Dynamics of Religious Organisations in Responding to COVID-19:
A Case of Islamic and Christians Organisations in Urban Tanzania

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Abstract

Despite the dynamics of public health policies during COVID-19 pandemic in Tanzania, religious organisations (ROs) enhanced healthcare services and support while adapting safe measures. The study assessed the health care and support activities conducted by ROs during COVID-19. Furthermore, the study explored how Islamic and Christians teachings, practices, and meanings were crucial to the design and execution of ROs' COVID-19 healthcare activities. The study employed the concepts of religion as a model for, and model of lived reality; and development as holistic process. The study used ethnographic approaches such as participant observation, interviews and focus group discussion. Findings showed that ROs conducted both medical and non-medical activities, formal and informal healthcare services and provided support to their members and the general public access to COVID-19 related healthcare services and support particularly for those coming from poor socioeconomic backgrounds. Religious teachings, practices and meanings informed and motivated ROs healthcare workers, followers and the management in responding to COVID-19. The study concludes that ROs' COVID-19 healthcare interventions are dynamic, adaptive and practical for they influence and are being influenced by religious teachings, practices, experiences and meanings

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as well as existing socio-economic and political realities.	

1. Introduction

One of the duties established in the teachings of both Christians and Islamic traditions is to help and support those in need (Dilger, 2014a, p. 52). Healthcare services and support to the sick and poor segment of the population has been linked with the reaping of rewards and blessings from God/Allah in both Christian and Islamic organisations (Muhoja, 2020, p. 312). In the face of challenges encountered throughout the COVID-19 pandemic in Tanzania, Christian and Muslim organisations enhanced the provisions of healthcare services, social support and preventive practices in response to COVID-19 (Ndaluka et al., 2021, p. 120).

The outbreak of COVID-19 in Tanzania was officially confirmed by the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) on 15th March 2020 with the first case reported in Arusha Region (Pipkin, 2022). In the face of these developments, the government introduced preventive measures such as closure of schools (which lasted for three months between March and July 2020), social distancing, wearing of masks, hand sanitization and frequent hand washing. In the wake of these preventive measures, religious organisations were not left behind as they employed a number of strategies and programs in responding to the outbreak of COVID-19 (WHO & organization, 2020a).

In Tanzanian context, religious beliefs and religious institutions play a dominant role in the lives of millions of the people including access to health care services, support and advice (Sundqvist, 2017, p. 69). Tanzanians engage in religious practices not only in the case of physical diseases, but also for social, psychological, and interpersonal problems (Ndaluka et al., 2014, p. 132). People tend to turn towards religious beliefs to deal with social, economic, and health challenges arising from calamities and diseases such as COVID-19 (Ndaluka et al., 2021). Studies have demonstrated that religious bodies' participation in healthcare provision, spiritual services and support is connected with better emotional health outcomes (Kowalczyk et al., 2020, p. 2671), adherence to hygiene practices and altitudes, ability to cope with diseases, recovery after hospitalization and positive attitude to life (DeFranza et al., 2021; Kowalczyk et al., 2020). Furthermore, Kowalczyk et al., (2020) noted that COVID-19 has made people more open to their religious beliefs and religious practices.

Existing literature has shown that religious leaders can influence voluntary compliance with government instructions when those with moral authority encourage followers to comply with them (Jones & Menon, 2022). Rafiq, (2022) noted that religious leaders can serve as mediators between health project goals and the wider population. Sundqvist, (2017, p. 19) and Muhoja, (2020, p. 342) have revealed that, in Tanzania, religion is highly influential in almost every sphere of life, as it informs spiritual, material and moral needs of both believers and non-believers and helps to determine decision-making in search for wellbeing, including healthcare issues (Mukandala, 2006).

The 2009 survey conducted by Pew-Templeton as part of the Global Religious Futures Project indicated that 9 out of 10 Tanzanians mentioned religion as very vital in their everyday lives. Nearly 80 percent of respondents reported that they attended religious services and gatherings at least once a week, and half of them attended more frequently. Tanzanians turn to religion for assistance with physical diseases, but also for solving social, psychological, and interpersonal problems (Ndaluka et al., 2021, p. 131), which contributes to better emotional health outcomes and support (Kowalczyk et al., 2020, p. 2671).

In the context of the COVID-19 pandemic in Tanzania, religious organizations continued to play an important role in public life. Ndaluka et al., (2021, p. 130) argued that COVID-19 increased religiosity in Tanzania in terms of frequent prayers, attending religious gatherings, and participating in fasting have been witnessed. New Religious organisations particularly those of Pentecostal origin and Muslim Revivalism organisations have also been influential in providing significant healthcare services and support, encouraging adherence to hygiene practices and attitudes, and assisting members and beneficiaries in coping with disease. Furthermore, Ndaluka et al., (2021), noted that many new ROs in Dar es Salaam started offering social and material support to their members including free COVID-19 related healthcare services, especially to the urban poor and middle class.

