Dynamics of Proselytization and Conversion in the Pentecostals' Healthcare Interventions in Urban Tanzania
(Ethnographic study of Bethel Revival Temple in Morogoro Tanzania)

Mussa Said Muhoja
Department of Economics and Social Sciences; Ardhi University, Dar es Salaam, Tanzania
mussa.muhoja@aru.ac.tz muhoja2020@gmail.com ; +255714283514

Abstract

This paper explores the dynamics of proselytization and conversion in the healthcare services, and healthcare related support provided by Pentecostal organisations in Urban Tanzania. With access to healthcare and health related support remaining a critical challenge in the country, religious organizations have filled the gap left by inadequate state services. Using ethnographic methods such as participant observation, key informant interviews, and focus group discussions, the study examines the various strategies Pentecostal groups employ in their healthcare interventions to facilitate religious outreach and the procedures for supporting new converts. The findings revealed that Pentecostal organizations adopt multiple approaches to intertwine healthcare interventions with religious activities. These include an implicit approach, where religious teams are part of healthcare interventions but refrain from direct evangelization unless specific circumstances arise. Additionally, an invitational strategy is used where healthcare beneficiaries are encouraged to attend religious events such as church services and prayer meetings outside of healthcare activities. The most prevalent strategy is relational, involving the sharing of religious messages by team members and leaders before and after healthcare services and healthcare related support. The study argues that in environments marked by socio-economic instability and personal crises, the integration of healthcare and religious outreach by Pentecostal organizations not only meets immediate health needs but also plays a

Journal of Policy and Development Studies (JPDS)

Vol. 15. Issue 1 (2024)
ISSN(p) 0189-5958
ISSN (e) 2814-1091
Home page
htttps://www.ajol.info/index.php/jpds

ARTICLE INFO:
***Keyword**:*
Religious organisations, conversion, healthcare, Pentecostal, proselytization, urban

Article History
Received 15th December 2023
Accepted: 3rd March 2024
DOI: https://dx.doi.org/10.4314/jpds.v15i1.13

crucial role in the spiritual and personal transformation of individuals.	

1. Introduction

In Tanzania, where access to healthcare remains a critical challenge, religious organizations have increasingly stepped into fill the void left by state services. In recent decades, Pentecostal churches have become prominent providers of both formal and informal healthcare services and support to their beneficiaries and the general public (Dilger, 2014a; Hasu, 2007; Muhoja, 2020a). This paper explores the intricate dynamics of proselytization and conversion[1] within the healthcare interventions[2] conducted by Pentecostal groups in Tanzania, examining how these religious entities leverage healthcare services as a means of religious outreach and the impact this has on local communities.

Pentecostalism in Tanzania, like in many parts of Sub-Saharan Africa, has seen rapid growth over the past decades, characterized by vibrant worship, charismatic leadership, and an emphasis on direct personal experience of God through the Holy Spirit (Fischer, 2011a, pp. 101–103; Hasu, 2012, p. 70). The expansion of Pentecostalism has not only transformed the religious landscape but also significantly impacted social and healthcare sectors (Dilger, 2014a). By providing healthcare services and support, Pentecostal churches engage in what they often term as holistic ministry aimed at caring for both the spiritual and physical well-being of individuals (Muhoja, 2023, p. 54).

This paper begins by setting the context of healthcare in Tanzania, detailing the deficiencies in public health services and the rising involvement of religious organizations in this sector in the neoliberal economy witnessed since 1990s. It then delves into the history behind the Pentecostal churches' involvement in healthcare, highlighting theological as well as strategic organizational reasons for this engagement. Following this, the paper examines the processes and techniques of proselytization and conversion employed by these churches within their healthcare interventions. Through this analysis, the paper aims to contribute to the broader understanding of how religion and healthcare intersect in contexts where both are of paramount importance to the social fabric and individual lives, offering insights into the broader implications of these practices for community health and religious conversion in Tanzania.

The history of the intersection between healthcare and evangelisation by religious organisations in Tanzania can be traced from the colonial period. (Green et al., (2010) noted that despite absence of a joint plan between the colonial state and Christian organisations, the colonial government created a favourable environment for the foreign missionaries to work smoothly. They used health institutions for evangelization and civilization of the target groups (Nyanto, 2014). Over a long period of evangelization of colonized people that went together with provisions of social services

[1] In other words, conversion in this work will mean a conscious spiritual transformative change whereby one views life in new perception in relation to new faith and life in Jesus Christ within one's social-cultural setting (cf. Bosch1991:126).

[2] In this study, healthcare interventions include both clinical and non-clinical services as well as support. In particular, the term includes any other activity in additional to clinical healthcare services that aim to support sick persons in terms of material, moral, psychological and physical aspects.

including healthcare, Christianity became increasingly allied with social service provision including healthcare services. For example, the Catholic missions connected expansion of churches and gospel to the establishment of healthcare services almost in every mission centre they established (Cleall, 2012; Leurs et al., 2011a).

While an FBO may deliver the same goods or services as a secular nonprofit, it may do so for two different purposes; one being to provide a space for the expression of religious faith and two, as a means to evangelize to those who are perceived to require spiritual development (Muhoja, 2020a). Therefore, FBOs operate under a stated dual identity: that of a service provider and a religious organization for the needy (Gomes, 2021, p. 33).

Clarke, (2013) noted that, there is no clearly demarcated line between what FBOs are doing in terms of religious ministry and what they are doing in terms of development ministry. His study finds that whilst there is a higher goal of evangelisation, there is a dynamic blurring between the two ministries. Therefore, FBOs working to improve social services important both in and of itself as it provides an opportunity to live the Gospel. He further explained that, this approach was found to reflect that of the church's early missionaries who saw physical and social well-being as being complementary in value to spiritual development (Clarke, 2013, p. 9).

The most comprehensive study on the intersection between evangelisation and development activities by religious organisations was conducted by Unruh, (2004). His study revealed that, religious organisations employs five strategic principles in intersecting religious obligations and social activities including healthcare. The first strategy used by a number of FBOs studied was termed as *implicit* where the program was known to include a religious team but no direct evangelisation occurred. The second strategy is *invitational* where the beneficiary is invited to a religious event occurring outside of the social project. The third strategy is *relational* in which members of the church will directly share information about the church during or in the vicinity of the social service. The fourth and most direct strategy *is integrated optional* which involves disclaiming the expressly religious components of the programmes to beneficiaries and providing them with the option to opt-out of the participation of those components of the service, while the fifth strategy is integrated-mandatory (Unruh, 2004, p. 317).

While recent scholarship on Pentecostalism and development has focused on how these religious movements foster a sense of commonality and concern among beneficiaries, contributing to social capital within communities (Dilger, 2014a; Hasu, 2012; Muhoja, 2020a), the specific discourses and practices of using healthcare interventions for proselytization and conversion have received limited attention. This oversight is significant considering the increasing prominence of Pentecostal groups as healthcare providers in Tanzania, where they often integrate healthcare services and support with religious outreach. Furthermore, the procedures and support systems established for new converts through these healthcare settings have not been thoroughly examined.

