

## **The Dynamics of Faith-based Organisations' Healthcare Interventions in Urban Tanzania: An Ethnographic Inquiry of Direct Aid and Bethel Revival Temple**

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### **Abstract**

*The study examines the ways the new generation of Christian and Muslim Faith-based Organisations (FBOs) have become engaged in the healthcare interventions in Urban Tanzania in recent decades. The study examines character and content of their healthcare interventions as well as religious and professional motivations for their healthcare workers, followers, beneficiaries and management. The study employs the concept of religion as a model for, and model of lived reality by Geertz (1973); and the concept of development as holistic by Bornstein (2005). Ethnographically, the study examines how religious discourses were embodied in social practices, how social and historical processes led to this particular embodiment, and how religion itself defined the discourses and practices of FBOs Healthcare Interventions in the context of changing socio-economic, and political circumstances since 1990s to 2020. Findings showed that FBOs healthcare activities were designed as alternatives for their beneficiaries and the general public access healthcare services, particularly for those coming from weak socioeconomic backgrounds and in the absence of sufficient community and family support. Religious ideas, practices and meanings motivated FBOs healthcare workers, followers and the management to engage in healthcare interventions and express for the same using spaces created by social, economic, and political changes since the mid-1990s.*

**Keywords:** Faith-based Organizations, Healthcare, Christians, Muslims

### **Introduction**

Since the late 18<sup>th</sup> Faith-based Organisations in sub-Saharan Africa have used healthcare services in order to get new members for their religious faiths (Hardiman, 2006). In the context, health institutions were used as centre for

the evangelization of the targeted communities (Nyato, 2014:40-41; Cleall 2012). Thus, the colonization of the then Tanganyika by both the British and Germans was accompanied by the establishment of social services institutions, including healthcare from Christian organizations (Nyato, 2014:44). During the German rule in Tanganyika, Christianity became increasingly allied with the provisions of social services, particularly health and education. In some areas, the Catholic Church constructed healthcare centers as one way of expanding their domination and acquisition of new members (Cleall, 2012; Nyato, 2018:74).

During the British colonization of Tanganyika, Christian medical organisations became part of the functioning of the colonial state. Christian medical organisations provided around 50 percent of all total hospital beds by 1961. The colonial government provided full support to the healthcare centers owned by Christian organisations in areas which lacked government healthcare services/facilities (Dilger, 2014:57-58). Similarly, Muslim organizations were established few healthcare services with the support from the Muslim Welfare Society of East Africa located in Mombasa. For example, during the late days of the British rule and early years of independence, the Ismailis had already established twelve (12) non-communal healthcare centers (Kaiser 1996:63) despite a continuous claim that Muslim organisations lacked state support (Dilger, 2014:57).

After Tanganyika got its independence from the British in 1961, Christian FBOs' supported developmental vision and goals of the newly established independent government as compared to Muslim institutions that felt segregated (Boulenger and Criel, 2012). For example, by mid 1960s, the Protestant denominations (which includes Africa Inland Church and the Anglicans) and Catholic Churches offered support to the development initiatives of the post-independence government and played a significant role in making the government policies and programs easily accepted by the people (Muhoja, 2020:19).

By 1965 the Christian Council of Tanzania established itself as the center for the development initiatives of the mainstream Protestant Churches. In the early 1970s, the Catholic Church established the Tanzania Episcopal

Conference (TEC) and its development organisation styled in the name CARITAS became the center of its development activities all over the country (Nyato, 2014). All these developed institutions worked close to the new government to realise various development initiatives that were designed to reflect different policies and programmes by the Nyerere's Government; one of them being connected to the access of primary healthcare services by all people (Jennings, 2008:69-70). The Islamic institutions like the Aga Khan Foundation and the Aga Khan Development Network, though having unfriendly relations with the Government, were significant as well (Jennings, 2008:66).

