's will and beyond human control. Her comment, "you just take it in stride," and "if it is in his will, there is nothing you could do that will change his mind," illustrates a deep theological surrender, suggesting that efforts like visiting a hospital, trying remedies, or even persistent prayer are ultimately futile if they contradict divine intent. This mindset diminishes personal agency, particularly for women, by discouraging practical responses to illness in favor of passive acceptance. Furthermore, her remark that "it becomes a very slippery slope when you try to ask God, why" may imply that questioning divine will is spiritually risky, which may suppress critical thinking or action. In the Ghanaian Pentecostal context, such beliefs may be culturally reinforced, especially in spaces where suffering is framed as part of spiritual testing. For women who already navigate social and institutional limitations, this fatalism can further constrain their ability to advocate for themselves or seek diverse forms of healing, reinforcing a cycle where submission is spiritualized and agency is diminished.

In all, participants voiced concerns about the healthcare system, citing high costs, poor treatment, and misdiagnoses, especially in public hospitals. Despite frustrations, they still valued medical care and believed faith and healthcare could work together. Some were also skeptical of healing promises from Independent Prophetic Churches and Pentecostal Charismatic Churches, highlighting the vulnerability of women and the disappointment when healing did not occur. The vulnerability of women in these churches could be linked to women's health issues, such as menstruation and maternity, as shared by some participants. Participants such as Gail, Flora, Linda, Tracy, and Mandy shared reproductive health experiences and how women may be sidelined when it comes to their health. It becomes more complex, especially when all

participants admit the influence of cost in seeking medical care. Mandy, for instance, commented, “I think there was a time that I was buying medicine and there was this medication that I was buying for 100 cedis, and at the time I was in undergrad studies, and that was quite expensive for me at the time”. She expressed further that in spite of the cost involved, the medications ceased to be effective after a short period of time, leaving her feeling frustrated and uncertain about continued medical treatment. This loss of confidence in biomedical care often prompted a turn toward faith healing. Although there are tensions in the faith healing process, participants expressed the role of positive emotions as they engage in their faith healing process. Several women shared that their faith helped them experience hope, confidence, and emotional strength, even when physical healing was not immediate. Alice, for one, described how faith healing improved both mental health and her relationship with God, saying, "I think that it really improves them, first of all, not just their mental health, but it improves their relationship with God." This hints that beyond seeking physical healing, faith healing practices provide important emotional and spiritual support for many Black women. Faith healing may also serve as a form of what Alice terms as “indirect evangelism” in her interview; a concept she used to describe the ripple effect that a healing testimony can have within and beyond faith communities. She explained that when someone who was previously skeptical or non-religious experiences healing through prayer after biomedical approaches have failed, that healing becomes a powerful tool of conversion and encouragement. She expressed that the testimonies of faith healing in church boost her faith and the faith of others. She stated, “Let us say you are not a believer and you have tried hospitals without success. A pastor prays for you, and suddenly you are healed. You have no choice but to trust God. That is what I call indirect evangelism. Your healing leads you to share your faith, and those around you start believing too”. It reinforces belief among

congregants, spreads spiritual conviction through testimony, and draws others into the fold. For Alice and many participants, this chain reaction illustrates how faith healing is not only a therapeutic practice but a persuasive, affective, and rhetorical force that sustains and expands religious life in their communities.

Chapter Five: Discussion

This chapter discusses how Black Pentecostal Christian women construct, interpret, and embody health through a deeply spiritual lens. Drawing from participants' narratives, three core themes emerge: (1) parental and communal influence on faith, (2) concerns about formal healthcare systems, and (3) the role of spirituality in health practices. These themes demonstrate how participants do not separate spiritual well-being from physical health; rather, they perceive the two as interconnected. Practices such as prayer, fasting, and faith healing are not simply supplementary but are central to their approaches to health and healing. From this study, it can be asserted that Ghanaian Pentecostal women are not simply choosing faith over medicine, but rather inhabiting a rhetorical landscape in which faith becomes a means of enduring, navigating, and sometimes transcending the failures of biomedicine.

Faith, Embodied Health, and Tactical Healthcare

In terms of tactical healthcare, Derkatch (2018) similarly explores how wellness discourse draws on moral, spiritual, and natural logics to validate alternative healing. In my study, participants' stories of healing and suffering reflect this rhetorical resourcefulness. They challenge dominant biomedical ideologies and assert new ways of knowing the body rooted in faith, community, and lived experiences. As Malkowski, Scott, and Keränen (2016) argue, health is not merely biologically determined but "socially constructed and culturally mediated''.The women's narratives in my study reflect a view of health that transcends the biomedical model. Health is experienced as both physical and spiritual, shaped not only by symptoms or diagnoses but by belief, emotion, and social context. This duality should not be mistaken for a simple division between medicine and faith. Rather, health emerges as an embodied, rhetorical practice, an ongoing negotiation of meaning, agency, and care within contexts shaped by systemic

inequality and cultural belief (Malkowski et al., 2016; Segal, 2008). For instance, in my interview with Tracy, she shared how she navigates illness through faith practices, which she learned from her grandmother. She stated, “As for my grandmother, any medication she has, you know, she prays on it. And if your tummy is paining you, she will pray on water, then you drink it”. This reflects a health decision where prayer is not separate from treatment. Instead, it is part of the treatment. Here, the act of praying over medicine or water may reveal a rhetorical and spiritual framing of healing. Also, the embodied effects of faith are subtly present. While not explicitly stated, the belief that prayer transforms the water or medicine suggests that the grandmother views health as something spiritually mediated and that healing is experienced not just physically, but through faith-infused bodily acts (drinking prayed-over water, for example).