This gap in the literature overlooks how these religious entities may leverage healthcare interventions not only as a means of proselytization but also as a platform for sustaining and expanding their religious influence. Therefore, this study aims to explore the intricate dynamics of proselytization and conversion within the healthcare activities conducted by Pentecostal groups in Tanzania. It will examine how these groups use healthcare as a means of religious outreach and assess the procedures they employ to support new converts.

2. Healthcare Interventions of Christian FBOs in the Neo-Liberal Economy in Tanzania

By the end of the 1970s, Tanzania was under severe economic crises caused by many factors, such as the rise of the oil prices in the world market, the war against the Dictator Idd Amin Dada of Uganda, drought and the crisis resulting from Ujamaa policy (Otunnu, 2018, p. 11). These factors resulted to reduction in the national budget, affecting the quality and quantity of service provisions in the country including healthcare service delivery (Bakari, 2012). In response, Tanzania accepted and implemented Economic Structural Adjustment Programmes (SAPs) promoted by International Financial Institutions such as the International Monetary Fund and the World Bank (Mujinja & Kida, 2014a). Among key conditions of SAPs included drastic reduction in government expenditure on social services, privatization of the major means of production, free market as well as liberalisation of the economy, privatization and commercialisation of social services including healthcare services (Lugalla, 1997; Ngowi, 2009).

Such structural reforms were highly expected to bring about improvement in both social and economic spheres, but it was contrary to expectations of the majority, the blessings of neoliberalism benefited only few, throwing the large population into extreme poverty (Hasu, 2012, p. 69). While majority of the population was negatively affected by the said changes, the government introduced a cost-sharing measure on healthcare, which used to be a free service offered by the postcolonial state during the country's socialist period (Dilger, 2009, p. 91, 97). Furthermore, the state privatized the health sector following reconfiguration of Tanzania's social welfare systems and engineered for commercialization of healthcare services (Mujinja & Kida, 2014b, pp. 1–2). Slowly, the role of the state as a sole provider of healthcare services diminished (Havnevik & Isinika, 2010; Ngowi, 2009).

Liberalization and commercialization of healthcare has had negative impacts on affordability of these services by the poor and disadvantageous groups both in public and private healthcare facilities (Kowalewski et al., 2002). Several studies have noted failure of many and particularly the poor to afford for costs of these services (Mamdani & Bangser, 2004, p. 141). In a study conducted in 2017 by Afrobarometer indicated that, lack of access to medical facilities and medical personnel is one of the most persistent issues facing Tanzania's health care sector today (Pring & Vrushi, 2019). The findings from this survey further reported that, 40 percent of respondents said they went back home without needed medical services many times in the past years.

The study by West-Slevin et al., (2015) noted that more often than not, public healthcare facilities go without proper equipment and medicines. The study further observed that in 2015, only 41 percent of healthcare facilities had all essential tracer medicines in stock, lacking medical doctors, leading Tanzania to one of the world's lowest physician to patient ratios hence nurses are frequently left to treat patients in ways that exceed their training, and more than 500 dispensaries lack qualified health care personnel (West-Slevin et al., 2015, pp. 3–4).

However, socio-economic and political transformations that occurred since 1990s, made FBOs to become highly visible and important partners in development initiatives including healthcare delivery (Sundqvist, 2017, p. 24). FBOs and other civil society organisations increased as a

response to conditions imposed by IMF and WB in an attempt to strengthen the so-called civil society in the neoliberal era (Shivji, 2006). By 2016, faith-based hospitals served an estimated 40 percent of the Tanzanian population (Avert, 2016). In this period, FBOs interventions on healthcare services increased as an attempt to deal with social, economic and spiritual drawbacks of globalization, modernity, and negative impacts of the SAPs and neo liberal policies on healthcare services including other essential social services (Dilger, 2009b; Hasu, 2012; Sundqvist, 2017).

In this period, FBOs started to find coping strategies against the changing world and acted on negative consequences of these changes (Hasu, 2012, p. 83), including restoring access to healthcare services through an establishment of various means for enabling their members and the general public to access as well as afford healthcare services and support (Muhoja, 2020b, p. 205). For example, in Dar es Salaam, many FBOs started offering social and material support to their members including free healthcare services to urban and middle classes strongly affected by development of urbanization, globalization, and structural-adjustment policies (Dilger, 2009b, p. 97, 2014b, p. 63).

Historical Overview of Pentecostalism in Tanzania

Pentecostalism in Tanzania can be traced back to 1913 when Canadian Pentecostal missionaries arrived in Tanganyika for the first time followed by ELIM Pentecostal Church, Holiness mission, Scandinavian missionaries and Assemblies of God (Fischer, 2011b). In 1930s, the Holiness Mission and the Swedish Free Mission established their first mission stations in South and Central Tanzania, respectively (Ludwig, 1999). However, it was until the end of 1960s and the beginning of 1970s when the newly introduced Pentecostal churches like the Assemblies of God and ELIM Pentecostal Church attracted a big number of followers (Fischer, 2011b, pp. 101–103; Hasu, 2012, p. 70). Such attraction of followers was partly contributed by their mediation of socio-economic tensions brought about by Ujamaa policy whereby they were able to react flexibly to social and spiritual vacuum created by the state's villagization program (Ludwig, 1999).

Despite such early presence, it was until the late 1980s onwards, that Pentecostal Christianity started to grow and spread more rapidly as well as became an important player on the religious scene. In this period, they benefited from negative outcomes and dilemmas of globalization, neoliberalism and SAPs (Hasu, 2012, p. 68). From the mid to the end of 1990s, the Pentecostal churches in Tanzania became increasingly divided into sub-churches found almost everywhere in the country, comprising over 3.6 million followers (Fischer, 2011b, p. 100) (Fischer.

Currently, the Pentecostal organisations in Tanzania present a very rich agglomerate of diverse denominations and/or congregations tied to a wide range of religious traditions at both national and international levels (Muhoja, 2020a). They include a highly growing group of neo-Pentecostal followers founded by Tanzanian pastors and bishops independently of international mother church that flourished from late 1980s. In the early 1990s, some of the classical Pentecostal churches tried to come together to form the so called Council of Pentecostal Churches of Tanzania, which did not become strong at all (Fischer, 2011b, p. 103). The neo-Pentecostal churches were not included in the council on the ground that their religious practices, and ideas were non-Pentecostal (Dilger, 2009a). Good examples of Pentecostal and neo-Pentecostal churches in Tanzania include Full Gospel Bible Fellowship, Efatha Ministry, Mikocheni B Assemblies of God, Dar es Salaam

Pentecostal Church, Bethel Revival Temple and Glory of Christ Tanzania Church (Muhoja, 2020a).