Despite remarkable contributions of religious organisations in the provision of healthcare services (see Dilger, 2009, 2014a; Jennings, 2008, 2013; Sundqvist, 2017); their efforts in responding to the outbreak of COVD-19 pandemic have received little attention in Tanzania. This study assessed the health care activities and support conducted by new ROs during COVID-19 pandemic in Urban Tanzania. Additionally, the study explored how Islamic and Christian teachings, practices and meanings were crucial to the design and execution of their COVID-19 interventions in the context of the changing public health dynamics in Tanzania following the death of President John Pombe Magufuli and the coming into power of President Samia Suluhu Hassan.

1.1. Public Health Dynamics during COVID-19 in Tanzania

The late Tanzanian president Dr. John Pombe Joseph Magufuli took what critics have referred to as a controversial approach to COVID-19 guidelines, directives, protocols, and restrictions. Instead of quarantines as imposed in many parts of the world, he emphasized non-scientific responses, such as a prescribing of a National Prayer Day to call for divine intervention and protection of the local population against the pandemic (Saleh, 2020, pp. 28–29). In spite of the government's ban on public gatherings and the directives from the WHO to practice social distancing and adopt safe measures, Magufuli emphasized that Tanzanians should attend religious services to pray for good health and against potential harm caused by the COVID-19 virus (Mwainyekule & Frimpong, 2020). On April 16, 2020, President Magufuli announced three days of national prayers to invoke God's divine intervention and end of the pandemic in Tanzania (BBC, March 18, 2021).

When the number of confirmed COVID-19 cases in Tanzania continued to rise, Magufuli questioned the validity of testing instruments, citing potential false-positive test results (Nakkazi, 2020a, p. 660). On May 3, 2020, he claimed that samples from animals such as goats and a sheep were marked with human names and sent to a COVID-19 laboratory for testing. He further

claimed that the animal samples tested brought positive results. He immediately suspended the director-general of National Health Laboratory, and after May 2020 the government stopped providing updates on new cases or deaths caused by COVID-19 (Nakkazi, 2020b, p. 660). On May 22, 2020, while addressing the public, Magufuli claimed that Tanzania was free from COVID-19 due to God's intervention powers and urgently instructed all the schools that had been closed in March 2020 to reopen in June 2020 (BBC News 2020). After declaring the country COVID-free, President Magufuli continued to run the country in the same way as he did before the outbreak of the pandemic (Patterson, 2022).

By late 2020 and early 2021, the WHO, in collaboration with other medical organizations, started to distribute COVID-19 vaccines to countries that submitted their requests. This was not the case with Tanzania, as President Magufuli distrusted these vaccines and expressed his doubtful feelings about them to the public, discouraging the local population from getting vaccinated (Pipkin, 2022). As opposed to scientifically-tested vaccines, the Tanzanian Minister for Health and other ministers encouraged Tanzanians to protect themselves against COVID-19 by using natural herbs. On March 17, 2021, the then Vice President of Tanzania, Samia Suluhu Hasan (who subsequently became President), appeared on the national television to announce President Magufuli's death due to what she called heart disease, despite prevalent rumors that he had died from COVID-19 (BBC, March 18, 2021). In an interview with *AfricaNews* and AFP, Tanzania's main opposition leader Tundu Lissu said that Tanzania's President, John Magufuli, had died due to the coronavirus infection. Mr. Lissu further claimed to have received these news from what he termed credible sources from one of the hospitals where President Magufuli had been admitted (AfricaNews, 2021)

After assuming office in May 2021, President Samia Suluhu Hassan took a different approach towards the COVID-19 pandemic. Shortly after being sworn in to the office of the President of Tanzania, she established a committee that involved scientists, doctors, and other elite Tanzanians knowledgeable about the pandemic to recommend and advise the state on the national decisions and direction to be taken with regard to COVID-19 (Pipkin, 2022). The committee released the report and advanced recommendations including advocacy for voluntary vaccinations by the public, release of COVID-19 updates to the public, and educating the public by medical professionals on the transmission and prevention of COVID-19. Many of the recommendations featured in this report contradicted the policies advocated by Magufuli during his presidency.

At the request of Tanzania's COVID-19 advisory team and several global relief agencies, in July 2021, Tanzania reported its first COVID-19 case update. President Samia also followed the recommendations of the taskforce by requesting COVID-19 vaccines from COVID-19 Vaccines Global Access (COVAX) (Bariyo & Steinhauser, 2021). On July 24, 2021, Tanzania received its first doses of the COVID-19 vaccine (WHO & organization, 2020b). By the end of July 2021, President Hassan publicly received her vaccine on television to demonstrate vaccine's safety and efficacy. She further expressed her desire to have vaccinations available to any Tanzanian who opted to receive the vaccine, while vaccination was not mandated for Tanzanian citizens (BBC, 2021).

2.0. Conceptual Application

While the meaning of the concept "religious organisations" has raised considerable debates, most scholars agree that, they (ROs) derive their legitimacy from the teachings of one, or more religious or spiritual traditions, that are faith-based or faith-inspired. They may be referred to many names like faith-based organisations, or religious motivated organisations but both of them rest on their capacity to use the religious doctrines to guide the conduct and direction of their activities as part of meeting their religious obligations (Berger, 2003, p. 16).