The church, especially within Pentecostal and Charismatic traditions, emerges as a trusted site of refuge when formal health systems feel alienating, inadequate, or financially out of reach (Levin et al., 2005; Dessio et al., 2004). Participants frequently turned to spiritual healing when biomedical care was either unavailable or emotionally unfulfilling. As Mandy, one of the participants, explained, “I think there was a time that I was buying medicine... it was 100 cedis, and at the time I was in undergraduate studies, and that was quite expensive for me.” When asked how she coped, she said, “I cry out of frustration, then I pray.” This sequence of emotional expression followed by prayer demonstrates not only a coping mechanism but what Johnson and Quinlan (2018) describe as affective labor, central to how people in marginalized contexts rhetorically navigate illness. Johnson and Quinlan (2018), in their article “The Affective Turn in Health and Medical Communication,” describe affective labor as the work of managing emotions, creating emotional connection, and navigating interpersonal dynamics in healthcare settings. They emphasize that this labor is not confined to medical professionals but extends to

patients, particularly those from marginalized backgrounds, who must often advocate for their care, interpret clinical encounters emotionally, and perform composure, gratitude, or resilience to be taken seriously. In doing so, affective labor becomes a rhetorical act shaping how care is accessed, how pain is expressed, and how agency is negotiated within systems that may overlook or undervalue certain bodies and voices. The emotional expressions coupled with prayer as a means to navigate health circumstances (As seen with Mandy, for instance), faith-based responses should not be dismissed as passive or anti-scientific. Rather, they represent a form of what Alexander and Edenfield (2021) call "tactical folk medicine," which they define as community-rooted, healing practices that emerge in response to systemic healthcare failures. Systemic healthcare failures as described by participants such as Flora, Suzzy, and Debra, as they recounted how they experienced professional laxity in some of the hospitals they had visited; issues such as inability to diagnose illness.

Faith healing thus becomes a form of rhetorical resistance for the participants I interviewed; not a wholesale rejection of medicine, but a strategic engagement with healing that is more emotionally resonant and spiritually coherent. These practices reflect what Van Cappellen et al. (2021) refer to as "upward spirals," cycles of religious engagement and positive emotion that reinforce both hope and perceived well-being. In this way, prayer and ritual are not mere supplements to medicine, but integrated forms of care that provide emotional clarity, social support, and spiritual legitimacy. The emotional validation, communal prayer, and spiritual hope offered by Pentecostal healing rituals address what Braxton et al. (2023) identify as the affective gaps in clinical settings spaces where pain is too often misunderstood, ignored, or racialized. Even when biomedical treatment is available, the spiritual coherence and sense of being seen

offered by faith-based healing can feel more meaningful than the distant, fragmented care of formal institutions.

However, the rhetorical work of faith is not without pitfalls. Some participants were candid about the limits of faith-based healing. Several women noted that healing through prayer or prophetic intervention did not always occur, even with consistent belief and participation. For instance, Debra recounted a vivid experience at an Independent Pentecostal Church (IPC), where the leader laid hands on her and prayed for her recovery, yet no healing followed. She, alongside others mentioned that while hospitals were often too costly, pursuing healing through IPCs or even some Pentecostal-Charismatic Churches (PCCs) came with their financial demands. Though less extreme than hospital bills, costs for special services, seed offerings, or consultation with church leaders still posed burdens. In simple terms, seed offerings are money or gifts given to a church or pastor with the hope or belief that God will reward the giver, often with healing, financial breakthrough, or other blessings.

This meant that in addition to the emotional toll of unmet expectations, some of the participants who are a part of these faith communities also faced economic strain without physical healing, complicating the narrative that faith healing is always a more accessible or reliable alternative. This becomes a significant dilemma at the heart of the study. Faith is both a source of strength and solace, and yet it can also demand investments of emotional, spiritual, and financial resources that do not always result in tangible healing, which adds to emotional strain. For women navigating healthcare systems, the decision to turn to prayer over medication is not simply a matter of belief but a complex negotiation of cost, trust, and hope. When healing does not arrive, and money has still been spent, the emotional dissonance can deepen. The tension between faith's promise and its practical limitations reveals the layered and sometimes

conflicting logics these women must reconcile in their pursuit of care. Participants such as Debra, Mandy decided to go to neither the hospital nor the church for healing as they had come to a state of acceptance of their medical condition. In the interview, Debra stated, " I try to justify it in a sense that it has not gotten worse for me physically, so I feel that is my healing". Aside from economic pitfalls, the Pentecostal church is not immune to gendered power dynamics or hierarchies of authority. Many participants expressed discomfort with Independent Prophetic Churches, often referred to as "one-man churches," where healing is linked to submission under male-dominated charismatic authority (Anderson, 2002; Quayesi-Amakye, 2012). While these spaces offer care, they may also reflect and reinforce patriarchal structures. Women's healing is frequently mediated through male voices and theological narratives that emphasize spiritual obedience over embodied autonomy. Harper (2021) and Frame et al. (1999) warn that such structures can limit the very agency that women seek through faith.

This paradox becomes evident in the recurring belief that "God will do it" (Nyame bɛyɛ in Twi). While this sentiment reflects spiritual trust, it can also represent a form of medical fatalism, which is a rhetorical stance where healing is removed from human control and placed solely in divine hands. As Hotz (2015) and Hamilton (2020) note, such beliefs may arise from both theological conviction and socioeconomic resignation, especially in contexts where healthcare feels unattainable. Constance's statement, "If it is in his will, there is nothing you could do that will change his mind," exemplifies this mix of faith and powerlessness.

This dynamic also mirrors the wellness discourses described by Derkatch (2018), where personal responsibility is emphasized often at the expense of recognizing structural inequities. Within Ghanaian Pentecostal contexts, these discourses take on spiritual tones. Practices like prayer, fasting, and prophetic deliverance become internalized mechanisms of health that speak

not only to belief but to survival strategies in the face of material scarcity and social precarity (Tuoyire et al., 2021). Importantly, these practices are not individualistic; they are also collective and culturally situated, rooted in testimony, and shared affective experience. Participants such as Alice shared how the testimonies of faith healing in church boost her faith and the faith of others. In her interview, she terms it "indirect evangelism". She stated, "Let us say you are not a believer and you have tried hospitals without success. A pastor prays for you, and suddenly you are healed. You have no choice but to trust God. That is what I call indirect evangelism. Your healing leads you to share your faith, and those around you start believing too". At the same time, the "cry and then pray" cycle as experienced by Mandy in times her medications do not work exemplifies a tactical adaptation to overwhelming circumstances. It is not a rejection of science but an embodied negotiation with structural barriers such as poverty, distance, and distrust that shape healthcare choices. In many ways, Ghanaian Pentecostal women are not choosing faith over medicine, but inhabiting a rhetorical landscape in which faith becomes a means of enduring, navigating, and sometimes transcending the failures of biomedicine. Even when biomedical care was accessible, its perceived effectiveness often fell short. This finding aligns with Tuoyire's (2018) findings on economic hardship and healthcare access in Ghana, where high costs limit treatment continuity. For many women, divine healing was not a naive alternative but a dual response to inequity. This echoes findings from The Black Church in the African American Experience by Lincoln and Mamiya, where the church historically functioned as a center of social, economic, and health support. For these women, faith was more than a belief system it was a practical strategy for navigating systems that often failed them, although faith did not always work. In the next section, I will be discussing concerns of the healthcare systems and the dilemmas involved with spiritual intervention and solutions.