Both Pentecostal and neo-Pentecostal churches in Tanzania have been associated with social, political, economic, and spiritual uncertainties that have shaped people's lives in the era of neoliberal reform processes as well as growing inequalities in urban areas (Dilger, 2007; Hasu, 2007). In the Tanzanian context, the Pentecostal and neo-Pentecostal organisations were often perceived as mostly engaged in evangelism and conversion rather than development programmes (Leurs et al., 2011b, p. 57). In recent years, this view has been proved to the contrary because some of them are showing increasing involvement in social service delivery including healthcare and education activities (Anangisye and Mligo, 2014). This situation has become highly attractive particularly for poor followers of the Pentecostal churches not only because of their gospel of health, healing and well-being, but also because of relief programs they have created for their followers and other urban population like healthcare facilities, social support networks, organized foodbanks, charity events for the poor and the neediest segments of the urban population thereby contributing to the new institutional (religiously inspired healthcare interventions) infrastructure in the urban setting (Dilger, 2014a; Hasu, 2012; Muhoja, 2023).

3. Conceptual underpinnings

Classical Sociologists like Emile Durkheim and Max Weber established an opposite relationship between religion and development of modernization (Berger, 2001, p. 443; Thomas, 2005, p. 49). Weber argued that as societies become modernized, religion is assumed to lose its significance in people's lives while secular life becomes more prominent, a process he referred to as *disenchantment of the world* (Hasu, 2012: 72). According to Weber, when societies undergo a process of modernization and rationalization, they also undergo a process of secularization, making religion to diminish in importance, both in society and in the consciousness of individuals (Berger, 2001, p. 443).

Over the last four decades, (since 1990's) modernisation theories and secularization theses, which predicted that religion would vanish from people's lives as societies become modernised, has come under critical attacks in social sciences. José Casanova (2008); Peter Berger (2001); and Thomas (2005) were among the scholars that critically challenged conventional assumptions about the decline and privatization of religion. Arguing against the privatization of religion, they explained that in many parts of modern societies, religion would still occupy a public role. They further contented that, in some areas, religion even assumed a new and greater public role in the context of increased modernisation and development of modern societies since (Casanova, 1994, p. 39, 215).

Geertz, (1973), viewed religion as having double aspects such that they are frames of perception, symbolic screens through which experience is interpreted; and they are guides for action as well as blueprints for conducts. He further showed that religious experience is not only continuation of the past tradition but also an extension of the present, very much alive, dynamic, and constantly influencing society, culture as well as personal life. This article started from this Geertz's conceptualisation of religion and move forward to the assumption that, gradual withdrawal of the state as a sole healthcare services provider to people in Tanzania, and the corresponding processes of privatization, globalisation, commercialisation as well as liberalization have become seminal

for the (re)immersion of religiously inspired healthcare interventions giving FBOs an opportunity to meet their religious obligations while praying important socio-economic roles.

In interpreting the findings, this study employs the concept of development as holistic advanced by Erica Bornstein (2005, pp. 48-49). For her, holistic development is a process of addressing human dual needs that include religious, socio-economic, psychological, spiritual and material. The main assumption, which Bornstein (2005) developed is that working with the poorest of the poor requires paying attention to poverty that is both material and spiritual. For her, bringing development to the poor is a religious act that involves the body and the spirit. She defined holistic approach as the one that 'bridges the gaps' between the spiritual and material worlds, and between the rich and the poor. By presenting God along with development, the FBOs provide a moral and religious interpretation of development transformation hence development serves a dual purpose: to introduce religious beliefs to individuals and to 'redeem' the earth's 'God-given potential" (Bornstein, 2005, p. 48).

Therefore, this study argues that the design of the FBOs healthcare interventions aimed to serve double purpose; to introduce religious beliefs to beneficiaries and to 'redeem' the earth's 'God-given potential through healthcare as part and parcel of meeting their religious teachings and obligations.

4. Methodology

This study is grounded in the ethnographic tradition. The rationale for choosing ethnographic approaches was to enable the researcher to gain an in-depth understanding from an emic perspective of how religious values, teachings, norms, ideas, and practices inform the character and content of the FBOs' healthcare interventions, particularly in relation to proselytization and conversion as part of fulfilling their religious obligations (Carroll, 2013, pp. 42–43). The study was conducted in the Morogoro region, which was selected purposively because it has the largest number of Pentecostal organizations (Jamal, 2017), thus providing a wider choice for the study.

The study targeted urban areas because previous research noted that the transformation of urban areas through religious healthcare interventions is an urban phenomenon (Dilger, 2014b, p. 55), linked to the increased role of religious institutions as urban service hubs, responding to urban challenges in the context of neoliberal policies (Beaumont, 2008, p. 2011). The selection of the case study was done purposively following a preliminary online study to identify Pentecostal FBOs that are highly engaged in healthcare interventions. Bethel Revival Temple was selected because it offers a range of healthcare activities, including operating a health facility, conducting charity-related healthcare and support, organizing blood donations, and visiting the sick and the needy.

The study population included members of the FBO in question, religious leaders, FBO management, healthcare workers in facilities owned by the FBO, healthcare officials from Morogoro Municipals, beneficiaries of the FBO healthcare interventions, and officials from the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGC). Purposive sampling was used to select these participants, while snowball sampling was employed to identify additional beneficiaries of the FBOs' healthcare interventions for key informant interviews.

Data were collected through participant observations (where the researcher participated in various FBO healthcare activities such as mobile clinics, blood donations, charity healthcare-related

events, facility-based healthcare services, religious teachings, prayers, and other events of the FBOs under study), in-depth interviews, key informant interviews, focus group discussions, and documentary reviews. Data were analyzed using a comparative approach typical of grounded theory, as well as content, thematic, and narrative analyses. NVivo11 software was used to organize the substantial volume of ethnographic materials collected over 13 months from the FBOs under study.

5. Findings and Discussion

Background of the case study: Bethel Revival Temple

Bethel Revival Temple (BRT) is a Pentecostal organisation registered under the Tanzania Assemblies of God (TAG) and is located in the Mwembesongo ward of Morogoro Municipality, approximately 2 kilometers from the municipal center. Founded in 1987 by Pastor Dr. Barnabas W. Mtokambali, BRT had, by early 2020, grown to operate five prayer sessions on Sundays and two on Wednesdays, with a total of 4,063 members (BRT, 2019).

The church is founded on five principles: worship, fellowship, discipleship, ministry/service, and evangelism. BRT has embarked on the establishment of several developmental projects that significantly contribute to the welfare of people in areas such as education, orphanages, sponsorship, healthcare services, evangelization, and community social support. BRT owns and operates a health facility known as Uzima Medical Centre (UMEC). It also organizes bi-annual blood donation campaigns in collaboration with government health officials and hosts charity events that include the provision of free healthcare services to attendees.