Olivier, (2011, pp. 5–6) presents the broad range of actors in the health sector including ROs which are the faith-forming entities such as churches, religious NGOs, community-based religious entities, networks, and health facilities. This study employs the concept of ROs to include churches, religious NGOs, community-based religious entities, and networks that provide some sort of healthcare services and support to their constituencies and other members of the community.

In interpreting the findings of this study, two concepts were employed, namely, religion as a model for, and model of lived reality, by Clifford Geertz, (1973); and development as holistic process, by Erica Bornstein (Bornstein, 2004). For Geertz, (1973, p. 90), religion is a system of symbols which acts to establish a powerful, pervasive and long-lasting moods and motivations in men by formulating conception of a general order of existence and clothing these conceptions with such an aura of factuality that the mood and motivations seem uniquely realistic. For Geertz, religious experience includes the continuation of the past and the extension of the current, being alive and dynamic that constantly inform society, culture and individual life. Geertz sees religion as a framework through which individuals experience the lived reality of the existing world. The religious symbols which Geertz refer to induce in the followers' certain sets of dispositions (which includes tendencies, capacities, skills, habits and liabilities). Furthermore, religious systems sharpen followers' worldview by constantly influencing both motivations and moods in which the followers regularly take up.

Using Geertz's conceptualisation of religion, this study argues that, religious teachings, practices, ideas, and experience are alive and dynamic, and constantly inform on ROs' COVID-19 healthcare interventions and support. Furthermore, the meanings attached by ROs to their COVID-19 healthcare-related interventions and support induce to the followers, management as well as healthcare workers certain dispositions and character that provide guidance on the flow as well as the manners in which these activities are carried out. The motivations generated instill various moods to ROs' followers, management and their healthcare workers for engaging in COVID-19 healthcare-related interventions and support.

Another concept employed in this study is development as being 'holistic' as conceptualized by Erica Bornstein, (2004). For her, holistic development involves a process of addressing religious, social, economic, psychological, spiritual and material human needs. In this regard, Bornstein states, "*Holistic approach is the one that bridges the gaps between the spiritual and material world; and between the rich and the poor."* For her, development serves a double purpose. Firstly, to introduce religious beliefs to the people and, secondly, to redeem the earth's "God-given Potential (Bornstein, 2004, p. 48). Using the concept of development as a holistic endeavour, the study argues that, the ROs' COVID-19 healthcare-related interventions and

support function to serve human dual needs which include but not limited to bridging the gap between the material and the spiritual aspects as well as between the rich and the poor.

2. Methodology

Using ethnographic approaches, the study was conducted in Urban Morogoro and Dar es Salaam. These cities were purposively selected for the reason that they had a big number of ROs compared to other urban areas in the country (BBC 2020); hence, provided a wide opportunity for the researcher's choice. The study focused on the urban areas because scholars have noted that the transformation of urban areas through ROs' healthcare interventions had been an urban phenomenon (Dilger, 2014, p. 55) connected to an increased role of religious institutions as urban service hubs that are responding to the new socio-economic and political challenges in the context of neoliberal urbanism (Beaumont, 2008, p. 2011).

The study drew insights from two major religions in Tanzania; Christianity and Islam. One Christian Organisation (Bethel Revival Temple) and one Muslim Organisation (Africa Muslim Agency) were purposively chosen for the study. The study collected data from ROs' healthcare workers, religious leaders, followers, religious management as well as the beneficiaries of the ROs COVID-19 healthcare interventions and support. Furthermore, data collection was done involving local leaders to which ROs were implementing their healthcare intervention measures, local and central government officials who included the regional health officials, the district health officials as well as officers from the relevant section of the Ministry of Health.

The study used ethnographic methods like participant observation (PO), key informant interviews (KII), in-depth interviews (IDI) and secondary sources (SS). Participant observation was employed to get a deep understanding of the practical part of the RO COVID-19 healthcare interventions and support, religious values, beliefs, ideas and reality of everyday lives of healthcare workers, beneficiaries of ROs' COVID-19 healthcare interventions, religious followers and management. IDIs were specifically employed to extract new information and to probe for further clarifications and interpretations of various practices, experiences and meanings that were connected to the ROs involvement in COVID-19 healthcare interventions and support. Furthermore, IDs were used to explore how religious ideas and experiences were connected to the nature, character and motivation behind ROs' COVID-19 healthcare interventions and support.

Key informant interview was used for understanding the lived experience as well as the underlying structure of those experiences for ROs healthcare workers as well as their healthcare beneficiaries. KIIs was employed to uncover the ways ROs' beneficiaries benefited from a certain or particular healthcare intervention. On secondary sources, the study extracted information from the ROs' written documents, annual reports, religious books, ROs' constitutions, newspaper articles, mission statements, flyers, theses and religious pamphlets written by local scholars on the ROs under study.