Concerns About the Healthcare System

Participants described public hospitals in Ghana as overcrowded, expensive, or poorly staffed. These structural barriers, confirmed by Dumedah et al. (2021) and Aikins et al. (2017), include long travel distances, low doctor-to-patient ratios, and high out-of-pocket expenses. These difficult conditions discouraged many women from seeking formal medical care, not only for themselves but also for relatives dealing with chronic conditions like hypertension or diabetes. Instead, Pentecostal churches filled this healthcare void. As one participant explained, the church offered "prayer, care, and comfort" when medical facilities did not. The local nature of churches, especially Independent Prophetic Churches and Pentecostal Charismatic Churches embedded within communities, made them more accessible and emotionally responsive than distant clinics.

Among participants living in the U.S., similar frustrations were voiced. While healthcare access was structurally better, women reported feeling dismissed or misunderstood by medical professionals. One participant shared: "The doctor did not look me in the eye. He just wrote a prescription and sent me away." Such interactions created a sense of invisibility and mistrust. These experiences resonate with Robinson's (2020) study on chronic illness among African Americans, where patients often feel unheard and unsupported. Braxton et al. (2023) also note that expressions of pain from African American patients are frequently "disbelieved, misinterpreted, or minimized," reinforcing medical skepticism. This aligns with Segal's (2008) work on rhetorical credibility, which argues that patients who lack educational or social capital may be seen as unreliable narrators of their health. In contrast, within Pentecostal spaces, pain is interpreted as spiritually meaningful, whether as a form of divine testing or attack, which restores purpose and dignity to suffering. Constance expressed that sometimes health experiences are a

wake-up call from God. This highlights a tension between secular medical spaces and Pentecostal religious spaces in how pain is recognized, validated, and given meaning, particularly for Black women navigating systems that often overlook or invalidate their embodied experiences. In U.S. clinical settings, participants describe feelings of invisibility, dismissal, and mistrust. These responses reflect structural and rhetorical failures in healthcare communication, where medical professionals may overlook the subjective dimensions of pain. In contrast, Pentecostal spaces offer an alternative rhetorical and theological framework in which pain is not only believed but made meaningful. Rather than being seen as a symptom to be fixed or dismissed, pain is imbued with spiritual purpose. It may be interpreted as a divine test, a form of spiritual warfare, or a wake-up call from God, as expressed by Constance in her interview.

Yet, this contrast is not free of tension. On one hand, the spiritual reframing of pain can be empowering as it offers emotional validation and theological coherence, whereas biomedicine offers detachment. On the other hand, it can also introduce new forms of burden or fatalism. If pain is always spiritually purposeful, there may be pressure to suffer silently or interpret every health crisis as a divine message, potentially discouraging proactive biomedical intervention. This spiritual reframing is both a refuge and a risk, creating a dilemma at the heart of the study that must be recognized as we consider the following implications for policy and practice within this terrain. It also calls for a reflection on how healthcare systems can meaningfully engage with spiritual worldviews without overlooking their contradictions.

Implications for Practice and Policy

The findings show the need to center faith in healthcare policy, research, and practice, although the concept of faith healing seems a bit more complicated than this, given that faith institutions such as IPCs can be a part of the problem, which I will be explaining further. Faith is

not a peripheral belief but a primary framework through which many Black Pentecostal women interpret illness and seek healing. Ignoring this reality may risk undermining patient trust and perpetuating health disparities. Healthcare professionals, especially those working with African immigrants or African American communities, must engage with religious frameworks compassionately. Instead of dismissing spiritual beliefs as unscientific, providers could collaborate with church leaders to promote integrated care models. Faith-based health education delivered in churches could bridge biomedical knowledge with spiritual values. Pastoral care also plays a critical role in shaping women's health behaviors. Church leaders who understand basic health principles can encourage balanced approaches, validating the power of prayer while supporting medical treatment, a trajectory different from what ensued in McKeown's health situation and dispute over faith healing in the church. This dual advocacy strengthens health outcomes without alienating spiritual identity. For Black Pentecostal women, faith is not a peripheral add-on to health. It is a framework through which illness is interpreted, healing is pursued, and emotional endurance is sustained. When healthcare systems ignore or dismiss these spiritual worldviews, they risk deepening mistrust, encouraging disengagement from biomedical care, and perpetuating health disparities. However, integrated models where providers collaborate with church leaders and faith-based education occurs within spiritual spaces offer culturally resonant pathways that affirm both prayer and medical intervention. Meanwhile, for RHM scholars, these dynamics challenge conventional notions of credibility, expertise, and care. Women's reliance on pastors, testimonies, and communal prayer demonstrates how spiritual epistemologies function as rhetorical frameworks. These rhetorical frameworks become a public, persuasive system that shapes how women decide to seek healing and support. Rather than viewing these as oppositional to science, RHM must recognize them as tactical responses to

medical neglect, adaptive and culturally situated forms of care. It is important to note that collaborating directly with the men who lead Independent Prophetic Churches (IPCs) also carries potential risks. Because authority in many IPCs is highly centralized and often vested in a single male pastor. Additionally, such environments can perpetuate chauvinistic attitudes, where male spiritual authority is presumed to override women's embodied knowledge or medical advice. This dynamic may silence women's concerns or lead them to defer critical health decisions to male figures. Fatalistic interpretations of illness, such as viewing sickness solely as divine punishment or spiritual attack may also deter medical treatment altogether, framing suffering as a test of faith rather than a call for care.