Proselytization and Conversion at Uzima Medical Center

Uzima Medical Centre (UMEC) is a dispensary owned by Bethel Revival Temple (BRT). Established in 2005, UMEC was the long-awaited vision, dream, and brainchild of Dr. Barnabas Mtokambali, the Senior Pastor and founder of BRT, inspired through grace and the workings of the Holy Spirit (as he referred to during one of our conversations). UMEC is located in the Mwembesongo area, often referred to as 'notorious' and one of the poorest neighborhoods in the Morogoro Region. The street serves as the boundary between Mwembesongo and Mji Mpya Wards, which together contribute 16 percent of the total population of Morogoro Municipality (BRT, 2019). UMEC was established with the purpose of reaching the surrounding communities with the gospel of Jesus Christ through Christian-based medical services. The center, operated and guided by the BRT Council of Elders, provides a range of healthcare activities including outpatient, laboratory, and clinical services

Since its establishment in 2005, UMEC has been the primary healthcare provider for residents of Mwembesongo and Mji Mpya Wards (Bethel Revival Temple, [BRT], 2019). It serves approximately 1,950 patients per month (BRT, 2019). Under the current strategic plan, which spans ten years from 2019 to 2029, BRT plans to expand UMEC into a full hospital. This expansion would utilize the left wing of its office building, which includes four floors, increasing its capacity to admit up to 150 patients at once. Currently, UMEC employs seventeen staff members with various specializations: one Operations Manager, one Medical Doctor, three Clinical Officers, three Nurse Midwives, two Laboratory Technicians, two Laboratory Attendants, and two Office Attendants. All healthcare workers are born-again Christians, followers of Pentecostalism, sharing the same religious faith as Bethel Revival Temple (BRT, 2019).

UMEC was established in accordance with BRT's vision and mission, which is derived from biblical verses and one of its sixteen core principles that states, “To be an agency of God for evangelizing the world” (derived from biblical verses: Acts 1:8, Matthew 28:19-20, Mark 16:15). UMEC was founded to reach the surrounding communities of Mwembesongo and Mji Mpya Wards, where 70 percent of the population were Muslims, with the Gospel of Jesus Christ through healthcare services. The purpose for establishing UMEC is to use medical services as a means for sharing the word of God with others, particularly with Muslims, with the aim of converting them to Christianity.

The UMEC medical process is divided into three main stages: registration, laboratory tests, and clinical consultations before and after laboratory tests. In participant observation, I noted that the medical process at UMEC begins with the registration process, where details of a patient are captured in a computerized system. At the registration stage, receptionists are very charming and cordial to establish immediate rapport with patients. Many leaflets containing encouraging Bible verses are available in the waiting lounge. I was particularly interested in the leaflets that contained the following Bible verses: Mark 10:27 "*Jesus looked at them and said, 'With man this is impossible, but not with God; all things are possible with God.'" Psalm 28:6-7 "Praise be to the LORD, for He has heard my cry for mercy. The LORD is my strength and my shield; my heart trusts in Him, and He helps me. My heart leaps for joy, and with my song I praise Him."*

At the waiting place, a big screen shows various church meetings, prayers, testimonies, mass sessions, and other development activities conducted by BRT. The next stage in the medical process involves clinical consultation and laboratory tests. At this stage, the clinical officers, who are all born-again Christians and skilled preachers, are trained and placed in their offices to play double roles; treatment and sharing the word of God. According to Dr. Richard (not his real name), during a clinical consultation, a patient is always welcomed with the famous greeting *“bwana asifiwe”* (Praise the Lord) followed by comforting and encouraging words from the Bible such as *“Mungu ana maksudi kukuleta hapa”* (translated as, “God has a purpose for bringing you here”) and *“Yesu ndiye mponyaji mkuu na kwake hakuna linaloshindikana”* (translated as, “Jesus is the chief healer and nothing is impossible for Him”).

Additionally, Dr. Samwel explained that during clinical consultations, they employ both medical and spiritual skills in diagnosing diseases. He further explained that diseases are divided into two major groups: those that emerge from flesh/blood and those that emanate from witchcraft and evil spirits. According to him, diseases from flesh/blood can be cured using biological medicines provided at UMEC, but those from witchcraft/evil spirits can only be cured through prayers and the exorcism of demons, in which all UMEC employees are filled with the Holy Spirit to undertake this divine task.

Dr. Richard, the head of the prayer session and clinician at UMEC, explained that they do not share the encouraging word from the Gospel of Jesus Christ with everyone during medical consultations, but only with those who are ready or whose health conditions allow it. In some instances, they wait for the Holy Spirit to guide them on who among the patients can share the gospel with them.
He said,

> *“We are guided by the Holy Spirit in identifying patients with whom we can share with the good word of God.”*

UMEC does not admit patients but has a resting room where a patient can relax for no more than 12 hours. If a person or patient is directed to rest or admitted for a short period, the researcher observed that UMEC healthcare workers responsible for taking care of them use that opportunity to demonstrate love and affection as well as care. Consequently, they establish friendships with those patients. Babito, a nurse at UMEC, explained that in the process of making friends with patients directed to go for short resting or admitted for a short time, they lead some patients to be very open about their lives or the misery they are facing. It is during such situations that Babito uses the opportunity to share the word of Jesus Christ to the patients. She further explained that some patients in this context require more prayers from church pastors. She gave the example of a patient who accepted to be a born-again Christian after being told that Jesus Christ was the answer to all diseases, including HIV/AIDS, which she was suffering from.

Responses by beneficiaries who were subjected to prayers after medical treatments were very positive because the same were administered after their consent. One of the patients who underwent this type of healing during the fieldwork is Ramadhan. He was of the view that although he is a Muslim, he believes there is only one God for both Christians and Muslims. Ramadhan further explained that the prayers he received at UMEC were very vital because his diseases were associated with witchcraft and evil spirits. He added,

> *"I am very much satisfied after receiving both medicine and spiritual prayers because I believe my disease emanated from witchcraft. Now I believe through these medicines and prayers I received I will fully be healed."*

Up to the period I completed my fieldwork, Ramadhan claimed that he felt better than before he attended medical services at UMEC. He used to attend prayer sessions regularly and he was in the process of becoming a registered follower of the Bethel Revival Temple.

Proselytization and Conversion in Charity events and thanks giving week at BRT

> *"A week starting from tomorrow will be especially dedicated to thanking God for His greatness. We will conduct a Thanksgiving week that includes several events, such as free health check-ups and medication, supporting the needy, visiting the sick, praying for them, and sharing the good news of the salvation of our Lord Jesus Christ. You are urged to pray for this week"*.

The section begins with a quote from the Senior Pastor of BRT, who invites people to actively participate in the charity events scheduled for Thanksgiving week, starting the next Monday, March 25, 2020. Annually, BRT organizes these events to express gratitude to God and give back to the community. The week features numerous social activities, including visits to the sick in various hospitals or homes (particularly those with chronic diseases), distribution of goods to the sick, community clean-ups, and free medical check-ups and medications.

Following the announcement, I awoke early the next day to attend the Morning Prayer session at BRT, which, unlike other days, was dedicated to the Thanksgiving week and BRT's charity events.