From 1967 onwards, the post-independence government introduced the '*Ujamaa Policy*' (African Socialism). The Policy was characterized by the nationalization of social institutions including healthcare centres owned by non-government institutions including FBOs (Njozi, 2003:16). In this period, the Nyerere Government (socialist government) was the main and key provider of social services including but not limited to free healthcare services. The private health centers were nearly non-existent with exceptions of the very FBOs' health care institutions (Muhoja, 2020: 189).

By the early 1980s, Tanzania was facing a severe socio-economic crisis thereby resorting to the terms of the Structural Adjustments Programmes advanced by World Bank and International Monetary Fund (IMF). These terms and conditions among others included the reduction of government expenditures in the provisions of social services including healthcare as well as privatisation and commercialisation of these services (Mujinja and Kida, 2014:1-2). SAP benefited the few while leaving the majority into extreme level of poverty as a result of an increase in unemployment and growing inequalities among the people (Hasu, 2012:69). At the mid of these uncertainties and setbacks, the government started to operate a cost sharing mechanisms on healthcare services, which were provided for free by the Nyerere's regime. Consequently, the State's role as the main and the only provider of social services, including healthcare, diminished (Muhoja, 2020:114, Mujinja and Kida, 2014:1-3).

The privatisation and commercialization of healthcare has had negative implications on the affordability as well as on the accessibility of the services among the poor (Muhoja, 2020:134). Scholars have noted and argued that the failure of the majority poor to afford the cost of these services emanated from these structural changes (Mamdani and Bangser, 2004:141). Despite the fact the government put in place a mechanism to enable the majority poor to access and afford healthcare services in government health institutions but the same has been criticised for being ineffective and inefficient (Mamdani and Bangser, 2004:147-149; Muhoja, 2020: 245).

At the mid of these changes which incapacitated the majority poor to access and afford healthcare services in Urban Tanzania, Faith-based Organisations came to play an important public role (Muhoja, 2020:343). Faith Based Organisations' interventions on healthcare increased mostly in urban areas as an attempt to cope with the existing social, economic and policy change as an outcomes of these neo liberal policies on healthcare (Hasu, 2012: 70). At the mid of the situation, Faith-based Organisations' started to look for coping strategies against the consequences of these changes including restoring access to healthcare by establishing a number of ways to enable their members and the general public to access and afford healthcare services (Hasu, 2012:83; Dilger, 2014:59-60). Social science scholars noted that at this period new FBOs including the churches mushroomed in urban Tanzania (Dilger, 2014: 55) as a result of their increased role that responds to the new urban challenges (Beaumont, 2008 :2011).

Nevertheless, the discourses, practices and socio-cultural effects of FBOs in healthcare interventions have received only scant attention in the recent decades. Therefore, this study examines how the new generation of both Christian and Muslim FBOs- represented by the Bethel Revival Temple (for Christians) and the Direct Aid in Dar es Salaam (for Muslims) – have become involved in the health sector and the broader public sector in the in recent decades. The study examines the nature and character of the FBOs healthcare intervention together with religious and professional motivation for their healthcare workers, followers and management.

### **Conceptual application**

This study employed two concepts, namely: religion by Geertz (1973); and development as holistic by Bornstein (2005). Geertz defined religion as; *A system of symbols which acts to establish a powerful, pervasive and long lasting moods and motivations in men by formulating conception of a general order of existence and clothing these conceptions with such an aura of faculty that the mood and motivations seem uniquely realistic* (Geertz, 1973:90). For Geertz (1973:125), religion should be studied by focusing on the analysis of the system of meanings contained in the religious symbols and connecting these systems to the social, cultural and psychological processes.

For Geertz, religious experience include the continuation of the past and the extension of the current, being alive and dynamic constantly informing society, culture and individual life. Geertz sees religion as a framework through which individuals experience the lived reality of the existing world. The religious symbols in which Geertz referred induce in the followers certain sets of dispositions (which includes tendencies, capacities; skills, habits as well as liabilities). The same therefore instill certain characters that provide guidance on the flow of their activities as well on their experience. Furthermore, religious systems sharpen followers' life world by constantly influencing both motivations and moods in which the followers regularly take up.