Partnerships can inadvertently reinforce patriarchal hierarchies. Church leaders may also demand exclusivity or control over health messaging, limiting women's voices or sidelining female ministry workers. There is also the danger that therapeutic collaboration becomes transactional as pastors might expect financial contributions or "seed offerings," which are faith-based donations given with the expectation of receiving healing, blessings, or divine intervention in return. These contributions and offerings given to church leaders are in exchange for support and healing, creating new barriers to care. To guard against these pitfalls, healthcare professionals should engage a broad spectrum of church stakeholders, which includes women's ministries and lay leaders. This could help establish clear expectations around medical ethics and ensure that any faith-based partnership amplifies, rather than constrains, women's agency in health decisions.

Contribution to Scholarship

This study adds to the growing literature at the intersection of health communication, religion, and social justice. While prior research has explored Pentecostalism's healing

narratives, this study foregrounds Black Pentecostal women in Ghana and abroad, showing how their spiritual frameworks actively resist healthcare disenfranchisement. The reliance on divine healing and prayer is not merely an act of desperation; it is a theological and cultural critique of healthcare systems that are often impersonal or inaccessible. These women are not passive victims but active agents negotiating health through embodied faith. Despite their demonstrated agency, many women also find themselves submitting uncritically to prophetic authority. As Tracy explains in Chapter 4, these congregations are overwhelmingly female, with only a handful of men occupying leadership roles, which shows women's deep vulnerability and urgent search for consolation and healing. When a prophet commands a specific prayer regimen or fasting period, women often comply immediately, trusting the pastor's word as divinely mandated rather than subject to negotiation. Financially, the pressure to make "seed offerings" or special tithes is seldom challenged, even when these contributions strain limited resources. And in community prayer meetings, doubts about a failed miracle are frequently silenced to avoid being labeled as lacking faith. These patterns reveal how prophetic authority vested in a small number of male leaders can both empower and constrain, leaving women caught between the hope of divine intervention and the risks of unexamined obedience.

By engaging with scholarship on health disparities, rhetorical health communication, and the history of religion and medicine, this research contributes an account of alternative healing epistemologies. It calls for integrative, models of care. Ones that do not force women to choose between God and the hospital, but allow for both.

Limitations of the Study

A few limitations emerged during the research process, affecting participant recruitment, interview structure, and data collection. Initially, the study aimed to recruit at least 20

participants to ensure a diverse range of perspectives. However, due to challenges in participant availability and scheduling, only 10 participants were ultimately interviewed. While the use of both convenience and snowball sampling helped in recruitment, the final participant pool primarily consisted of individuals within my existing network as a researcher or their direct referrals. This introduced a potential bias, as participants may have had similar socio-religious experiences and perspectives. Additionally, the age range of participants (23-26 years) was narrower than originally intended (23-40 years). While this allowed for a more focused generational analysis, it limited the study's ability to capture insights from older women who may have had different or more extensive experiences with Pentecostal faith and healthcare systems. Another important limitation relates to my positionality as a researcher. As a Ghanaian Pentecostal Christian woman with similar experiences to those of the participants, I shared cultural and religious understandings with the interviewees. While this insider status facilitated rapport and a sense of shared language during interviews, it may have also led to assumptions or unspoken agreements that limited probing or critical questioning. The shared background could have contributed to moments of "unspoken understanding," where certain religious practices or experiences were mentioned without elaboration, as both participant and I assumed mutual knowledge. Seidman (2006) cautions that interviewing friends or acquaintances can present challenges, as it may compromise objectivity or inhibit participants from expressing themselves freely. While many participants were not close personal friends, the prior familiarity may have influenced the openness or direction of some responses. Participants may have filtered their answers, intentionally or unintentionally, based on what they assumed the researcher already believed or wanted to hear.

Second, the original research design proposed a three-session interview structure, with each session lasting approximately 60 minutes. However, due to participants' time constraints and availability, the format was modified into a single 60-minute session. While this adaptation ensured participation, it may have limited the depth of discussion and follow-up inquiries that could have emerged in a multi-session format. A longer engagement period could have allowed for more narratives, particularly on complex topics such as faith healing, interactions with healthcare providers, and evolving religious beliefs over time.

Future Research

Future research could expand on the current study in several meaningful directions. Including older participants would allow for an exploration of generational differences in how faith shapes health beliefs and practices. Broadening the scope to compare the experiences of Ghanaian, African American, and other diasporic Christian women could provide deeper insights into how location, culture, and history shape religious health practices. It would also be valuable to examine the experiences of men in Pentecostal communities, who may engage with faith and health differently than women. Additionally, future studies could investigate how second-generation African women living abroad navigate the intersections of healthcare and spirituality, especially as they balance inherited beliefs with new cultural contexts. Comparative research between Pentecostalism and other religious traditions, such as Islam or African Traditional Religions, could reveal both unique and shared approaches to healing. Hence, scholars might explore how healthcare systems can ethically and effectively integrate spiritual care without compromising professional medical standards, especially in settings where religion plays a central role in community life.

Chapter Six: Conclusion

By giving voice to the testimonies and lived experiences of Black Pentecostal Christian women in Ghana and the United States, this research sought to understand the ways in which participants talk about how their faith shapes decisions when it comes to their health and healthcare. What began as an inquiry into the role of faith healing soon evolved into an exploration of survival, identity, and care. This conclusion brings together the insights, themes, and personal reflections that emerged throughout this study. It centers not only on what was discovered but also on what these discoveries mean for rhetorical scholarship, health equity, and the recognition of Black women's experiences in the domains of health and healing.

At the core of this research lies a conviction that Black Pentecostal Christian women, whether in Accra or Atlanta, are not merely recipients of healthcare systems or spiritual traditions. They are active rhetorical agents, navigating between spiritual truths and medical realities, crafting culturally resonant forms of health advocacy, and sustaining theological frameworks of healing that operate outside biomedical paradigms. Their testimonies reveal a faith that does not deny sickness but refuses to be defined by it; a faith that is not opposed to medicine but refuses to surrender agency to it. The dialectic between biomedical authority and spiritual sovereignty was a defining feature across interviews and literature, reinforcing the need for scholarly approaches that hold space for this feature. It is also seen that in as much as medical systems may have their limitations such as high cost of medication and unprofessionalism, faith healing also presents some limitations in terms of fatalist mindset of religious members, the unquestioned sovereignty of male-gendered authority in the Church, and also the cost that comes in seeking faith healing.