Throughout the week, both followers and non-followers were encouraged at every corner of the BRT premises to donate items such as clothes, money (with bank accounts and phone numbers for electronic transfers prominently displayed), food, or anything else that could help someone in need. On March 27, 2020, in collaboration with UMEC and Morogoro Regional Hospital, BRT organized a day of free medical check-ups and medication that attracted many attendees, including church members and non-members, who also received various forms of material support such as second-hand clothes donated by other members. The charity week saw a total of 22 beneficiaries of medical services becoming new converts to BRT.

The week also included sermons delivered by the Senior Pastor and other pastors before the medical sessions began. These sessions led to some attendees converting to Christianity, others being freed from demonic possession, and still others registering as new followers of BRT. On the final day of the charity week, BRT followers and leaders visited several places including orphanages, prisons, and centers for children in difficult circumstances, Morogoro Regional Hospital, and homes of individuals suffering from chronic illnesses.

I was part of the team that visited patients at Morogoro Regional Hospital, where we distributed clothes, food, and fruits, prayed with the patients, and shared the word of God. Additionally, we provided some financial support to a few patients for their personal use while admitted. At the end of these visits, a total of 9 patients accepted Jesus as their savior. BRT members continued to support these patients in the hospital, hoping that upon discharge, they would join the church as new converts. However, by the end of my ethnographic study, only 3 out of the 9 had joined BRT as new converts.

Proselytization and Conversion in the Blood donations exercise

Each year, Bethel Revival Temple, in cooperation with the safe blood section of Morogoro Regional Hospital, conducts two blood donation sessions to save the lives of patients in need across various hospitals in Tanzania. In 2020, the blood donation was organized during the week commemorating 33 years of BRT and 10 years of Strategic Planning at BRT. Leading up to the event, announcements were made throughout the BRT premises and UMEC, with prayers specifically directed towards the success of the upcoming donation day.

The Senior Pastor of BRT emphasized the importance of participating in the event, describing it as a crucial opportunity for born-again Christians to exercise the 'fruits of the Spirit' and fulfill their duty of evangelizing and showing Christ's love to those in need. He highlighted the importance of blood donation in saving lives, urging members to fulfill their religious obligations by participating. He referenced Galatians 5:22-23 to reinforce this message, which reads:

> *"But the fruit of the Spirit is love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control. Against such things there is no law."*

The 2020 blood donation campaign began with a week of dedicated prayers at BRT, seeking God's blessing for widespread participation and a successful process. The exercise was officially inaugurated by the Senior Pastor of BRT and representatives from the District Medical Office of

Morogoro District. Before the blood donation began, the Senior Pastor led a prayer to bless the event:

> *"Our Father who art in heaven, we ask you to oversee our blood donation exercise. Jehovah King, protect this initiative, grant Your children the strength and courage for full participation, so that the blood donated here may save lives and inspire discipleship wherever it may reach."*

Following this invocation, the Senior Pastor, along with other BRT leaders and members, proceeded to donate blood, following a brief health check conducted by experts from Morogoro hospital. On the second and final day of the event, the Senior Pastor made a brief speech encouraging conversion to Christianity for divine protection against all insecurities, which was broadcasted through various media outlets and live-streamed on social networks. The blood donation exercises at BRT are meaningful in three ways: they provide a critical second chance for those in need of blood, they offer an opportunity for recipients to encounter the word of God, and they allow donors to witness and share the greatness of God. This interpretation of blood donation at BRT motivates members, healthcare workers, and management alike, encouraging actions consistent with their religious duties, including sharing the word of God.

Yesu ameniokoa (Jesus has saved me) - The case of Abdul

Abdul Juma was born into a very poor Muslim family in Machame Moshi in 1987. Due to the family's poverty, he struggled to access basic necessities like food and healthcare. His mother, who had been employed as a clerk in a government office, was retrenched during the Structural Adjustment Programs (SAPs) in the 1990s. As she aged, Abdul found himself without any means to support her. Consequently, he dropped out of school while in standard four, travelled to Arusha, a nearby city, and engaged in petty trading, a business commonly known as *"Wamachinga"*. In 2006, he received news of the premature death of his father, who had been left unattended at Machame District Hospital due to the inability to pay the required fees for medical services.

Abdul Juma was highly frustrated after the death of his father. He returned to Machame for the burial ceremony and used the little money he had to support the funeral activities. After the mourning period ended, he went back to Arusha, but all his capital had been spent on his father's funeral. He started looking for employment, but all his efforts were in vain. His life became even more miserable than before. He eventually found himself sleeping on the streets like the notorious *"watoto wa mitaani"* (street children), and began smoking marijuana and stealing. One day, he and his colleagues robbed an Arab man, taking TZS 500,000 from him, stabbed him in the shoulder, and fled. The police began investigating the crime, and during their preliminary investigation, many street children were caught and taken into custody. His colleagues mentioned him as an accomplice in the robbery and stabbing.

After hearing that the police were looking for him, Abdul decided to flee from Arusha to Morogoro, where he had previously heard there were many casual employment opportunities in the sisal plantations. Unfortunately, he was unable to find such work as he had hoped. He used all the money he had obtained from the robbery in Arusha. Life became miserable again. While in Morogoro, Abdul made new friends and resumed his previous habits of robbery, excessive drinking, and

smoking marijuana. He continued this miserable lifestyle for more than four years, during which he injured hundreds of people in various illegal activities.

It was one Saturday morning when Abdul woke up early. The night before, he had slept without eating, due to the large amounts of illicit alcohol (gongo) he had consumed and the marijuana he had smoked. Even worse, he had nothing in his pockets and was very hungry. Hurriedly and without hesitation, he left home. By chance, on his way, he encountered a Sokoine University of Agriculture (SUA) student in a dark alley known as *"kichochoro."* He attempted to rob the lady who was chatting on her cell phone, but he did not succeed. The lady screamed loudly, and to his surprise, when he tried to escape, there were people on every corner of the dark street. He was caught and beaten severely. He nearly died but was fortunate to be rescued by an elderly man who turned out to be an officer in the military.

The angry mob left Abdul badly injured and few persons who identified him assisted to seek for medical assistance in the nearest dispensary. He landed at UMEC where they assisted him and later on, they offered some food and water to drink. Because he had nothing in his pockets, one of the UMEC healthcare employees agreed to meet all medical costs of Abdul from her pockets. Abdul Juma spent the remaining part of the day at the UMEC rest room. Several healthcare workers of the facility often visited him, shared the word of God and convinced him to be converted. He agreed to accept Jesus Christ and became a convert after several days of prayers. He was led and guided to perform *"sala ya toba"* (a repentance prayer). His narrative went as follows:

> *"When they told me that Jesus was able to forgive even the sins that are as red as mine, I felt relieved. I wanted to become a new, reliable, and trusted person. When they led me in the repentance prayers, I truly felt like I had become a completely new person."*

After the procedures, Abdul was connected with the pastor of the church responsible for new converts and received further assistance to strengthen his faith. He began attending Bible classes every evening as well as Shemasi prayers every Friday. After a month, Abdul secured a job at a brick factory *('kiwanda cha kufyatua matofali')*, owned by one of the BRT members, earning a modest wage that enabled him to survive. Since then, he started sending some money to his mother, who was living in rural Machame. Abdul became a choir singer and planned to marry by the end of 2020. He was transformed to the extent of being considered one of the upcoming young members of the church (BRT), filled with the Holy Spirit and gifted in praying in tongues.