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

Another concept employed in this study is development as 'holistic' by Bornstein (2005). For her; holistic development involves a process of addressing religious, social, economic, psychological, spiritual and material

human needs. Bornstein states; “*Holistic Approach is the one that “bridges the gaps “between the spiritual and material world; and between the rich and the poor.* For her, Development serves a double purpose. First; to introduce religious beliefs to the people and second to redeem the earths “God-given Potential (Bornstein, 2005: 48). Using the concept of development as Holistic, the study argues that, nature and character of the Faith-based Organisations’ health interventions function to save human dual needs which includes but not limited to bridging the gap between the material and the spirit as well as between the rich and the poor.

### ***Methods***

Using ethnographic approaches, the study was conducted in two cities in Tanzania, namely Morogoro and Dar es Salaam. The two cities were purposely selected for the reason that they contain a big number of faith-based organisations in the country (Jamal, 2017: 14) hence provided a wide opportunity for the researcher’s choice. The study focuses on urban areas because scholars have noted that the transformation of urban through FBOs’ health care interventions is an urban phenomenon (Digler, 2014:55) connected to an increased role of religious institutions as urban service responding to the new socio-economic and political challenges in urban (Beaumont, 2008a:2011).

The study aimed at developing a comparative analysis between Christian and Muslim Faith-based Organisations on healthcare interventions. In the context, one Christian Faith-based Organisation (Bethel Revival Temple) and one Muslim Faith Based Organisation (Direct Aid) were purposely chosen for the ethnographic data collection. The study collected data from different interlocutors which includes but not limited to; FBOs healthcare workers, religious leaders, followers, management as well as the past and current beneficiaries of the FBOs healthcare intervention. Furthermore, data collection was done to local leaders to which FBOs were implementing their healthcare interventions, local and central government officials which include the regional health officials, the district health officials as well as officers from the relevant section of the Ministry of Health.

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

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

After the ethnographic data collection was completed, data was then subjected to transcription and coding. The process behind organization and management of the bulk ethnographic materials were done by the use of Nvivo12. Later on, data was then conceptualised and transformed into meaningful information through the engagement of a number of analytic strategies parallel with the research questions together with the conceptual framework. A constant comparative approach was then employed for understanding the similarities and differences in the FBOs' healthcare interventions. The comparative approach was preferred to enable the study arrive at the understanding of the common patterns in the context of FBOs' healthcare interventions. As the study wanted to go beyond the patterned experiences; phenomenological reduction together with hermeneutic were applied to fill the gap. However, the study paid much attention on the depth

and detail of the lived experience together with the underlying structure of those experiences. This called for a reflective engagement with the data themselves hence necessitated the need for the use of researcher's own reflections and/or interpretations.

### **Findings and discussion**

This ethnographic study was done in two FBOs in Urban Dar es Salaam and Morogoro; Direct Aid (*formally known as Africa Muslim Agency*) found at the outskirts of Dar es Salaam City in an area known as Tabata and Bethel Revival Temple found at the famous Mwembesongo area in Morogoro Region. Direct Aid (DA); an Islamic Organization that focus on charity, development and Da'wa was established in 1981 by Dr. Abdurrahman H. Sumayt from Kuwait (Ahmed, 2009:427-428). The Direct Aid mission is to empower the less fortunate individuals and communities by improving socio-economic and issues through support in different areas like in education, development projects, healthcare interventions (which is the focus of this study), social care and construction (Direct Aid, 2019)

Direct Aid owns and operates health center called Prince Saud Health Center (PSHC). The health center is located at a famous and highly urbanised and congested area of Tabata Street in Dar es Salaam. Before the establishment of PSHC IN 1998, people had to travel for more than ten kilometres to receive medical care. As clearly stated by the management of Direct Aid, the PSHC was opened with the focus to help and support disadvantaged group including the poor and the needy people in the area and other surrounding areas. The development of the healthcare services at PSHC came as a response in meeting the vision and mission of Direct Aid in Tanzania, which among others focus on fighting against poverty, communicable and non-communicable diseases as well as ignorance to poor individuals and communities. In the in-depth interview with the Head of the Department of Health at DA, he narrated to the researcher that at the material time they established PSHC in 1998 at Tabata, the area did not have even a single health institution. The people of Tabata and the surrounding communities used more than two hours to travel to the City Centre (approximately 10 kilometres) to get healthcare services.