The literature reviewed in Chapter Two provided an essential foundation for understanding the sociohistorical and theological dynamics that shape the health behaviors of Black Pentecostal women. Several scholars, such as Lincoln and Mamiya (1990), argue that religion and spirituality are not marginal to health practices in African or African American communities. They are central organizing forces. For instance, Holt et al. (2015) demonstrate that prayer, faith-based counseling, and communal worship often serve as alternative or complementary modes of healing, particularly among populations historically underserved by biomedical institutions. In Ghana, the literature foregrounds how Pentecostal theology emerged within a postcolonial context of spiritual assimilation, where indigenous religious beliefs and colonial missionary Christianity coexist. Rather than completely displacing traditional cosmologies, Pentecostalism often absorbed and reinterpreted indigenous spiritual frameworks, particularly beliefs about ancestors, witchcraft, and spiritual causality.

As Meyer (2004) argues, Pentecostalism offered not only theological answers but ontological security, reinterpreting illness as a site of spiritual warfare and deliverance. Faith healing ministries, overnight prayer vigils, and fasting became not just religious acts but modes of therapeutic intervention. Meanwhile, in the African American context, studies by Taylor et al. (2009) affirm that faith practices are often inseparable from health experiences. Historical legacies of medical racism, socioeconomic marginalization, and systemic neglect have compelled many Black communities to seek holistic care that addresses not just the body but the spirit and soul. This thesis contributes to that body of work by showing how these women speak health into being through prayer, prophecy, ritual, and rhetorical resistance. They build bridges between the clinical and the sacred, drawing on personal conviction, communal memory, and divine encounter. And yet, as this study and interviews with participants show, they also carry

burdens of spiritual responsibility, of faith-based expectations, and of navigating a world that often misreads their needs and expectations in both the medical and faith settings.

One of the primary findings of this research is that healing, in Pentecostal contexts, is not merely an outcome but a process of rhetorical negotiation. Healing occurs not just in hospitals or clinics. This healing is often mediated through the body through tongues, laying on of hands, oil, declarations of faith, and earnest prayers. We must consider that these women's bodies are not only the sites of health and illness, they are rhetorical instruments, inscribed with theology, testimony, and social history. This embodiment of healing is evident in the language used by participants. Some participants described illness not as a medical diagnosis but as a spiritual condition requiring discernment. The use of scriptures and theological references was made by some participants. Constance in her interview refers to Paul, who states in Romans 9 verse 15, which says "I will have mercy on whom I will have mercy and I will have compassion on whom I will have compassion when I asked her about the issue of faith healing. By this, Constance seems to be stating her belief that God's mercy and compassion, and healing are not earned, but freely given according to His purpose and grace, signaling that for these women, health is both material and metaphysical. This does not mean that these women reject medicine outright; rather, they interpret medical events through a spiritual lens. A migraine might be spiritual warfare. A fibroid might be a generational curse. Recovery might be seen as grace, and death as divine will.

Such interpretations do not preclude medical intervention. On the contrary, several participants emphasized the importance of seeking both prayer and professional care. Alice, for instance, explained in the interview, "I go to the hospital, but I also pray. I believe God uses both ways". This shows what Alexander and Edenfield (2021) call "tactical folk medicine," a strategy by which marginalized communities reframe spiritual traditions as valid epistemologies of

healing and resilience. These rhetorical practices are not arbitrary; they are culturally embedded responses to institutional neglect. When access to healthcare is limited, when doctors do not listen, and when pain is dismissed, faith becomes more than belief. It becomes the grammar of survival.

This study also explored the ways in which Black Pentecostal women confront silences both within their faith communities and outside them. On one hand, they are often entrusted with spiritual roles and fellowship duties, such as small group leaders, as mentioned by participants such as Debra, Tracy, Flora, Alice, and Suzzy. On the other hand, they may be expected to remain silent about doubt, suffering, or unhealed illness. The burden of "strong faith" can make it difficult to confess when healing does not come. This silence can be seen in how Debra in recounts her prophetic experience as seen in Chapter 4. She does not confront or question the prophet; instead, she questions herself on why healing was not attained. She stated, "When we go for prophetic services, I see people falling down and being delivered, but for me, I never fall down…Is it that my faith is not strong enough? I know I believe". Such stories point to a tension within Pentecostal rhetoric between the empowering promise of divine healing and the quiet trauma of unfulfilled expectation. In recognizing these silences, this thesis joins a growing body of scholarship that seeks to amplify marginalized spiritual voices, particularly those of women. It affirms that rhetorical studies must account not only for what is said, but for what is not said and what is carried in gesture, memory, and spiritual labor.

As I bring this study to a close, I am reminded that this thesis is more than a scholarly contribution. It is a combination of spiritual resilience, cultural identity, and rhetorical power rooted in the lives of Black Pentecostal women who have lived, prayed, healed, and endured under conditions often ignored by biomedical systems. Their stories are not footnotes to health

narratives but valuable texts. I began this work with curiosity and reverence for the spiritual legacies of the women who raised me. I watched my mother fast for days when illness struck. I saw my grandmother pour oil into her palms and press it to her chest, declaring healing in Jesus' name. These moments were not extraordinary in the context of Ghanaian Pentecostalism. They were expected, embodied rituals that framed the way we understood sickness, suffering, and restoration. When I entered academic conversations on health, I found the opportunity to explore these embodied rituals and how other black Pentecostal Christian women talk about faith healing. This thesis became an act of re-centering and an effort to create space for concepts of healing that do not begin in clinical offices or with scientific evidence but in fellowships and prayers. In doing so, I found that Black Pentecostal women's experiences of health are not only culturally distinct; they are rhetorically essential. These women are theologians of everyday life. Some interpret health through scripture. Some measure health through prophecy. They do all these while taking strides to access medical care. Yet, as I engaged more deeply with their narratives, I also came face to face with complexity. As seen earlier in Chapter 4 of the study, these women are not immune to fear, disappointment, or contradiction. Due to inefficiencies the healthcare system may have, some found healing in prayer; others sought it but did not receive it. Some avoided hospitals out of fear or financial strain, while others combined medical treatments with spiritual practices, which did not always work.

