The Dynamics of the Relationship between Religious Organizations and the Government on Healthcare Interventions in Tanzania since 1990s

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Abstract

The relationship between Faith Based Organisations (FBOs) and the government on healthcare provision in Tanzania has evolved over time. This study focused on examining how the new Faith Based Organisations relate with the government in their healthcare activities from 1990s to date. The results from this study are situated in the larger historical and theoretical underpinnings on the relationship between Faith Based Organisations and the government on healthcare activities in Tanzania. Using ethnographic approaches, this study aimed to uncover how the new FBOs and the government relate to each other on healthcare interventions since 1990s in the context of the changing social, economic and political contexts. Results showed that the socio-economic and political context since 1990s created more space for the new FBOs to strengthen their visibility on healthcare provision activities, as well as enhance their social, religious and policy agenda in the country. Furthermore, the relationship between the new FBOs and the government on healthcare provisions was embedded in longstanding history of religious diversity in Tanzania that was characterized by the need for the Muslim and Christian communities to harmoniously enhance their relationship with each other and the government based on power, faith and politics.

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1. Introduction

This study focused on examining how the new Faith Based Organisations (those formed from 1980s onwards) relate with the government in their healthcare activities since 1990s up to date. The findings from this study were situated in the larger historical and theoretical underpinnings on the relationship between Faith Based Organisations and the government on healthcare provisions in Tanzania, which have developed over time. Historically, FBOs have been working in the health sector in Africa since the colonial period, and they offer up to fifty percent of all healthcare services provided in the Sub-Saharan Africa (Olivier, 2011, pp. 5–6). In Tanzania, faith-based healthcare institutions served about forty percent of the population by 2016 (Avert, 2016). Since 1990s, the fragmentation of African states and their inability to provide healthcare services to their citizens has left international donors without an alternative but to recognize the Faith Based Organisations as recipients of funds and implementers of healthcare projects (Benn, 2017).

The relationship between the government and Faith Based Organisations on healthcare provisions can be traced back to the Germany rule in Tanganyika (Muhoja, 2020, p. 31). Immediately after the Berlin Conference which placed Tanganyika in the control of Germany, FBOs from Germany expanded their missions to Tanganyika, and through collaboration with the colonial government they started to establish healthcare institutions in different areas (Muhoja, 2020; Nyanto, 2012). After the First World War, Tanganyika was placed under the British as a trust territory whereby the British colonial government provided grants and funding to FBOs healthcare institutions that were established in rural and marginalized areas (Dilger, 2014a, p. 57; Jennings, 2013, pp. 948–950).

During the colonial period, Muslim religious organisations did not put much emphasis on establishing healthcare centres, caused partly by their unhealthy relationship with the British colonial government (Ndaluka et al., 2014, p. 62). Despite the unhealthy relationship, the Islamic organizations were able to establish few heath institutions dominated mostly by Ismailis. The Ismailis healthcare institutions were mostly located in urban centres (Kaiser, 1996, p. 62); hence did not qualify for British support which focused on health institutions established in the rural and marginalised areas (Dilger, 2014a, p. 57). While receiving support from internal and external Muslim organisations like the East Africa Muslim Welfare Society (EAMWS), Muslim organisations including the Ismailis were able to establish twelve (12) non communal healthcare institutions by 1965 (Kaiser, 1996, p. 63)

At the time of independence in December 1961, Christian organisations provided almost half (50%) of all hospitals as well as dispensary beds in Tanganyika (Dilger, 2014a, p. 57). The Christian FBOs worked along the post-colonial government to meet a number of development objectives of the new government including ensuring availability of primary healthcare services to everyone (Jennings, 2008, pp. 69–70). In 1967, the Nyerere government introduced *Ujamaa* policy that advocated for the nationalization of private social welfare institutions including those owned by FBOs. Contrary to the Christian FBOs, Muslim organisations like the EAMWS openly opposed the *Ujamaa* policy; hence, lost favour of the Nyerere government and received stiff criticisms form pro-*Ujamaa* Muslims (Mesaki, 2011, p. 253).