Procedures for supporting the new converts

The first procedure involved leading the new converts in a repentance prayer, conducted by either an employee of UMEC at the health facility or a member of the BRT church, immediately after the beneficiary agreed to accept and receive Jesus Christ as their savior. After the repentance prayer, details of the converted patients, including names, ages, ethnic groups, occupations, phone numbers, emails, and locations, were recorded in a large counter book. This information was then given to the leader of the new converts department of BRT as well as to the leader of the Shemasi from which the person comes.

I perused the book in which the number of new converts at BRT had been recorded and found a total of 92 converts from January 2019 to June 2020. When I tried to locate them, I managed to meet only 26. I conducted key informant interviews with four of them: Abdul, Baraka, Hassan, and Irene, who were still undergoing capacity-building training organized by BRT for the new converts. I met Irene at a training session for the new converts and engaged in some informal conversation at the end of the session. She showed me some messages that she usually received from the church, reminding her to attend such capacity-building sessions every Sunday and Wednesday. The messages read;

> *"Praise the Lord Jesus Christ. How are you this Sunday? I remind you that the more you keep attending church so you can hear the word of God, the more you will be liberated from satanic chains and become truly free. Therefore, I request that you do not miss the class sessions. Today's class will be at 9:00 AM at Bethel Church."*

The second message read:

> *"Praise the Lord Jesus. How are you? I request that you do not miss today's teachings and prayers on the word of God, which will be from 4:00 PM to 6:00 PM at this church."*

I also managed to see Irene's notebook in which she had recorded various topics taught in the classes. These included steps to knowing the truth, principles of salvation, committing life to Jesus Christ, and seeking the Holy Spirit's guidance in becoming a born-again Christian. On another occasion, I met Baraka at one of the Shemasi locations in his area. He was very happy and explained that he had chosen to convert and become a born-again member of BRT because it relieved the great burden he used to carry in his heart.

Discussion: Emerging Opportunities for Proselytization and Conversion through Pentecostal Healthcare Interventions in Tanzania

The strategic placement and operational methods of BRT within a predominantly Muslim community, and the ways it intertwines healthcare provision with religious evangelization, exemplify a broader global trend where faith-based organizations (FBOs) fill service voids created by the retreat of state welfare systems since 1990s (Dilger, 2014a; Hasu, 2012; Muhoja, 2023). Following the SAPs that reduced the state's role in healthcare, FBOs like BRT found opportunities to establish services in underserved areas and particularly in areas not claimed by the state or other non-government organisations (Dilger, 2014a, pp. 55–56). Their presence in such locations is not merely a response to a healthcare void but also a strategic evangelical opportunity (Muhoja, 2020a).

Following state's inability to provide essential health services and support to the vulnerable groups in Tanzania since the introduction of SAP; FBOs often step in to fill gaps left by state in providing essential services like healthcare and social support. This situation gave the Pentecostal organisation an opportunity not only to offer material aid but also provide spiritual and emotional support, which became appealing to individuals in desperate situation in urban areas (Dilger, 2007; Hasu, 2007).

BRT was located in an area composed of majority Muslims and in area that previously did not own any other health facility, whether private or public. The UMEC was located on the place for the purpose of smoothing people's hearts by giving them healthcare services and support and consequently using the same opportunity as an entry point for proselytization and conversion to Christianity (see Dilger, 2009a). The findings from this study revealed that the SAPs, liberalism and globalisation, which took away the role of the state as a sole provider of healthcare services (Mujinja & Kida, 2014a, pp. 1–2; Ngowi, 2009), created space for BRT to use *"weakened individuals"* in meeting their healthcare needs and turned them into subject of their religious ideologies (Salemink et al., 2004; Ter Haar, 2011). The location of BRT's healthcare activities (both medical and non-medical) at Mwembesongo and nearby communities is part of the process in which the organisation appropriated and reconfigured urban space imagined to be inhabited by people with particular social, material, and spiritual needs and turned them into targets of their spiritual welfare (Dilger, 2014a, p. 64).

The findings from this study shows a complex intersection of healthcare interventions and religious proselytization and conversion. The BRT's approach revealed that healthcare interventions accompanied by spiritual care can be perceived as more holistic, potentially improving patient satisfaction and outcomes hence easily turning them into targets of their religious ideologies. The strategy of supporting people by giving their needs during difficult times fostered a positive view of the church and its associated activities, partly contributing in smoothing their hearts hence easily to be converted (Muhoja, 2020a, pp. 171–172).

Furthermore, the BRT's strategy of integrating local beliefs about diseases caused by witchcraft and evil spirits into their religious sermons conducted during healthcare activities highlights an essential aspect of their appeal. By acknowledging and addressing these culturally specific health beliefs, BRT positions itself as a culturally sensitive organisation, which enhances its legitimacy and acceptance within the community. Despite the fact that BRT provided medical services based on biological explanation, which is Western in nature, in informal services like charity events and visiting of the sick they also connected some of the diseases to be emanating from witchcraft and evil spirits which are culturally connected. These kind of diseases are well defined within the Tanzanian community as well as in the general African context (Freeman, 2012, p. 10; Mesaki, 1993).

As pointed out clearly by Freeman, (2012); and Meyer, (1998), the Pentecostal organisations like in the case of BRT's healthcare activities attract more followers due to their ability to integrate African cultural beliefs as well as traditions and translate them into religious beliefs. For BRT, conceptualization as well as interpretation of diseases and treatments encompassed local beliefs including traditions translated into religious solutions. In so doing, they attracted beneficiaries not only for their medical services but also to become members of their church whereby they could enjoy protection emanating from the blood of Jesus Christ against witchcraft and other evil spirit. This can be exemplified by massive growth of BRT members in recent years from eight members in 1987 to 4500 in 2019 (BRT, 2019)

However, the findings revealed that a number of people 'accepted Jesus as their savior' during the healthcare events and services. Yet, only a fraction of these individuals followed through by joining the church. This raises questions about the sustainability and authenticity of conversions occurring in the context of receiving healthcare services and support, and whether such conversions result in long-term engagement with the church.