After the ethnographic data collection was completed, data was then subjected to transcription and coding. The process behind organization and management of the bulk ethnographic materials were done by the use of Nvivo12. Then, data was interpreted and transformed into meaningful information through the engagement of a number of analytic strategies that were concordant with

the research questions and the conceptual framework. A constant comparative approach was then employed for understanding the similarities and differences in the ROs' healthcare interventions. The comparative approach was preferred to enable the study arrive at the understanding of the common patterns in the context of ROs' healthcare interventions. As the study aimed to go beyond the patterned experiences, phenomenological reduction together with hermeneutic interpretations were applied to fill the gap. However, the study paid much attention to the depth and detail of the lived experience vis-à-vis the underlying structure of those experiences. This called for a reflective engagement with the data themselves hence necessitated the need for the use of the researcher's own reflections and/or interpretations.

3. Discussion and Findings

3.1. Africa Muslim Agency's Response to COVID-19 in Urban Dar es Salaam

Africa Muslim Agency is an Islamic organization that focused on charity, development and da'wa. AMA was established in 1981 by Dr. Abdurrahman H. Sumayt from Kuwait (Ahmed, 2009, pp. 426–427). The Africa Muslim Agency mission was meant to empower the less fortunate individuals and communities by improving socio-economic issues through support in different areas like education, development projects, healthcare interventions (which is the focus of this study), social care and construction. Based on the posters that were placed in the office of the Country Director of AMA, the vision and mission of AMA focused on fighting against poverty, diseases, and ignorance in communities with high levels of poverty (AMA, 2021). In addition to the existing healthcare interventions, AMA integrated COVID-19 related healthcare services and support since the pandemic was announced in Tanzania in March 2020. AMA supported COVID-19 patients, engaged in preventative measures, distributed soaps, sanitizers, gloves, masks, and other personal protective equipment (PPE) to its centers, aid recipients, and government facilities.

3.1.1. Facility-based COVID-19 Healthcare Interventions: Africa Muslims Agency's Prince Saud Health Centre (PSHC) in Dar es Salaam

The Prince Saud Health Centre (PSHC), AMA's healthcare facility in Dar es Salaam, offers subsidized health services that were provided by medical staff who were available 24/7. Located in a highly urbanized and infamously congested area of the well-known Tabata Street, PSHC was opened with the goal of supporting disadvantaged groups in the Tabata area and its surroundings. The development of PSHC was one of the responses to AMA's vision and mission in Tanzania, which focused on the fight against poverty, ignorance, and communicable and non-communicable diseases among the poor and economically disadvantaged communities. PSHC offered the market rate for medication to "keep care affordable for the people," the director stated.

Furthermore, the Country Director narrated in an interview that, during the first COVID-19 peak in 2020, AMA continued its general healthcare work in Dar es Salaam and Tanzania while taking on board all preventive measures. During this period, they also received additional funding from its headquarters in Kuwait to distribute soaps, sanitizers, gloves, masks, and other personal protective equipment (PPE) to its centers, aid recipients, and government facilities. Through participant observation, the researcher noted that, the patients who were received at PSHC were educated on how to prevent the spread of COVID-19 and were provided with masks and sanitizers, social distancing was enforced to ensure patients were seated far enough away from

one another so as to prevent contamination between individuals. Tables and chairs were set up outside the center, where staff held meetings and visitors were not allowed to enter the offices. Patients were required to wash their hands upon entering the clinic.

Nevertheless, given the Magufuli government's skeptical stance towards preventative measures and COVID-19 prophylaxis and vaccination, there was little demand for PPE or vaccines among Tanzania's general population, which was predominantly uninformed about the virus. Africa Muslim Agency provided relevant information to patients seeking care through its health centres in Tanzania by posting pamphlets about COVID-19 that were received from the Tanzanian government and WHO on noticeboards. Once Tanzania began to receive COVID-19 vaccinations under the administration of President Samia Suluhu Hassan, AMA's clinics also served as vaccine providers despite the fact that there was limited demand from the targeted populations, despite the provision of the vaccine without costs.

In an interview with the Director of Health services at AMA, it was revealed that during the peak of the pandemic, the orphanage center run by AMA was closed during the mandatory lockdown of social, religious, and educational institutions in Tanzania (March-July 2020). The Director further explained that, during this period, AMA created a taskforce responsible for following up weekly with the households of children enrolled in the orphanage program, where they returned during the lockdown. As part of weekly visitations to these households, the Africa Muslim Agency team conducted brief awareness sessions about COVID-19 for all household members, shared reflectors that listed preventive measures to take against COVID-19 and other reading materials about the virus, and provided counseling sessions for families that had lost their loved ones or which were caring for COVID-19 infected patients. At the end of these visits, the AMA team members distributed sanitizers and supplied households with facemasks and food supplements to boost their immune systems in order to fight illness and/or resist infection from the COVID-19 virus.