By the early 1980s, Tanzania faced a severe economic crisis; consequently, decided to accept the conditions stipulated in the Structural Adjustment Programmes (SAPs) as advanced by the International Monetary Fund and the World Bank. The SAP led to the privatisation and

commercialisation of social services including healthcare and education (Mujinja & Kida, pp. 1–2). The changes in the socio-economic policies adopted from the SAP were believed to be the necessary instruments for poverty reduction; however, the situation became worse than before due to increased cost of living and unemployment in both urban and rural areas of Tanzania (Dilger, 2009, p. 63; Hasu, 2012, p. 69).

As a result of the commercialization of healthcare services, the government introduced user fees styled in the name of cost-sharing, making the poor fail to access and afford these services (Mujinja & Kida, pp. 1–2). A study by Afrobarometer conducted in 2017 indicated that 40 percent of the respondents were unable to access the needed medical services. At the mid of these hustles, FBOs started to cover the gap on healthcare provisions that was vividly left of by these changes, specifically in helping the poor segment of the population to access healthcare services (Sundqvist, 2017, p. 24). While the dominance of the government as the only healthcare provider was coming to an end (Havnevik, 2010), FBOs emerged as the alternative providers making them indispensable actors in the provision of healthcare services (Sundqvist 2017:24). The civil society institutions including FBOs increased in number as a response to the requirements advanced by the international neoliberal institutions in an effort to improve the functioning of the private sector including FBOs and other civil society organisations (Shivji, 2006).

Studies have shown that the relationship between FBOs and the government on healthcare provision in recent decades have taken various forms. Sundqvist, (2017) has noted that some of the Christian organisations like Christian Council of Tanzania (CCT) and Tanzania Episcopal Conference (TEC) have been working collaboratively with the government under the auspices of Public-Private-Partnership (PPP). In 1992, the government signed a memorandum of understanding with TEC and CCT whereby the government agreed to fund some of the healthcare services and projects of the private-owned organisations following its bilateral agreement with the Federal Republic of Germany (Sivalon, 1995).

Furthermore, Faith Based Organisations and the government have collaborated on joint management of FBOs' healthcare facilities that run as the referral hospitals. For example, Bugando Medical Centre (owned by TEC) and Kilimanjaro Christian Medical Centre (owned by CCT) are jointly operated and run by the government of Tanzania and the respective religious organisations (Mallya, 2010). Additionally, some of the Faith Based organisations' healthcare institutions have been transformed to operate as designated district hospitals run jointly by the government and the respective FBOs (Boulenger & Criel, 2012).

The relationship between Faith Based Organisations and the government on health care provisions in Tanzania have received significant attention over the past few years. Literature on Faith Based Organisations relationship with the government on healthcare provision in Tanzania have revealed that FBOs operationalized both the colonial and post-colonial milieu (Jennings, 2013). This relationship is rooted in longstanding historicity of religious diversity as well as their competitive activities in Tanzania (Dilger, 2014b; Ndaluka et al., 2021). This has compelled the Islamic and Christian organisations to enhance their relationship and collaboration which have long been influenced by the historically-shaped relationship based on power, faith and politics (Nyanto, 2018; Sundqvist, 2017).

While recognising the contribution of other scholars on FBOs' relationship with the government on healthcare provision in Tanzania (Dilger, 2014a; Mesaki, 2011; Ndaluka, 2012a; Nyanto, 2014; Sundqvist, 2017); there is little information on the ways the new FBOs have become engaged, and established in the provision of healthcare services and how they have relate with the government since 1990s. Specifically, this study aimed to answer three questions: How have the new FBOs and the government involved each other in their healthcare interventions since 1990s? What are the government's support initiatives to new FBOs' healthcare interventions since 1990s? How have the new FBOs supported the government's healthcare interventions since the 1990s?

While the conceptualization of FBOs has raised considerable debates among scholars, this study adopted the definition of FBOs as advanced by Berger (2003):

> *"Formal organizations whose identity and mission are self-consciously derived from the teachings of one or more religious or spiritual traditions and which operate on a nonprofit, independent, and voluntary basis to promote and realize collectively articulated ideas about the public good at the national or international level " (Berger, 2003: 16)*

1.1. Religion in Public Sphere

Over the past forty years, modernisation and secularization theories, which prophesied that religion would disappear from people's lives as individuals and societies become more modernised, has been heavily criticised by various scholars all over the world. The proponents of secularization thesis and modernisation theories assumed that faith and religion would be eliminated from the public sphere and constrained to the private sphere of people. Thus, the idea that religion would turn out to be more confined to the matter concerned with private choice and, therefore, come to an end to have any influence on the public life of individuals and society or the modern world (Casanova, 2008, 2011) has been negated. Until late 1970s, modernisation theories and secularization theses were most acceptable frameworks in the analysis and interpretation of modernity, development and religion (Stark & Finke, 2000, pp. 55–59).