As a researcher and as a woman raised in the very faith I was studying, I carried these stories carefully. There were moments I paused while transcribing because a participant's voice echoed too closely with my past. There were interviews that brought back memories I had buried concerning my mother's frantic search for healing from one Pentecostal church to another. My experience in the faith allowed me to listen not just as a scholar, but as a daughter, a witness, a

believer with questions. It reminded me that objectivity does not require distance, and that rigorous research can be personal. I leave this work with profound gratitude not only for the academic journey but for the spiritual one. I leave with new questions, and with respect for the women who taught me what it means to pray and to seek healing, and the issues that surface, be it applying faith healing or medical care.

References

Agyapong, Kwasi Atta. *Witchcraft in Ghana: Belief, Practice and Consequences*. Noyam Publishers, 2021.

Alexander, J.J., and A. C. Edenfield. "Health and Wellness as Resistance: Tactical Folk Medicine." *Technical Communication Quarterly*, vol. 30, no. 3, 2021.

Anderson, Allan H. "The Newer Pentecostal and Charismatic Churches: The Shape of Future Christianity in Africa?" *Pneuma: The Journal of the Society for Pentecostal Studies*, vol. 24, no. 2, 2002.

Attard, Joan, Linda Ross, and Karen W. Weeks. "Corrigendum to 'Design and Development of a Spiritual Care Competency Framework for Pre-Registration Nurses and Midwives: A Modified Delphi Study.'" *Nurse Education in Practice*, vol. 43, 2020.

Benavidez, Gabriel A., Whitney E. Zahnd, Peiyin Hung, and Jan M. Eberth. "Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area." *Preventing Chronic Disease*, vol. 21, 29 Feb. 2024.

Braxton, C., Begian-Lewis, K. M., Marback, R., and Fritz, H. "Pain, No Gain?: A Narrative Analysis Exploring the Accounts of Older African American Patients and Their Discussion of Pain Management Related to Chronic Illness." *Rhetoric of Health & Medicine*, vol. 6, no. 2, 2023.

Centers for Disease Control and Prevention. *Chronic Diseases: The Leading Causes of Death and Disability in the United States*. CDC, 2016.

Crotty, Michael. *Foundations of Social Research: Meaning and Perspective in the Research Process*. Routledge, 1998.

Derkatch, Colleen. “The Self-Generating Language of Wellness and Natural Health.” *Rhetoric of Health & Medicine,* vol. 1, no. 1, 2018.

Dessio, Whitney C., Christine Wade, Maria T. Chao, Fredi Kronenberg, and Linda E. Cushman. “Religion, Spirituality, and Healthcare Choices of African-American Women: Results of a National Survey.” *Ethnicity & Disease,* vol. 14, no. 2, 2004.

Doku, Alfred, Lawrence Sena Tuglo, Vincent Boima, Francis Agyekum, Pearl Aovare, Martha Ali Abdulai, Anthony Godi, Ron J. G. Peters, and Charles Agyemang. “Prevalence of Cardiovascular Disease and Risk Factors in Ghana: A Systematic Review and Meta-Analysis.” *Global Heart,* vol. 19, no. 1, 20 Feb. 2024.

Frame, Marsha Wiggins, Carolyn B. Williams, and Edward L. Green. “Balm in Gilead: Spiritual Dimensions in Counseling African American Women.” *Journal of Multicultural Counseling and Development,* vol. 27, no. 4, 1999.

Hamilton, Jada B. “Religion and Spirituality in Healthcare: Distinguishing Related and Overlapping Concepts From an African American Perspective.” *Cancer Nursing,* vol. 43, no. 4, 2020.

Harper, Kimberly C. *The Ethos of Black Motherhood in America: Only White Women Get Pregnant*. Lexington Books, 2021.

Hotz, K. G. “Big Momma Had Sugar, Imma Have It Too”: Medical Fatalism and the Language of Faith Among African–American Women in Memphis.” *Journal of Religion and Health,* vol. 54, no. 6, 2015.

Johnson, J. R., & Quinlan, M. M. (2018). The affective turn in health and medical communication. *Health Communication,* 33(4), 355-366.

Levin, Jeffrey, Linda M. Chatters, and Robert J. Taylor. “Religion, Health and Medicine in African Americans: Implications for Physicians.” *Journal of the National Medical Association*, vol. 97, no. 2, 2005.

Malkowski, Jennifer, John B. Scott, and Lisa Keränen. “Rhetorical Approaches to Health and Medicine.” *Oxford Research Encyclopedia of Communication*, 2016.

Meyer, Birgit. “Christianity in Africa: From African Independent to Pentecostal-Charismatic Churches.” *Annual Review of Anthropology*, vol. 33, 2004.

Monroe, Rachel. “How Essential Oils Became the Cure for Our Age of Anxiety.” *The New Yorker*, 2 Oct. 2017.

Peprah, Prince, Razak M. Gyasi, Prince Osei-Wusu Adjei, Williams Agyemang-Duah, Emmanuel Mawuli Abalo, and Josephine Nii Amon Kotei. “Religion and Health: Exploration of Attitudes and Health Perceptions of Faith Healing Users in Urban Ghana.” *BMC Public Health*, vol. 18, no. 1, 2018.

Quayesi-Amakye, Joseph. “Prophetism in Ghana’s New Prophetic Churches.” *Journal of Pentecostal Theology*, vol. 21, no. 2, 2012.

Robinson, Michael A., Irang Kim, Orion Mowbray, and Tiffany Washington. “The Effects of Hopelessness on Chronic Disease Among African Americans and Caribbean Blacks: Findings from the National Survey of American Life (NSAL).” *Journal of Racial and Ethnic Health Disparities*, vol. 7, 2020.