When the researcher interviewed AMA's healthcare manager in Dar es Salaam and healthcare workers at PSHC, they responded that for them, the rationale for helping people during the pandemic was grounded in the religious teachings, ideas, and meanings attached to healthcare by the Islamic faith to which they belonged. According to the PSHC healthcare manager, the establishment of AMA's COVID-19 interventions was in response to God's instructions to help and support the sick and needy, especially when they are in need of external support to fight against the disease and protect their lives. In this regard, he had this to say:

> *In Islam, we have been instructed to protect the brain and health of individuals. If there is an area where people die after failing to access healthcare services, sin is manifested on the whole community. When someone or a group of people assists those in need of healthcare services, those who provide for religious motivation are rewarded blessings and the whole community is forgiven of its sin. This is an instruction from Allah.*

When the researcher accompanied the Africa Muslim Agency taskforce on their weekly follow-up visits to the households of beneficiaries, he witnessed the poverty of the households, which

resided in congested areas of urban Dar es Salaam. For example, he visited Mchangani and Zogowali streets and learned that neither area had any government-owned health facility, and that both depended upon a single private healthcare center located in their areas despite the dense population size of around 7,000 and 8,200 people respectively. The closest government health institution for Mchangani was located nearly six kilometers away, with an estimated transport cost of about TZS 4,000-6,000 (approximately 3 USD) per trip using '*bodaboda*' (motorcycles). The two areas of Mchangani and Zogowali lacked direct access to '*daladala*' (public transport by minibus) to enable residents to more easily and affordably travel to the nearest health facility. The chairperson of the Mchangani Street said:

> *Our area has more than 7,000 people and we do not have a government health center or facility where we can get vaccines, masks, hand sanitizers, education, and treatment of the diseases connected to COVID-19. We only have one privately-owned health facility. Its medical services are very expensive, and people living in this area cannot afford to pay for the services due to their poor economic status.*

3.1.2. Africa Muslim Agency's Mobile Clinics in the Outskirts of Dar es Salaam Region

Findings revealed that the AMA conducted free monthly outreach/mobile clinics in areas that lacked basic healthcare services, had not been under the influence and/or service of either government or other non-government institutions. Between 2016 and 2019, AMA provided free medical through the use of mobile clinics to 52,317 beneficiaries covering more than 41 areas of Temeke and Ilala districts in Dar es Salaam at a total cost of USD 82,418,000 (AMA, 2021). After the outbreak of COVID-19 in Tanzania, AMA improved the mobile clinics to include COVID-19 related services and education sessions as well as awareness raising (AMA, 2021).

The researcher attended the monthly mobile clinics conducted by Africa Muslim Agency at Pugu Kajiungeni, Kichangani, Zogowali and Chanika in Dar es Salaam region between 2020 and mid-2021. Through participant observation, the researcher noted that, the preparation of mobile clinics in the areas visited involved a number of procedures so as to ensure that preventive measures against COVID-19 were taken seriously. Upon arrival, the head of the mobile clinic team introduced the mode of access to the healthcare services. The head organizer would first explain the procedures the beneficiaries should follow in order to access medical services ranging from consultation to laboratory diagnosis to being provided medication. He then invited the spiritual leader who accompanied the medical team to give a sermon and pray for both healthcare seekers, service providers, funders and the whole management of AMA.

The spiritual leader explained that in Islam, helping the poor to access free healthcare services in their environment has a particular significance. He underscored the belief that these services were believed to provide religious rewards to those involved and improved their relationship with Allah. He further urged beneficiaries to be calm and to have faith that their health problems, including worries against COVID-19, would be resolved because Allah was going to work through the healthcare workers in front of them. In delivering his sermon, the religious leader repeatedly quoted the following Qur'anic verses: *"Everything good that happens to you (O Man)*

is from God, everything bad that happens to you is from your own actions"), Qur'an 17:82 (*And if God touches thee with affliction, none can remove it but He: if He touches thee with happiness He has power over all things"* (Qur'an 4:79).

After the sermon from the religious leader, the medical officer in charge of the mobile clinics then expounded on safe and hygienic practices in combating COVID-19, such as the regular act of wearing of masks, hand washing, and maintaining social distance. Mobile clinic staff distributed soap, sanitizers, and personal protective equipment to all those in attendance. The relationship between the Tanzanian government and AMA extended during the pandemic to collaborating in joint healthcare programs, seminars, and trainings. The government worked in partnership with PSHC and AMA in the implementation of the national, regional, or district health campaigns during COVID-19, particularly during the second phase of the fifth government under President Samia S. Hassan. As part of these joint activities, Africa Muslim Agency sent one or two of their employees on government missions to different areas to sensitize the population about hygiene practices, distributed masks and sanitizers, and provided other COVID-19-related healthcare services.

During President Samia's phase, AMA assisted government health facilities with personal protective equipment (PPE) like temperature readers, masks, sanitizers, gloves, and soap. In 2021, AMA provided the District Medical Officer of Ilala with PPE to be distributed to different health facilities throughout the Ilala Municipality. When Africa Muslim Agency management was given a chance to say a few words during the handing over of the equipment, they called for greater allocation of government funds to meet the healthcare needs of people in the context of COVID-19, and provision of more assistance for the families of those who had been affected by the virus, particularly those coming from poor socio-economic backgrounds.