Casanova, (1994), in *Public Religions in the Modern World* pioneered these criticisms against the relegation of religion to the realm of private life. Casanova challenged the dominance of privatization thesis by explaining that, in several parts of the modern world, religion continued to occupy a public role, both in life of individuals and societies. Casanova, (1994, p. 215) further adds that in some parts of the world, religion even presumed a new and superior public role. He further explain that development process works alongside secularization; hence, what happens is not the process of privatization of religion or jeopardise its influence in the public sphere, but what emerge out of its differentiation process between different spheres of society. Casanova concluded that religion refused to confine itself to the private sphere; hence, continues to impact the public sphere (Casanova, 1994, pp. 5–6).

After Casanova, a number of scholars emerged to support the influence of religion in public life. Berger, (1999) one of the advocates of secularization in 1960s changed his mind and viewed the thesis as false (Berger, 1999, pp. 2–3). He argued that religions have not vanished from the public life of individuals and societies in both the developed and developing countries. He used a number of examples to defend his arguments including citing the influence of Protestantism in the United States (US), the power of the Pope of Rome on influencing various world affairs as well as the

strength of different religious groups in Arabic countries like Egypt and Iran (Berger, 2006, p. 445). Another scholar, Thomas (2005), saw the secularization thesis as a *myth* that emerged out of enlightenment assumptions as well as inaccurate reading of the history of Europe (Thomas, 2005, pp. 52–53). He referred to the process of the increasing the religion presence in public life as a global resurgence of religion. He gave an example of the Iranian Revolution of 1979, the role of the Roman Catholic Church in the collapse of Communism as well as the September 11/2001 incidences (Thomas, 2005, pp. 1–10).

Currently, the emergence of Muslim revivalism in some Arabic nations and the flourishment of Pentecostal Christianity worldwide have forced scholars to re-think on the power of religion in the public sphere (Beckford, 2016). Social scientists have started to stress that limits between the place of religion in public matters versus private matters are more dynamic in least developed nations and differ from place to place (Clarke et al., 2007; Mkandawire, 2001). In Tanzania, religion is deeply rooted in people's lives as a fundamental part of their life, which guides material and moral issues (Muhoja, 2023, p. 22; Sundqvist, 2017, p. 219). Recently, Tanzania has witnessed increased involvement of religious leaders and institutions in politics, economic affairs and social life (Green et al., 2010a). By indulging their involvement in the framework of religious values, teachings and meanings, religious leaders have proved to have the capacity to initiate and frame significant discussions on issues that touch and influence the public sphere (Muhoja, 2020, p. 258).

By conceptualising religion in the public sphere, this study argues that the relationship between Faith Based organizations and the government on healthcare provision flow into the public sphere to recompense for the market and the government in the provisions of these services following the social, economic and policy changes since 1990s. The study further argues that the relationship between the Faith Based organizations and the government on healthcare interventions is an outcome of the desire of Christian and Islamic organisations to recapture the public space that underpins all areas of society. In addition to that, the relationship between FBOs and the government on healthcare provisions is rooted in the longstanding historicity of religious relationship with the government.

2. Materials and Methods

The study was carried out in two regional urban areas in Tanzania, Morogoro and Dar es Salaam. The selection of these regions were done purposely due to the good number of new FBOs that existed in these regional urban areas compared to others in Tanzania (Jamal, 2017). The selection of case studies was also done purposively. One Christian organization and one Islamic organization were selected in order to develop a comparative analysis between the two because existing literature has shown that, despite the sharing of historical, socio-economic and political contexts, the way Christian and Muslim FBOs relate with the government has differed since colonial times (Dilger, 2014a; Muhoja, 2020). Data collection was done among the FBOs healthcare workers, beneficiaries of the FBOs healthcare interventions, local leaders, district and the regional medical officers where the FBOs conducted their healthcare activities. Furthermore, data was collected from officials in the Ministry of health. Purposive and snowball sampling techniques were used to select the respondents for this study.