Saldana, Johnny. *The Coding Manual for Qualitative Researchers*. 2nd ed., SAGE Publications, 2013.

Scott, J. Blake, Judy Z. Segal, and Lisa Keränen. “The Rhetorics of Health and Medicine: Inventional Possibilities for Scholarship and Engaged Practice.” *Poroi: An Interdisciplinary Journal of Rhetorical Analysis and Invention*, vol. 9, no. 1, Apr. 2013, pp. 1–25.

Seidman, Irving. *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences*. Teachers College Press, 2006.

Segal, Judy Z. *Health and the Rhetoric of Medicine*. Southern Illinois University Press, 2008.

Taylor, Robert Joseph, Linda M. Chatters, Jeff Levin, and David B. Larson. “Religion and Spirituality in the Lives of African Americans, Caribbean Blacks and Non-Hispanic Whites.” *Journal of the National Medical Association*, vol. 101, no. 6, 2009.

Tuoyire, Derek Anamaale, Leonard Baatiema, Duah Dwomoh, and Samuel Bosomprah. “Healthcare Utilization in Ghana: Insights from the 2017 Ghana Living Standard Survey.” *BMC Health Services Research*, vol. 21, no. 1, 2021.

Van Cappellen, Patty, et al. “Upward Spirals of Positive Emotions and Religious Behaviors.” *Current Opinion in Psychology*, vol. 40, 2021.

Van der Watt, A. S. J., et al. “The Perceived Effectiveness of Traditional and Faith Healing in the Treatment of Mental Illness: A Systematic Review of Qualitative Studies.” *Social Psychiatry and Psychiatric Epidemiology*, vol. 53, no. 6, 2018.

Ward, Brian W., Jeannine S. Schiller, and Richard A. Goodman. "Multiple Chronic Conditions Among US Adults: A 2012 Update." *Preventing Chronic Disease*, vol. 11, 2014.

Wyllie, Robert W. “Pioneers of Ghanaian Pentecostalism: Peter Anim and James McKeown.” *Journal of Religion in Africa*, vol. 6, no. 2, 1974.

Appendices

Appendix A

Consent for Research Participation

Research Study Title: Health and Religion:" A Rhetorical Inquiry into the Role of Pentecostal Christianity in the Health of Black African Women".

Researchers: Jeffrey Michael Ringer, Associate Professor, University of Tennessee, Knoxville, and Stefania Grant, University of Tennessee, Knoxville.

Why am I being asked to be in this research study?

I am asking you to be in this research study because you are very much involved in Christianity as a personal symbol of identity and have also shown continuous interest in your Christian background and evolving experiences.

What is this research study about?

The purpose of this research study is to understand Pentecostalist Christianity as a form of identity that may shape how Black African women engage in healthcare.

How long will I be in the research study?

If you agree to be in the study the total time commitment will be no longer than three hours. There will be a three-part interview which will last for no more than an hour.

What will happen if I say "Yes, I want to be in this research study"?

If you agree to be in this study, I will contact you via email to schedule an interview. Interview length will vary, but is intended to last no more than 60 minutes. I may then contact you to ask follow-up questions if necessary. I will record the interviews, transcribe and analyze them for my Master's thesis. I will also share with you complete or partial drafts of any scholarship I write

that references your words from this study to make sure that I am representing you and your perspective fairly and accurately.

What happens if I say, "No, I do not want to be in this research study"?

Participating in this study is up to you. You can say no now or leave the study later. Either way, your decision won't affect your relationship with me or with the University of Tennessee.

What happens if I say "Yes" but change my mind later?

Even if you decide to be in the study now, you can change your mind and stop participating at any time. If you decide to stop before the study is completed, you can simply contact the P.I at jeff.ringer@.utk.edu or the Co-PI at sgrant21@vols.utk.edu. You can also tell me whether you would like to withdraw your data from the study. If you choose to withdraw it, then I will neither analyze nor publish about it nor share it with my class.

Are there any possible risks to me?

There is a chance that you may experience mild discomfort as we interact on a personal level. While I will mask participants' identities using pseudonyms, there is a chance that others reading what I publish may figure out who the participants are. You have the right not to answer a particular interview question if you would prefer not to do so.

Are there any benefits to being in this research study?

Participants will receive 50 dollar Amazon gift cards for participating in the study. Your participation will help me learn more about the relevance of Pentecostal Christianity in the health lifestyles of Black Pentecodstal Christian women, which can in turn benefit other Christians and create new perspectives.

Who can see or use the information collected for this research study?

I plan to publish results from this study as part of my thesis. There is also the possibility that I will present this study at a conference and may even publish the findings in a book or article form. I do not plan to use your name in any publications, for in any publication I will refer to you using a pseudonym instead. I will also delete the recordings and make sure that the transcriptions do not include names of the participants or contact information.

I will keep confidential all study information and research records (e.g., consent documents, etc.) by storing them in a password-protected Google Drive folder. Only I will have access to this Google Drive folder. The transcripts will not have any identifying features linked to participants as audio recordings will be deleted.

What will happen to my interviews after this study is over?

I will keep the transcriptions of the interview after the study is done in a password-protected Google Drive folder provided by the University of Tennessee, Knoxville, for future reference.

Who can answer my questions about this research study?

If you have questions or concerns about this study or have experienced a research-related problem, contact me at sgrant21@vols.utk.edu.

For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact the Co-PI for this project at jeff.ringer@.utk.edu. For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board

The University of Tennessee, Knoxville, 1534 White Avenue

Blount Hall, Room 408

Knoxville, TN 37996-1529

Phone: 865-974-7697

Email: utkirb@utk.edu

Statement of Consent

I have read this form, and the research study has been explained to me. I have been given the chance to ask questions, and my questions have been answered. If I have more questions, I have been told who to contact. By selecting "Yes" below, I agree to be in this study. I will receive a copy of this document after I agree to the study.

Name ……. Signature ……..

Date …….

Appendix B

Recruitment Email

Hi [insert name],

I hope you are doing well. I write to find out if you would be willing to participate in a research study I am about to commence. This study is for my thesis research for my Master's program at the University of Tennessee, Knoxville. My research is on the influence of the faith of Black Pentecostal Christian women on their health. It also explores how faith plays a role in their health and the health of other women they have witnessed with extreme health complications, for instance.