3.2. Bethel Revival Temple's response to COVID-19 in Urban Morogoro: Facility-based COVID-19 Healthcare Interventions

Bethel Revival Temple is a Pentecostal church founded in 1987 and located at Mwembesongo area in Urban Morogoro. Mwembesongo is an area located at the outskirts of Morogoro Region and it is believed to be one of the notary areas with high incidences of crimes, witchcraft and inhabited by the majority poor (these are not official statistics but the respondents involved in an interview repeatedly narrating for the same). BRT owned and ran the Uzima Medical Centre (UMEC), a health facility established in 2005 following a long waited vision, a dream of Dr. Barnabas Mtokambali who was a Senior Pastor and founder of BRT through the grace and working of Holy Spirit (as he referred to during one of conversations).

UMEC was located at the *"notorious"* Mwembesongo, one of the district's poorest neighborhoods/street in Morogoro Region as per the explanation from Ward Executive Officer of Mji Mpya Ward and Chairperson of Mji Mpya Street. The street was the boundary between Mwembesongo and Mji Mpya Wards, which all together contributed about 16 percent of the total population of Morogoro Municipality. UMEC was established in order to meet the vision and mission of BRT which was derived from the Bible and one of its sixteen core principles which, among others, focus on being God's agency for evangelizing the world as documented in the Gospels of Mathew 28:19 (*Go ye therefore, and teach all nations, baptizing them in the name of the Father, and of the Son, and of the Holy Spirit*), and Mark 16:19 (*And He said unto them,*

Go ye into all the world, and preach the Gospel to every creature). UMEC was established for the purpose of reaching surrounding communities with the gospel of Jesus Christ through Christian-based medical services. Based on the compiled 10 years report of BRT, since its establishment in 2005, UMEC had been the main source of healthcare activities for the people living in Mwembesongo and Mji Mpya wards (BRT, 2021).

Immediately after the outbreak of COVID-19 in Tanzania, UMEC supported COVID-19 patients, and engaged in serious medical and non-medical preventative measures. Patients received at UMEC were educated on how to prevent the spread of COVID-19 and provided with masks and sanitizers, and directed to keep social distancing to prevent contamination between individuals. A water tap was also placed outside where the patients were required to wash their hands upon entering the centre. Bethel Revival Temple provided relevant information to patients seeking care through its social networks by posting pamphlets about COVID-19 that were received from the Tanzania government and WHO and particularly the document entitled; *Practical Considerations and Recommendations for Religious Leaders and Faith-Based Communities in the Context of COVID-19: Interim Guide* (WHO & organization, 2020a), which acknowledged early in the pandemic the fundamental importance of religious institutions in combating COVID-19.

Once the Samia's government came into power in May 2021 following the sudden death of President Magufuli, UMEC started to implement the recommendations that were advanced by the probe committee that was commissioned by President Samia. When Tanzania began to receive COVID-19 vaccinations under the presidency of Samia Suluhu Hassan, UMEC also served as vaccine providers. Clinical encounters at UMEC (registration, clinical consultation, laboratory tests and medication) focused not only on patients' illnesses, but also on their social, cultural, and spiritual wellbeing. Healthcare workers used both medical and religious approaches to interpret the nature of COVID-19 and the medication they provided (including medical treatment and spiritual healings).

3.2.1. Beyond Healthcare Facilities: Bethel Revival Temple's Charity Events, Thanksgiving Week, Blood Donation and the Shemasi Healthcare Support System

Every year, BRT organized charity events and thanksgiving week accompanied with thanking God and supporting the community in different areas, including the provision of healthcare for free. The charity events and thanksgiving week were connected to many social activities, like visiting the sick who had been admitted in different hospitals as well as homes of patients known with chronic diseases, and supplying the target groups with different necessities as well as organizing free medical check-ups and medication. In 2021, BRT in collaboration with the Department of Voluntary Testing and Counselling of Morogoro Regional Hospital organized medical testing and medication for COVID-19. In that particular week, a good number of people both from the church and outside the church tested for COVID-19 and those who were found positive received free medical services. Apart from medication, those in need were provided with other necessities including but not limited to clothes and food which were donated by the members of the church and other sympathetic segment of the population.

Through the researchers' engagement in an informal conversation with the head of the medical services, it became apparent that a total number of 119 people tested for COVID-19 and 24 among them tested positive. The whole exercise was accompanied by sharing the word of God from different pastors and choirs that were singing all the time. At the end of the event, all the participants were supplied with masks, sanitizers and soaps. In the charity event and thanksgiving week, other activities that were conducted by BRT included visiting COVID-19 related patients who were admitted at Morogoro Regional Hospital. Among others, the visiting team distributed second hand clothes, conducted prayers and shared some few bible verses. On the same occasion, the team supported few patients by giving them some funds, especially those who were recognised as facing the challenge of either lacking support from relatives or those who had no relatives or those coming from poor socio-economic backgrounds and were incapable of meeting their health costs. After the end of the charity event week, the women members of the BRT kept on visiting and supporting the COVID-19 related patients at Morogoro Regional Hospital who were identified as having no relatives to take care of them or were economically unable to meet the costs of their hospitalization and food.