The study employed ethnographic approaches such as in-depth interviews (II), participant observation (PO), key informant interviews (KII), focus group discussion (FGD) and gray

literature. In the PO, the researcher attended healthcare activities of the FBOs, and seminars that the FBOs health units attended in different government health offices. PO was used in order to understand the practical aspects of the FBOs relationship with the government on healthcare provision and how religious teachings, values and meanings informed this relationship. In-depth interviews were used to extract new information, seek for clarifications and interpretations on various issues witnessed during the PO. KII and FGD were employed to local leaders, government officials at the district, regional and ministerial levels and FBOs management personnel to extract information on how the longstanding historicity of the FBOs relationship with the government inform the current collaboration between FBOs and the government on healthcare provision in the country. On gray literature, the study used FBOs' annual reports, FBOs' compiled reports, religious books and pamphlets, district and regional reports from medical offices, reports from the Ministry of Health, mission and vision statements, minutes and newspaper articles.

In terms of data analysis, data were first transcribed and organised through the Nvivo12 software. After coding, data were analysed and interpreted in line with the research questions and the conceptual underpinnings. A constant comparative analysis was then employed for the purpose of identifying similarities and differences in the Faith Based Organisations' healthcare activities and their relationship with the government. By using the comparative strategy, the study examined the common patterns in Christian-Muslim healthcare interventions and their relationship with the government. However, the study did not end at understanding the patterned experiences only hence necessitated the use of phenomenological reduction and hermeneutic approaches. The researcher's own reflection was included to capture the depth and details of the lived experiences of the Faith Based Organizations' healthcare activities and their relationship with the government.

3. Results Analysis

3.1. Description of Case Studies: Bethel Revival Temple in Morogoro Region and Direct Aid in Dar es Salaam Region

Bethel Revival Temple (BRT) is a Pentecostal organization established in 1987 in Morogoro region in Tanzania. The vision of BRT is '*To turn the non-believers nationally and internationally into fully devoted followers of Jesus Christ in the power of the Holy Spirit'*. The organisation is engaged in the provisions of healthcare services in order to bring its spiritual services closer to the needs of the people. BRT owns and operates a health facility known as Uzima Medical Centre (UMEC). It also organises bi-annual blood donations campaigns in collaboration with the government health officials, organises health related charity events that are accompanied by the provision of free healthcare services to the attendees.

The second case study is Direct Aid (DA) which is an Islamic religious organization that focuses on development and Da'wa through charities established in 1981 by Kuwait based citizen Dr. Abdurrahman H. Sumayt (Ahmed, 2009, p. 428). The vison and mission of DA is centred on empowering the less fortunate people and communities socially, economically through support in healthcare services, education, development projects, social care, and construction of boreholes and mosques. According to the Country Director of DA in Tanzania, the organisation uses Islamic teachings and values to help poor people and communities fight against poverty, diseases, and ignorance. DA owns and runs a health centre namely Prince Saud Health Centre (PSHC), conducts free monthly mobile clinics in selected areas of Dar es Salaam, finances beneficiaries to access healthcare services in big and more specialised hospitals in and outside the country. Therefore,

this study examined the activities of the two religious organizations to address its research questions mentioned earlier in this paper.

3.2. Involvement of Government Leaders in FBOs' Healthcare Interventions

The findings showed that the involvement of government officials in the Faith Based Organizations' healthcare activities included fund raising, inauguration and implementation of their healthcare activities. The Director of healthcare projects at DA explained that in 2016, the then Permanent Secretary (PS) of the Ministry of Health inaugurated free eye camp which provided free eye services to all without any costs. The camp was conducted by DA in collaboration with international organizations from Kuwait and Saudi Arabia. The PS congratulated DA and promised to provide significant support from the government in making the camp meets its target and objectives particularly in helping those who were unable to meet the services in other healthcare institutions. Furthermore, in 2017, DA invited the Regional Administrative Secretary (RAS) of Dar es Salaam region to officiate the opening of the Reproductive and Child Healthcare service at PSHC.

In 2022, the RAS of Dar es Salaam was once more invited to inaugurate the opening of DA hospital at Tabata. This hospital which has a capacity of admitting 150 patients at once was inaugurated during the reception of Uhuru Torch in Ilala district. The RAS and head of Uhuru torch congratulated DA for the historical achievement because the inaugurated hospital was one of the best health facilities in Dar es Salaam region which was equipped with modern facilities and buildings. Both the RAS and the head of Uhuru torch emphasized that the government was ready to offer its support of whatever kind in order for the hospital to perform well and reach the targeted group of the poor segment of the population.