On a different note, other findings revealed that the majority of poor people falling into poverty and crime in urban areas (Fourchard, 2005; Munishi & Hamidu, 2022) can be traced back to broader economic policies, such as the Structural Adjustment Programs (SAPs), which led to job losses and increased poverty for many (Dilger, 2007, p. 63; Hasu, 2012, p. 69). This highlights the need for immediate interventions to address the long-term social consequences of such policies and develop appropriate interventions. For example, the BRT's role in Abdul's recovery and conversion presents an example of how faith-based organizations can contribute to personal transformation and societal rehabilitation arising from poverty and the negative impacts of SAP since 1990s. Abdul's portrait offers a comprehensive understanding of how individual lives are intertwined with larger social, economic, and spiritual landscapes (Muhoja, 2023).

The relationship between faith-based organizations (FBOs) and healthcare, particularly in contexts marked by socio-economic instability and personal crises, provides an opportunity for the FBOs to enhance their religious activities through proselytization and conversion. This intersection is particularly pronounced in cases where desperate circumstances lead individuals to seek support from religious organizations, which then play a pivotal role in their lives, not just in terms of providing immediate help, but also influencing deeper personal transformations (Dilger, 2007; Hasu, 2007).

The findings from this study have revealed that BRT employs three of the five strategic approaches outlined by Unruh (2004, p. 317), for using FBOs' social services as entry points for proselytization and conversion. BRT employed an implicit approach, where the healthcare interventions at Uzima Medical Center included a religious team (all employees were trained born-again Christians), but direct evangelization did not occur unless certain circumstances dictated otherwise. The second strategy is invitational, where beneficiaries are invited to religious events outside of the healthcare interventions, such as church attendance and prayer sessions. The third and most common strategy at BRT was relational, in which BRT members and leaders shared the word of God before and after the execution of almost all healthcare interventions, with the exception of those provided at UMEC. The fourth strategy, integrated optional, and the fifth approach, integrated mandatory, were not applicable at BRT.

Generally, the integration of healthcare and religious evangelization by faith-based organizations (FBOs) like BRT in contexts such as Tanzania illuminates a significant intersection of socio-economic factors, healthcare provision, and religious activities. The strategic placement of these organizations in areas devoid of adequate state healthcare facilities, especially following the long-term impacts of the implementation of SAPs, reflects a nuanced response to both material and spiritual needs within communities. This dual response not only addresses immediate health concerns but also aligns with broader objectives of religious conversion and community integration.

Funding
This research paper received funding from the German Research Foundation (DFG) under Grant reference number DI 893/14. It is part of the collaborative project titled "Religious Reforms, Faith-Based Development, and the Public Sphere in Sub-Saharan Africa," led by Professor Hansjörg Dilger. The project is conducted jointly by the Freie Universität Berlin (Germany), the University of Dar es Salaam (Tanzania), the School of Oriental and African Studies (University of London), and the University of Cape Town (South Africa).

References

Anagisye, W. A. L., & Mligo, A. D. (2014). The contributions of religious institutions to the development of secular education in Tanzania: The case of Pentecostal churches in Dar es Salaam region. In C. Wolhuter & C. de Wet (Eds.), *International Comparative Perspectives on Religion and Education* (pp. 53–74). Sun Press.

Avert. (2016, December 14). A closer look at the healthcare system in Tanzania. Retrieved from https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/tanzania

Bakari, M. A. (2012). Religion, secularism, and political discourse in Tanzania: Competing perspectives by religious organizations. *Interdisciplinary Journal of Research on Religion, 8*. https://www.religjournal.com/pdf/ijrr08001.pdf

Beaumont, J. (2008). Introduction: Faith-based organisations and urban social issues. In *Urban Studies* (Vol. 45, Issue 10, pp. 2011–2017). SAGE Publications Sage UK: London, England.

Berger, P. (2001). Reflections on the sociology of religion today. *Sociology of Religion, 62*(4), 443-454.

Bethel Revival Temple. (2019). *Report on 32 years of Bethel Revival Temple 1987-2019*. Morogoro: Bethel Revival Temple.

Bornstein, E. (2005). *The spirit of development: Protestant NGOs, morality, and economics in Zimbabwe*. Stanford University Press.

Carroll, J. J. (2013). Key theories from critical medical anthropology for public health research. Part I: Starting with Foucault: Cultures of medicine and meanings of illness. *Tobacco Control and Public Health in Eastern Europe, 3*(1), 39-46.

Casanova, J. (2008). Public religions revisited. In H. de Vries (Ed.), *Religion: Beyond a concept* (pp. 101-119). Fordham University Press.

Clarke, M. (2013). Good works and God's work: A case study of C hurches and community development in V anuatu. *Asia Pacific Viewpoint*, *54*(3), 340–351. https://doi.org/10.1111/apv.12030

Cleall, E. (2012). *Missionary discourses of difference: Negotiating otherness in the British Empire, 1840-1900*. Springer.

Dilger, H. (2007). Healing the wounds of modernity: Salvation, community and care in a neo-Pentecostal church in Dar Es Salaam, Tanzania. *Journal of Religion in Africa*, *37*(1), 59–83.

Dilger, H. (2009a). Doing better? Religion, the virtue-ethics of development, and the fragmentation of health politics in Tanzania. *Africa Today*, *56*(1), 88–110.

Dilger, H. (2009b). Doing Better? Religion, the Virtue-Ethics of Development, and the Fragmentation of Health Politics in Tanzania. *Africa Today*, *56*(1), 88–110. https://doi.org/10.2979/AFT.2009.56.1.88

Dilger, H. (2014a). Claiming territory: Medical mission, interreligious revivalism, and the spatialization of health interventions in urban Tanzania. *Medical Anthropology*, *33*(1), 52–67.

Dilger, H. (2014b). Claiming Territory: Medical Mission, Interreligious Revivalism, and the Spatialization of Health Interventions in Urban Tanzania. *Medical Anthropology*, *33*(1), 52–67. https://doi.org/10.1080/01459740.2013.821987

Fischer, M. (2011a). "The Spirit helps us in our weakness": Charismatization of Worldwide Christianity and the Quest for an Appropriate Pneumatology with Focus on the Evangelical Lutheran Church in Tanzania. *Journal of Pentecostal Theology*, *20*(1), 95–121.

Fischer, M. (2011b). “The Spirit helps us in our weakness”: Charismatization of Worldwide Christianity and the Quest for an Appropriate Pneumatology with Focus on the Evangelical Lutheran Church in Tanzania. *Journal of Pentecostal Theology*, *20*(1), 95–121.

Fourchard, L. (2005). URBAN POVERTY, URBAN CRIME, AND CRIME CONTROL. *African Urban Spaces in Historical Perspective*, *21*, 291. https://books.google.com/books?hl=en&lr=&id=SBj3HTJ3wJ4C&oi=fnd&pg=PA291&dq=poverty+and+crime+in+urban+areas+of+Tanzania&ots=kbqgKKqxmU&sig=onKhFh5FjgdcXW2Nc-rXqczhrgE

Freeman, D. (Ed.). (2012). *Pentecostalism and Development*. Palgrave Macmillan UK. https://doi.org/10.1057/9781137017253

Geertz, C. (1973). *The interpretation of cultures* (Vol. 5019). Basic books.