Another healthcare intervention conducted by BRT was blood donations campaign that was done for two days accompanied by extensive prayers against COVID-19. The aim of the blood donation exercises was to save the lives of COVID-19 patients admitted in different hospitals across the country who needed blood as part of their treatment but were not in a position to meet the costs incurred. The followers of BRT used this exercise as a unique opportunity for them to participate in what they regarded as part of demonstrating the fruits of the Holy Spirit. The exercise was interpreted as an avenue for doing God's work of evangelization and spreading the love of Jesus and acting like Him as narrated in the book of Galatians 5:22 *(But the fruit of the Spirit is love, joy, peace, longsuffering, gentleness, goodness, faith)*. In that particular week, all prayers at BRT were directed towards COVID-19 pandemic. The Senior Pastor, one Dr. Mtokambali used the occasion to remind the followers on the importance of their participation in the event. He repeatedly referred to the book of Galatians which called upon the believers to practice the spirit of the fruits of the Holy Spirit like love, joy, peace and kindness for COVID-19 patients and victims for them to truly become sons and daughters of Christ. A total number of 113 people (both followers and non-followers of BRT) participated in the exercise of donating blood. During the opening ceremony of the blood donation exercises, the Senior Pastor made an encouraging prayer to his followers. While crying loudly and speaking in tongues; he prayed:

> *'Our father who art in heaven, observe our blood donation exercise where it will be initiated, we plead to you Jehovah King, protect us against COVID-19, give power, strength and ability to overcome this deadly disease" (He started crying loudly and speaking in tongues)*

Shemasi is the smallest administrative unit at BRT that was composed of 5 to 10 households that lived close to each other. The Shemasi healthcare support system was another informal healthcare interventions and support conducted by BRT to help patient suffered from COVID-19 and other chronic diseases. Through the Shemasi system, BRT had developed a mechanism for members who lived close to each other in defined boundaries to help and support each other during hardships like illness and other related social problems. Mama Victoria, the chairperson of SUA Shemasi explained to the researcher that during the COVID-19 pandemic, they increased

the number of times they offered prayers and enhanced cooperation in supporting the sick (or a close relative of a shemasi member) to access healthcare services as well as social support. Mama Victoria was once supported by the members of the Mkwajuni Shemasi when her father contracted COVID-19 and become admitted at Mchwangili Hospital in Morogoro for six days. Apart from providing food and washing clothes for the sick, they also paid the medical bill amounting to TZS 210,000 (equivalent to 84 USD).

Another scenario was that of Teddy, a woman aged 56 years and an active member of a Shemasi at Ilungu area. In an interview, Teddy explained that in July 2021, she contracted COVID-19 and got admitted at Morogoro Regional Hospital for 8 days but she had no funds to meet her medical costs. While being admitted at the hospital, Teddy enjoyed constant support of her fellow Shemasi members. The visits were accompanied with constant prayers and acts of washing her clothes on rotational basis while taking on board COVID-19 preventive measures. However, the Shemasi members support did not end at Teddy alone but also was extended to other patients who were admitted along with her. While taking precautionary measures like hand sanitization and mask wearing, the Shemasi members supported other patients and Teddy by providing them with all necessities like food, clothes as well as sharing with them the word of Christ

The COVID-19 healthcare interventions and support of the ROs described in this study were developed as alternatives for their beneficiaries and the general public to access and afford healthcare services during the pandemic, with specific focus being on those coming from poor socioeconomic backgrounds, those who lacked and or missed sufficient community, clan and family support (see Dilger, 2014a, p. 55). The findings from this study have generally shown that, many communities particularly from the growing urban areas lacked essential COVID-19 services and support. The situation was aggravated by the government-limited budget as well as increased demand from population against the available limited health institutions (Muhoja, 2020, p. 198). For example, despite Tabata and Mwembesongo streets being located in the urban area, both areas lacked healthcare services, whether government or private owned ones. The mobile clinics conducted by AMA targeted areas lacking healthcare services and the same had not been claimed or occupied by other private or government organizations in the struggle for claiming urban space and influences.

The findings of this study, thus, confirms what Dilger, (2014a, p. 64) observed that new religious organisations in Tanzania were reconfiguring urban spaces inhabited by populations with certain social, material, and spiritual needs, who were, therefore, more receptive to religious and healthcare activities. The government's inability to provide preventive measures and equipment (including masks, sanitizers, and food supplements) to even the poorest households in the country led to an increased dependence on healthcare services provided by AMA in these areas. The selection of the places for the conduct of COVID-19 mobile clinics were influenced by the socio-economic status of the people living in those areas. For example, despite the fact that Kichangani and Mpiji-Magohe are located in Urban Dar es Salaam, the level of poverty in these areas were very high to the extent that some community members failed to afford and access these services both in government or privately-owned healthcare facilities. The situation had, therefore, resulted in the dynamics in both religious ideas and practices for the followers of the ROs, healthcare workers, funders and the general management connected to the ROs under this study.