Furthermore, the weekly mobile clinics conducted by DA in different parts of Dar es Salaam were mostly inaugurated by District Commissioners (DC) and councilors in their respective administrative units. For example, the launching of the mobile clinics at Zogowali, Pugu, Chanika, Viwege and Mgeule were officiated by the DC of Ilala. Among others, the DC congratulated DA and promised that the government was ready to work closely with the private sector so as to ensure that all people accessed quality healthcare services.

At BRT, the construction of UMEC was preceded by a fundraising that was inaugurated by the then Prime Minister and Vice President John Malecela in 2003. In 2005, when UMEC was in place, the official opening ceremony was led by the then Regional Commissioner of Morogoro Region Hon. Juma Nkangaa. In his speech, the RC commended BRT for the commendable work of helping poor communities to access healthcare services at reasonable costs (at UMEC) or free healthcare services in different health related charity events. He further underscored that the government doors were open all the time in case support was needed by BRT for smooth implementation of its healthcare activities.

In 2020, during the commemoration of 32 years of BRT in Tanzania, the organization invited the Prime Minister (PM), Kassim Majaliwa, as the guest of honour. During the commemoration week, the BRT provided free healthcare services in the Arusha region, constructed five boreholes in areas believed to be inhabited by the majority poor within Arusha Urban. Furthermore, the BRT donated 1800 bags of building materials (cement) to back up the construction of a healthcare facility at Kijenge Juu, the areas inhabited by the poor segment of the population.

On the last day of the event, the BRT church led by Dr. Mtokambali (Senior Pastor) prayed for the nation. In addition to that, Dr. Mtokambali congratulated the government for the good job that they had been doing. Before concluding his speech, which was live through Instagram, Facebook and YouTube, Dr. Mtokambali requested the government to increase its efforts in reaching out to the majority in need of healthcare services. Dr. Mtokambali requested the Prime Minister to initiate a process to enact the healthcare policy that would cover all people in the country regardless of their socio-economic status. He further urged the government to review the laws that allowed gambling and betting. He viewed these laws as going against not only the will of God but also of Tanzanian morals and culture as demonstrated when he said:

> *Honourable PM, the 32 years of BRT have been the years of critical development interventions in various areas affecting people's lives, most notably in health and education. Today, I congratulate the government but I urge it to increase efforts in making the majority of Tanzanians access better quality health services for all and, if possible, they should be provided for free. Lastly, I request the government to review the laws that guide gambling and betting because they are contrary to not only religious morals but also Tanzanian cultures.*

In his speech, the PM congratulated the church for its service to the people, particularly on the provision of healthcare services and education. He promised the organisation that the government would support whatever kind of initiative that the church embarked upon in improving the lives of people from poor socio-economic backgrounds.

3.3. Government Support of FBOs Healthcare Interventions

The results of this study showed that the government supported the healthcare interventions of BRT and DA at different levels ranging from the local, district, and regional to the national levels. At the local level, local leaders worked hand in hand with the FBOs to ensure that all healthcare intervention efforts (charity events, mobile clinics, healthcare facilities) planned to take place in their locality were executed accordingly. For example, in Dar es Salaam where DA conducted its mobile clinics, the local leaders from these areas provided different forms of support. Firstly, they proposed appropriate areas for the execution of the mobile clinics. Secondly, they supported the DA mobile medical team to prepare places for the execution of the mobile clinics. Thirdly, in some areas, the ward councillors and ward executive officers were used to open/officiate the provision of healthcare services during mobile clinics in their respective areas. At BRT, the street leaders were used to share information about blood donations campaigns and health related charity events that involved the provision of free healthcare services. They were also responsible for the preparation and execution of these events in their locality.

At the district and regional levels, DA and BRT benefited from a number of the support they received from the government officials in the implementation of their healthcare activities. For instance, at Ilala medical office, the district authorities used to grant permission to DA to conduct mobile clinics services in the areas they targeted even if the application for doing so was submitted to the district authorities out of the described application time. The analysis of the DA and AMA annual reports revealed that the two FBOs benefited from a number of capacity building sessions that were organized by the officers from the district and regional levels. Information on some of the training that the researcher extracted from these reports that had been conducted to healthcare providers of DA and BRT included seminars on diversity and human rights in healthcare services,

fire and safety, complaints and grievances handling, hand hygiene, information governance and medicines handling and management.