I would be glad to have your perspective on this topic through an in-person interview. It is going to be a three-part interview session of no more than 60 minutes and they will be recorded via the Zoom application. Pseudonyms will be used to mask the identity of each participant. Amazon gift cards of 50 dollars per participant are also available for women willing to participate in the study as a form of appreciation.

If you prefer any medium other than in-person, I can certainly work it out with you. I have also attached the consent forms to this email.

If you have any questions, do let me know. I hope to hear from you soon. If interested, kindly reach out to her on +233 50 165 8648

Regards,

Stefania Grant

Graduate Student

Rhetoric, Writing, and Linguistics English Department

Appendix C

Recruitment by Word of Mouth Script

Stefania: Hi! I hope you are doing well.

Recruit: I'm good. You?

Stefania: I'm well too.

Recruit: That is great to hear.

Stefania: Would you be willing to participate in a research study I am about to commence? My research is on the influence of the faith of Black Pentecostal Christian women on their health and how faith plays a role in their health in extreme health complications or witness for instance. I would be glad to have your perspective on this topic through an online interview which would last approximately 45-60 minutes per session.

Recruit: That's cool. Give me some time to think about it.

Stefania: Certainly, if you have any questions, do let me know. One more thing before I leave… It is going to be a three-part interview series of no more than 60 minutes, and it will be recorded via the Zoom application. Pseudonyms will be used to mask the identity of each participant. Amazon gift cards of $50 per participant are also available for women willing to participate in the study as a form of appreciation.

Recruit: Alright

Stefania: If you agree to participate, I will send you the consent forms via email. If you prefer any medium other than online, I can certainly work it out with you.

Recruit: That's fine

Stefania: Sure. Thanks for your time, and I hope to hear from you soon. Have a great day.

Recruit: Thanks, you too!

Appendix D

Recruitment Referral Script

Hi everyone,

A friend of mine seeks to interview Ghanaian Pentecostal women with significant experience in the Pentecostal faith for her thesis research as part of her Master's program at the University of Tennessee, Knoxville. Her research explores how the faith of Black Pentecostal Christian women influences their health decisions and experiences. She is particularly interested in how faith plays a role not only in their own health journeys but also in the care and outcomes of other women they have seen go through serious health issues.

She is looking to conduct in-person interviews (or virtual, if needed) with participants who are open to sharing their experiences. The study involves a three-part interview session, each lasting no more than 60 minutes, and conducted via Zoom. All interviews will be recorded, and participant identities will be protected through the use of pseudonyms.

As a token of appreciation, each participant will receive a $50 Amazon gift card. If you or someone you know fits this description and might be interested, please feel free to reach out to her directly at +233 50 165 8648 on WhatsApp. Consent forms and further information will be shared upon contact.

Thanks so much for helping spread the word!

Appendix E

Interview Schedule

Interview 1: Religious background and faith journey

This interview will follow a semi-structured format. In addition to the questions below, I may also ask follow-up questions like "You said X, can you say more about that, please?"

Q1. Tell me the story about your journey of Christian faith. How did you get to where you are today in your faith?

Q2. Can you recount some of your important moments in the course of this journey?… To be more specific, what are some of the moments in your faith journey that, if they had not occurred, you would not be who you are in life today?

Q3. You have talked about your Christian journey in general and about some key moments in it. Now think about that journey in terms of health and healthcare. Can you give me a story of an important moment in your faith journey that relates to health and healthcare?

End of first session: Thank you for a beautiful session and for taking the time to answer the questions on your faith journey. In our next session, we will be focusing on some of the experiences you have had in health/healthcare.

Interview 2: Experiences in health.

This interview will follow a semi-structured format. In addition to the questions below, I may also ask follow-up questions for both this interview and interview 1, such as "You said X, can you say more about that please?" or "In interview 1, you said X, can you say more about that please?"

Q1. Could you tell me a story about some of the experiences that have shaped your notions on health and healthcare?

Q2. Do you mind telling me about a story of an encounter where you or any of your friends/family had health complications, if yes, how did you/they go about it?

Q3. In relation to question 2, did your faith or the faith of the women play a role in the health complications? If yes, how? If not, do you think there might have been a way for faith to play a significant role?

Q4. Can you tell me about a time when you approached a health expert about your health?

Follow up: How comfortable are you talking about your health experiences and conditions when you approach health experts?

Q5. Have you ever heard about faith healing? If yes, what is it to you, and how do you feel when you or other Christian women approach health issues with their faith?

Q6. Have you ever sought out a religious remedy like faith healing? If so, can you tell me about that experience? How did you feel emotionally and health wise?

End of second session: Thank you for a beautiful session and for taking the time to answer the questions on your experiences in health/healthcare. In our next/last session, we will be looking at some of the interrelationships between your Christian faith and your health.

Interview 3: The Relationship between religion and health experience

This interview will follow a semi-structured format. In addition to the questions below, I may also ask follow-up questions such as “You said X, can you say more about that please?” or “In interview 1, you said X, it would be great if you could throw more light on that?”

Q1. We have spent the last few weeks talking about the relationship between your faith, your health, and your views on healthcare. What else would you like to tell me about how those things are connected for you?

Q2. If you had the chance, would you change how you may have addressed your health issues with Christian religious remedies, such as faith healing, in the past? If so, what do you believe you would have done differently?

Q3. What role do you believe Christian religious practices such as prayer, worship, reading the Bible, and laying of hands play in your health/healthcare behavior?

End of third session: Thank you so much for dedicating your time, attention, and creating a thorough and candid interview session. We have come to the end of our three-fold interview. Let us continue to keep in touch while I assess the data, the results of which will be shared with you soon!

Have a great day!

Vita

Stefania Grant grew up as a third-generation Pentecostal in Ghana, West Africa. She received her Bachelor of Arts in English from Kwame Nkrumah University of Science and Technology before going on to pursue a master's degree at the University of Tennessee in Rhetoric, Writing, and Linguistics. She plans to continue to teach English Writing classes at UTK following her graduation. She hopes to continuously pursue her passion for teaching and writing both academically and creatively.