After the establishment of PSHC in 1998, the centre became very popular in Tabata and the surrounding areas of Gereji, Mawenzi and Kinyerezi. The centre provided both specialised and non-specialised healthcare services which include but not limited to gynecology, dental services, inpatient and outpatient, sexual and reproductive health and education, minor operations and all primary healthcare services (Direct Aid, 2019). In 2005, the DA management closed the Centre for what was termed as management crises that resulted to poor supervision and lack of qualified personnel to run and manage the center. In 2007, the center was re-opened following critical needs and demands from the people of Tabata, local leaders and the surrounding communities. According to the DA Country Director in Tanzania, the PSHC was re-opened following a request letter that was sent by some Muslim and other people in Tabata including local leaders to DA in Dar es Salaam and headquarters in Kuwait. The Centre was re-opened in 2007. From 2017 to 2019, PHSC provided healthcare services and attended 1,147, 294 patients (Direct Aid, 2019).

In addition, the DA conducts free monthly outreach/mobile clinics in areas that lacked basic healthcare services, had not been under the influence and/or service of either government or other non-government institutions. Between 2016 and 2019, DA provided free medical through the use mobile clinics to 52,317 beneficiaries covering more than 41 areas of Temeke and Ilala districts in Dar es Salaam at the total cost of USD 82,418,000 (Direct Aid, 2019). The mobile clinics in both areas were opened by the head of the services who used to introduce the modes, procedures and stages that the beneficiaries have to follow in order to get the service.

After the introduction, the head of the mobile clinics used to invite the spiritual leader to explain from an Islamic point of view the genesis behind the provisions of the free mobile clinic services and as to why the services were provided in the areas where the target population live. In most of his sermons, the religious leader used to tell the beneficiaries that the healthcare services that is going to be delivered has a reward from Allah to both the healthcare workers, beneficiaries and management in strengthening their relationship with the Creator. The religious leader called this as a '*reward Mutaed*', the one in which the providers of the service and the recipients are

rewarded. They further told the recipients of the mobile medical services to believe that their healthcare challenges were going to quickly be resolved because Allah has promised health to the believers and the same was going to be attained through the services to be provided. In delivering their sermons, the religious leaders that used to accompany the mobile clinics services repeatedly quoting Qur'anic verses from Qur'an 10:57<sup>1</sup> and Qur'an 17:82<sup>2</sup>

At Mchangani and Mpiji-Magohe areas, the researcher learnt that both areas had no government owned health facility, and both had to depend on only one private healthcare center located in their areas despite the fact that the population of the areas was around 7000 and 8200 people respectively. The closest government health institution for Mchangani was Pugu Health Centre located nearly eight kilometers away whereby the transport cost was estimated to be around Tshs 5000-7000 (approximately 3 USD) per trip, using 'bodaboda' (motorcycle). The two areas of Mchangani and Mpiji-Magohe had no 'daladala' (commuter mini-buses) to enable them access the nearest health facility. It was also an opportunity for the researcher to understand that even the Mchangani Street chairman and his family were among the beneficiaries who received medical services during the mobile clinic at his area. The researcher asked him about the status of access to healthcare services in his area. This is what he said:

*'Our area has more than 7000 people and we do not have a government owned health centre. We only have one health facility, which is privately owned. Its medical services are very expensive to the extent that majority of people living are poor and cannot afford the costs.'*

During a mobile clinic at Zogowali, the investigator met with Amina, a widow woman aged 58 years who was suffering from typhoid for quite long-time. Amina failed to afford services at the nearest private health facility due to lack of funds to meet the costs of the medicine which was at the tune of Tshs

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<sup>1</sup> "O Mankind: There has come to you a direction from your Lord and healing for the (Disease) in your hearts -and for those who believed a guidance and mercy.