At the central government level, DA and BRT received support in numerous areas, the most notable being tax exemption for their imported equipment and those of their partners, offer of free visas and working permits to international medical personnel that came to work under the auspice of BRT and DA. For example, in 2019, DA conducted eye camp at PSHC where all services including spectacles were provided for free. In this event, the government exempted tax to all equipment that were imported for this exercise, and the medical personnel from collaborative organisations (Al-Baser and Al-Makkah from Sudan) were all granted free visa and work permits (DA, 2021).

The results further showed that when the FBOs wanted to initiate a particular healthcare service, the government was there to support them with all the necessary equipment provided that the service was not intended to reap profit from the services offered. In 2015, DA wanted to introduce Child and Reproductive Health at its medical facility (PSHC), the DMO office for Ilala supplied them for free all the needed equipment including vaccines, vaccine carriers, syringes, and safety boxes. Therefore, the child and reproductive health services were being provided for free at DA, the same as in government healthcare facilities.

3.4. Joint Healthcare Activities and FBOs' Support to Government Healthcare Interventions

Apart from the above relationship, AMA and DA collaborated in doing joint healthcare programs and campaigns, seminars, and trainings. For example, the two FBOs worked with the government hand in hand in conducting district, regional or national health campaigns like immunization and vaccination, administration of vitamin A drops, anti-worm drugs and elephantiasis of the scrotum and elephantiasis. In these activities, BRT and DA were required to provide either two or more of their healthcare workers that would participate in training activities and other capacity building sessions before introducing these activities at UMEC and PSHC respectively.

The involvement of DA (through PSHC) and BRT (through UMEC) in joint healthcare programs and campaigns with the government extended beyond healthcare provision to developing joint strategies and initiatives on how to improve accessibility, availability and utilization of different healthcare services. In 2015, the Director of Health Services at DA and the Head of Healthcare Services at BRT attended a joint session with the government in developing guidelines and strategies for improving the availability, accessibility and utilization of Sexual and Reproductive Health services for all. In FGD, the two directors who attended the meeting explained that the meeting discussed and deliberated on key SRH areas such as the mode of financing those services, the target groups, the myths, norms and values surrounding SRH and the role of the private sector in the said endeavours. In the meetings, the FBOs and the government agreed to start with sensitization to the public campaigns, behaviour change trainings and campaigns to young generation, and inclusion of SRH programs in all of the FBOs healthcare activities.

Another area that yielded meaningful collaboration between the FBOs and the government was on conducting of joint capacity building sessions that involved participants from both sides. To mention a few, DA and BRT together with the government in different years (2015, 2016, 2017, 2018, and 2019) conducted joint capacity training sessions on issues such as electronic health records keeping, use of Malaria Rapid Disease Test (MRDT), HIV/AIDS rapid test, management of private healthcare facilities, and sound provision of reproductive healthcare.

On the other hand, and contrary to BRT, Direct Aid had prepared its own capacity building sessions that invited government officials and other healthcare stakeholders. For example, in 2018, DA in collaboration with its headquarters in Kuwait, organised a training seminar on Strategic Healthcare Management and invited government officials and healthcare stakeholders to attend. This training was facilitated by international facilitators from DA headquarters in Kuwait, Saudi Arabia and Sudan.

Furthermore, DA funded some of the government healthcare intervention activities and projects. For example, in 2016, the Ilala Municipal Medical office (MMO) planned to conduct mass treatment of schistosomiasis in five of its wards, but it lacked enough funds to implement the exercise. The MMO wrote a letter to the DA Director asking for their financial support in the implementation of the exercise. The funds requested by the municipal office were granted accordingly. A more current financial support request from the government to DA in Dar es Salam was in 2019/2020 when the government asked for funds and medical equipment so as to overcome the eruption of skin diseases at Segerea Prison. This was accordingly granted too as per MMO requests.

In an interview with the DA Country Director (CD) in Tanzania, he underscored the fact that their organisation was charity based; hence, usually had a special and separate budget for emergency issues as one of their focus areas. He narrated further that in a situation of emergencies or when an issue of public concern emerges like the eruption of diseases, *forcemajure* or a public health campaign, the emergency fund might would be used after a critical assessment, consultation and discussion with their donors in Kuwait. He further explained that, before financial support was provided to the government healthcare project, they had to satisfy themselves that the intended project or intervention was urgent in nature and had a wide public impact; hence, if not addressed expeditiously the life and health of the majority poor will be in danger.