The outbreak of COVID-19, and its consequences for the people from socio-economically poor backgrounds touched their role as Muslims towards the fulfilment of their religious duties as stipulated in the holly books – Qur'an and Hadith - in relation to supporting the sick, the needy and the poor whose life was endangered by the outbreak of COVID-19. In that context, they employed their religious resources (Ndaluka et al., 2021, pp. 129–130) that motivated them to engage in the provisions of COVID-19 healthcare related services and support. The examples drawn from Teddy collaborate with the findings from DeFranza et al., (2021) and Kowalczyk et al., (2020) who argued that COVID-19 had made people more open to their religious beliefs and religious practices.

Another issue that emanate from the findings of this study is that religious ideas, experiences and practices dictated the meanings that ROs followers, healthcare workers and management attached to their engagement in COVID-19 related healthcare interventions and support. For example, the provision of COVID-19 related healthcare interventions and support by following people in the areas they lived was interpreted at AMA as an act of reaping rewards for the beneficiaries, service providers, funders and the management. These interpretations and meanings attached to helping the poor segment of the population, the sick and the needy to access COVID-19 related healthcare services and support induced optimistic moods for the ROs' followers, healthcare workers, management and funders to fully engage for the same.

The study further noted that the healthcare activities and support conducted by AMA and BRT in the context of COVID-19 functioned to reduce the gap between the rich and the poor and met both material and spiritual needs of the urban population. The COVID-19 related healthcare interventions and support by these ROs like mobile clinics, charity events, blood donation and Shemasi support system provided an opportunity for the poor to access medical services; hence, played a significant role in bridging the gaps as well as inequalities with regard to different groups' access to COVID-19 related healthcare services and support in the urban context. Based on participant observations and interviews, the COVID-19 related healthcare interventions and support conducted by BRT and AMA played a double role. Firstly, they introduced religious beliefs to the beneficiaries and, secondly, they met their healthcare needs related with COVID-19. The findings from this study provides affirmative answers to the questions posed by Meza (2020) who asked whether people become so religious during the time of pandemic periods compared to normal times.

Generally, the study argues that religious teachings, ideas, experiences, practices and meanings played a remarkable role in informing the ROs healthcare workers, followers, funders and management on the healthcare needs of a certain group of people in specific contexts and time. They proved to be much alive and dynamic, constantly informing on the nature and focus of their COVID-19 related healthcare interventions and support. The findings from this study correspond with the arguments advanced by Ndaluka and his colleagues (2021) who asserted that COVID-19 can be said to have increased religiosity in terms of increased frequency of prayers, attending religious gatherings, and participating in different religious interventions. Furthermore, the findings conform to what was revealed from the 2009 Pew Forum Survey which, among others, showed how religion was an important aspect in the public life of the population in Tanzania.

The dynamics of religious organisations in responding to COVID-19 as revealed in this study can be seen in two areas. Firstly, the dynamics on target areas and groups of their healthcare activities. For instance, during the colonial era and post-independence period, religious organisations' healthcare interventions mostly targeted rural areas and particularly the poor segment of the rural population. The new generation of religious organisations pay much more focus on urban areas that seems to be occupied by the urban poor. Secondly, the nature as well as the character and direction of COVID-19 related healthcare and support of religious organisations embodied both perspective of two Tanzanian presidents who served during the tumultuous period of COVID-19. During President Magufuli's regime, the president emphasized on the need for prayers while adapting safety measures like social distancing and wearing of masks, (BBC 2020). During Samia's regime, the ROs started to act as centers for COVID-19 vaccines and helped the government to implement the guidelines that were provided by the World Health Organisations (WHO & organization, 2020a).

5. Conclusion

The study findings showed that new religious organisations in Tanzania engaged in a number of healthcare intervention measures, both medical and non-medical activities, in responding to COVID-19 pandemic. These activities included medical diagnosis and treatment, healthcare related charity events and support, and blood donation. Furthermore, ROs supported the beneficiaries through providing preventive education, and distributed soaps, sanitizers, gloves, masks, and other personal protective equipment (PPE) to its centers, aid recipients, and government facilities. The study recommends that ROs should improve documentation of their COVID-19 healthcare interventions in both formal, informal, clinical, non-clinical and non-institutionalized settings in order to allow for complete analysis of the role they performed in combating COVID-19 in Tanzania.

The study further showed that religious values, practices and meanings are highly dynamic; hence, informing the ROs COVID-19 healthcare related interventions and support. These interventions were designed and executed while reflecting the existing socio-economic and political contexts, necessitating the targeting of socio-economically weaker groups to reflect their religious teachings and obligations which call for support to the poor including the sick. They were designed to extend into the public so as to broaden alternatives for people to access COVID-19 healthcare related services and support. In so doing, ROs have become the mediators between government's health policy and interventions and the general population - a relationship that will continue long after pandemic threats subside. The study recommends that there is a need for health policies to take into account the contributions of informal healthcare support, non-institutionalised and other non-clinical healthcare interventions rather than ignoring them or taking them for granted by assuming that they contribute nothing to the overall healthcare system. This study revealed that the informal healthcare support system, non-institutionalised and other non-clinical healthcare interventions contributed significantly towards meeting the healthcare needs of the large population, especially the urban poor who were not covered by the existing health insurance mechanisms.

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