Gomes, P. F. (2021). Evaluating Evangelisation in Faith-Based Organisations: A Study of Catholic Educational Centres. *SPNHA Review*, *17*(1), 6. https://scholarworks.gvsu.edu/spnhareview/vol17/iss1/6/

Green, M., Mercer, C., & Mesaki, S. (2010). *The development activities, values and performance of non-governmental and faith-based organizations in Magu and Newala districts, Tanzania*. http://epapers.bham.ac.uk/1595/

Hasu, P. (2007). Neo-pentacostalism in Tanzania: Godly miracles, satanic interventions or human development? In *Anomalies of aid: A festschrift for Juhani Koponen* (pp. 223–243). University of Helsinki, Institute of Development Studies.

Hasu, P. (2012). Prosperity gospels and enchanted worldviews: Two responses to socio-economic transformation in Tanzanian Pentecostal Christianity. In *Pentecostalism and development: Churches, NGOs and social change in Africa* (pp. 67–86). Springer.

Havnevik, K., & Isinika, C. (2010). *Tanzania in transition: From Nyerere to Mkapa*. African Books Collective.

Jamal, S. (2017, February 1). Mlipuko wa taasisi mpya za Kiislamu na Kikristu Tanzania. *Mwananchi*, p. 15.

Kowalewski, M., Mujinja, P., & Jahn, A. (2002). Can mothers afford maternal health care costs? User costs of maternity services in rural Tanzania. *African Journal of Reproductive Health*, 65–73. https://www.jstor.org/stable/3583147

Leurs, R., Tumaini-Mungu, P., & Mvungi, A. (2011a). *Mapping the development activities of faith-based organizations in Tanzania*.

Leurs, R., Tumaini-Mungu, P., & Mvungi, A. (2011b). *Mapping the development activities of faith-based organizations in Tanzania*. http://epapers.bham.ac.uk/1659/

Ludwig, F. (1999). *Church and State in Tanzania: Aspects of Changing in Relationships, 1961-1994* (Vol. 21). Brill.

Lugalla, J. (1997). Economic reforms and health conditions of the urban poor in Tanzania. *African Studies Quarterly*, *1*(2), 19. https://ecommons.aku.edu/eastafrica_ied/93/

Lugalla, J. L. P. (1995). The impact of structural adjustment policies on women’s and children’s health in Tanzania. *Review of African Political Economy*, *22*(63), 43–53. https://doi.org/10.1080/03056249508704099

Mamdani, M., & Bangser, M. (2004). Poor people’s experiences of health services in Tanzania: A literature review. *Reproductive Health Matters*, *12*(24), 138–153.

Mesaki, S. (1993). *Witchcraft and witch-killings in Tanzania: Paradox and dilemma*. University of Minnesota.

https://search.proquest.com/openview/f53c9720b126da55219dbf032087724f/1?pq-origsite=gscholar&cbl=18750&diss=y

Meyer, B. (1998). 'Make a complete break with the past.'Memory and Post-colonial Modernity in Ghanaian Pentecostalist Discourse. *Journal of Religion in Africa*, *28*(Fasc. 3), 316–349. https://www.jstor.org/stable/1581573

Muhoja, M. S. (2020a). *The dynamics of faith-based organizations healthcare interventions in Tanzania: Ethnographic Study of Bethel Revival Temple and Africa Muslims Agency* [PhD Thesis]. University of Dar es Salaam.

Muhoja, M. S. (2020b). *The dynamics of faith-based organizations healthcare interventions in Tanzania: Ethnographic Study of Bethel Revival Temple and Africa Muslims Agency* [PhD Thesis, University of Dar es Salaam]. https://libraryrepository.udsm.ac.tz/handle/123456789/16411

Muhoja, M. S. (2023). The dynamics of the relationship between religious organizations and the government on healthcare interventions in Tanzania since 1990s. *NG Journal of Social Development*, *12*(1), 43–58. https://www.ajol.info/index.php/ngjsd/article/view/261130

Mujinja, P. G. M., & Kida, T. M. (2014a). *Implications of health sector reforms in Tanzania: Policies, indicators and accessibility to health services*. Economic and Social Research Foundation.

Mujinja, P. G. M., & Kida, T. M. (2014b). *Implications of health sector reforms in Tanzania: Policies, indicators and accessibility to health services*. Economic and Social Research Foundation.

Munishi, E. J., & Hamidu, K. M. (2022). Urban crime and livelihood implications among the motorcycle taxi riders in Dar Es Salaam City-Tanzania. *International Journal of Research in Business and Social Science (2147-4478)*, *11*(4), 246–254. https://www.ssbfnet.com/ojs/index.php/ijrbs/article/view/1850

Ngowi, H. P. (2009). Economic development and change in Tanzania since independence: The political leadership factor. *African Journal of Political Science and International Relations*, *3*(5), 259. https://academicjournals.org/article/article1379789169_Ngowi.pdf

Nyanto, S. S. (2014). Religion and State in Tanzania: A Historical Perspective with Reference to the White Fathers in Buha and Unyamwezi, 1878-1990s. *Religion and State in Tanzania Revisited*, 31–46. https://ixtheo.de/Record/1752298837

Otunnu, O. (2018). Mwalimu Julius Kambarage Nyerere's philosophy, contribution, and legacies. In *African Political Thought of the Twentieth Century* (pp. 18–33). Routledge. https://api.taylorfrancis.com/content/chapters/edit/download?identifierName=doi&identifierValue=10.4324/9781315624112-3&type=chapterpdf

Pring, C., & Vrushi, J. (2019). *Global corruption barometer: Africa 2019*. Transparency International. https://apo.org.au/node/247681

Salemink, O., Van Harskamp, A., & Giri, A. K. (Eds.). (2004). *The development of religion/The religion of development*. Eburon.

Shivji, I. G. (2006). *Let the people speak*. Codesria. http://repository.costech.or.tz/handle/20.500.11810/2335

Sundqvist, J. (2017). *Beyond an instrumental approach to religion and development: Challenges for church-based healthcare in Tanzania* [PhD Thesis]. Acta Universitatis Upsaliensis.

Ter Haar, G. (2011). Religion and development: Introducing a new debate. In G. ter Haar (Ed.), *Religion and development: Ways of transforming the world* (pp. 3-25). Hurst.

Thomas, S. (2005). *The global resurgence of religion and the transformation of international relations: The struggle for the soul of the twenty-first century*. Springer.

Unruh, H. R. (2004). Religious elements of church-based social service programs: Types, variables and integrative strategies. *Review of Religious Research*, 317–335. https://www.jstor.org/stable/3511989

West-Slevin, K., Barker, C., & Hickmann, M. (2015). Snapshot: Tanzania's health system. *Target*, 400. https://www.healthpolicyproject.com/pubs/803_TanzaniaHealthsystembriefFINAL.pdf