The most recent DA support to the government's healthcare activities was the construction of a borehole at Mnazi Mmoja hospital (of which the researcher attended). When DA's representative was given time to address the attendants, he connected the act of funding the initiative to their religious teachings, ideas, practices and experiences that instruct the Muslims to help the poor, the needy and sick people. He further urged the government to allocate more funds to cover for the healthcare needs of all people, particularly those coming from poor economic backgrounds.

However, the DA funding of the government healthcare activities were subject to some conditions. In an interview with the CD of DA, he emphasized that one of the conditions they attached to the intervention that they funded was the display of DA's symbol and logo, which contains their messages to the public. The condition does not end there, but required that the DA should be given some minutes to talk to the audience during the inauguration, execution and closure of the funded project. Therefore, they used these chances to share their message to the congregate and government authorities.

4. Discussion

The involvement of government leaders and officials in the healthcare related activities of the FBOs can broadly be interpreted in four corners. Firstly, it is the dynamic role of the FBOs in issues of public interest against how they relate with the government. Secondly, is the improved capacity of the Faith Based organizations to disagree with some of the government policies and laws in the context of the increased working relationship between these entities. Thirdly, is the increased role of the new FBOs (BRT and DA in this context) in influencing the direction of the policies and direction of the government.

On the first issue, this study argues that, in the context of the changing social, economic and political environments since 1990s, FBOs have increasingly acted as a voice of the poor, the needy and those coming from marginalised communities on issues that have direct impact on their daily lives. For example, Dr. Mtokambali's speech before the Prime Minister as seen in this study represented the interest of the majority poor because studies have shown that since 1990s following the commercialisation and privatization of healthcare services, the majority poor have failed to access and afford these services (Mamdani & Bangser, 2004, pp. 1–2). In 2017, Afrobarometer's survey revealed that 40 per cent of the respondents failed to access the needed medical services, many times in the past years. Dr. Mtokambali's speech in front of the Prime Minister which urged the government to introduce a free healthcare policy represented the need of the majority of Tanzanians. As noted by various scholars (Muhoja, 2020, p. 258); the speech from Mtokambali was crucial in shaping public discourse and discussion on issues around free access to healthcare services for all, the capacity which has been noted to emanate among others, from religious leaders (Green et al., 2010b).

In the above context, FBOs used the opportunity of involving different governmental and political leaders in their activities to exert both political and social impact while connecting for the same with their spiritual and religious issues to wider society's matters of health inequality and policies (Dilger, 2014a, p. 55). This study supports the arguments put forward by Kirsten (2004: 16) that for the FBOs to be in good position to influence policies and governmental action, they should ensure that the government and political leaders are involved in their activities.

Contrary to the Faith Based Organisations that had a contractual agreement with the government under the auspices of PPP as shown by Sundqvist, (2017), which directly use the contractual opportunity in influencing policy on health (Boulenger & Criel, 2012; Leurs et al., 2011), the new generation of FBOs, (which are not part and parcel of the PPP or bilateral agreement (see Sivalon, 1995, p. 189)), use the strategy of inviting the government and political leaders in their healthcare activities as an avenue to air their concerns on issues of public concern like free healthcare policies and the existing laws and regulations. However, the articulation of FBOs views on government policies, laws and direction has been attracting suspicious relationships and conflicts between the two. In 2017, the late President of Tanzania Dr. John Magufuli wanted to ban all FBOs including the church that raised questions on various issues of public interest on the argument that they had deviated from their religious duties of evangelization and become political institutions; a situation he described as the act of mixing religion and politics (Jamal, 2017).

Furthermore, the results on government support on Christian and Islamic FBOs on healthcare interventions can be interpreted in a number of areas. One, the Tanzanian government creates favourable environment to support the smooth functioning of the Faith Based Organisations on healthcare as a reaction to the policies and socio-economic and political changes from neoliberal

policies and institutions (Sundqvist, 2017: 246). These changes called for those in power to create meaningful space for private institutions such as FBOs to implement their intervention initiatives. As a result of the changes that the government received from the International Monetary Funds and World Bank in an effort to strengthen private institutions in healthcare delivery (Shivji, 2006), the government was compelled to re-examine its relationship with the market forces on one part, and with the FBOs on the other (Mkandawire, 2011). Lastly, the government's support to the healthcare intervention activities of the FBOs at different levels aimed to show that the government was working through the FBOs in meeting the healthcare needs of the urban people living in poor environments.

This study further argues that the joint healthcare interventions and Faith Based Organisations' support to government healthcare activities was an outcome of religious teachings, ideas, meanings and motivations which went further to inform on the relationship between them on healthcare interventions. The government requested for funds from FBOs to implement several of its healthcare activities that aimed at supporting the poor segment of the population, whereas the FBOs employed their religious resources (Ndaluka, 2012a, p. 237) to finance these interventions. For instance, DA funding to mass treatment of schistosomiasis in Ilala District, and the eruption of skin diseases at Segerea Prison showed that they paid close attention on the government healthcare interventions that had public impacts. Therefore, the results from this study contradict the arguments advanced by Max Weber and the supporters of modernisation theories and secularization thesis which predicted that as societies become modernised, religion would lose its public significance, both in society and in individuals' consciousness (Berger, 2001, p. 443)

Furthermore, this study noted that the relationship between Faith Based Organisations and the government had extended to the public sphere. As seen in the findings of this study, in lacking resources to implement some of its healthcare activities and projects, the government was highly becoming more dependent on the Faith Based Organisations to cover that gap; hence, the FBO's impacts on the public sphere (Bornstein, 2004, p. 110). In the context, the Faith Based Organisations had gained a vantage positon from such dependence; consequently, getting more opportunities to press for both religious, socio-economic and political agenda including policy concerns (Mallya, 2010).

However, it has to be clearly noted that the funding of government healthcare activities and projects were done by DA only. This can be construed as one of the approaches in which DA uses to increase its involvement in development activities including healthcare delivery following a wide perception of their segregation embed in the long standing history between them and the government of Tanzania (Dilger, 2013, 2014b; Ndaluka, 2012b).

The DA funding to some of the government healthcare activities can thus be seen as one of the means through which the organisation employed to improve its relationship with the government after the strained relationship between the two that resulted in the seizure of DA's office in Dar es Salaam in 2000s. Furthermore, the government stopped the flow of funds from DA's headquarters in Kuwait following the accusations that the organisation funded terrorist groups in Tanzania (Dilger, 2013, p. 471). Furthermore, DA organised various training events that among others focused on government officials, the most notably being the strategic management training. Such training events were conducted for the purpose of influencing the government's direction by building a cordial relationship based on trust and enhanced collaboration. This revelation fully

underscores the notion that the relationship between Faith Based Organisations and the government is based on the historical relationship between the two (Muhoja, 2020, p. 246).

5. Conclusion

This study concludes by arguing that, invitation of government officials to the FBO's healthcare activities, the execution of joint healthcare activities and Faith Based Organisations' support to government's healthcare initiatives can be interpreted as a means used by the new generation of FBO (the likes of DA and BRT) in strengthening their public visibility in the development arena, including the delivery of healthcare services. Studies have shown that the socio-economic and political changes happened from 1990s onwards went together with the emergence of the religious revivalism as part of the struggle to reclaim political and social visibility in Sub-Saharan Africa. For Islamic organisations in Tanzania, religious revivalism formed part of the Muslim reformation (Masebo, 2014, p. 25); while for Christian organisations it marked the development of Neo-Pentecostalism in the public sphere (Hasu, 2012, p. 70).

The dynamics of the relationship between Faith Based Organisations and the government on healthcare provisions in Tanzania can be understood in different phases. In the colonial period, the government highly supported the healthcare activities of the FBO through grant in aid, mostly in poor and marginalised rural areas (Dilger, 2014a, p. 57; Jennings, 2013, pp. 948–950). Through such relationship, Faith Based Organisations healthcare interventions were structured to serve the interest of the colonial masters (Jennings, 2008, p. 65). During the socialist period, the Tanzania government discouraged the provision of healthcare services by the private sector and became the sole provider of these services. However, the socio-economic and political changes from early 1990s forced the government to create a favourable environment for the flourishment of the private sector in the provision of healthcare interventions following the increased inclusion of FBO as recipients of donor funds (Benn, 2017).

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