<sup>2</sup> "And we sent down in the Qur'an that which is healing and a mercy to those who believe; to the unjust it caused nothing but loss after loss."

98,000 (equivalent to 40 USD). She returned home without medication. On the next day, she visited the district hospital located nearly 15 kilometers from Zogowali. Despite the fact that she was able to get laboratory diagnoses from the hospital, but at the end they did tell her that the hospital was out of stock for the required medication and advised her to buy for the same from the nearest pharmacy. When she visited the pharmacy, she was surprised to learn that the costs of the medication were around Tshs 115,000 (equivalent to 50 USD). In the context, she failed to get the required medication hence lived with the disease for a period of two weeks until the mobile clinic from Direct Aid visited her area, and supplied her with all the medication for free. She had the following to say;

*“Dad without Muslim I would have died. These Muslims came after us to our areas and gave free medical services that I failed to afford at a private and at the Government hospital. I was told that the medicines that were needed for me were out of stock.*

Financial and medical support to selected beneficiaries to access healthcare services was another healthcare intervention conducted by DA. Zuhura Shaaban was a resident of Chanika area who fell sick and needed a total of Tshs 800,000 to meet the costs of her treatment. Zuhura used more than two months looking for support from his family members and close relatives, but in vain. Later on, she decided to seek support from the local government authorities of Chanika. However, she did not manage to get money as she expected. The local government authorities of Chanika Street gave her a referral letter to the District Commissioner’s office for support. Upon arriving at the DC’s office, Zuhura was informed that the office had no funds allocated to support people facing difficulties in accessing healthcare services. The DC’s office gave her an authorisation letter that allowed her to pass in different office both government and non-government organisations to ask for monetary contributions or any other support useful to solve her health problems.

Zuhura spent more than a month moving from one office to another seeking for contribution and or assistance. At the end, she managed to collect a total

of Tshs eighty-one thousand (81,000) only. She was totally frustrated and desperate. In the context, she ended up crying due to her excruciating pains. She felt that she was almost a walking but already dead human being. One day Zuhura heard a trumpet blown through mosque speakers, informing the community members that there would be outreach programmes that would provide free medical services to the needy, the sick and the public.

Zuhura attended the outreach mobile clinic and shared her challenge with the head of the mobile clinic and cried for support. Due to the complexity of her problem, which needed a big operation, the mobile clinic team was not in a position to help her. Zuhura went on crying again until she was informed by the head of the mobile clinic that they were going to the office to discuss her problem with the management and that they would inform her on the decision to be made with regard to her request for support. After five days since Zuhura met the mobile clinic team, she received a phone call from Dr. Yassin who attended her at Chanika when she visited the mobile clinic. Among others, Dr. Yassin told her to write a formal letter to DA requesting financial support to meet her healthcare challenges. Second, she was to obtain a declaration letter from the chairperson of Chanika Street confirming that Zuhura was a poor woman, incapable of solving her healthcare problem and that she was asking for help. Third, she was to attach a medical report showing the kind of healthcare problem she was suffering from, the treatment needed and the overall costs of the medical intervention.

The second FBO involved in this study is Bethel Revival Temple (BRT). Bethel Revival Temple is a neo-Pentecostal church founded in 1987 and located at Mwembesongo area in Morogoro. Mwembesongo is an area located at the outskirts of Morogoro Region and it is believed to be one of the notary areas with high incidences of crimes, witchcraft and inhabited by the majority poor. The Bethel Revival Temple runs the Uzima Medical Centre (UMEC), a healthy institution that serves a total number of more than 567 per month for people residing at Mwembesongo and other surrounding communities of SUA and Mwembeni. UMEC was established in 2005 in order to meet the vision and mission of BRT derived from Bible as well as from one of its sixteen (16) core principles which, among others, focus on being the God's agency for evangelizing the world derived from the Gospels

of Mathew 28:19<sup>3</sup>, Mark 16:15<sup>4</sup>). UMEC was opened to meet their religious obligation to be a God's agency for evangelizing the world.

In this context, the UMEC's provision of medical services served the dual-purpose of sharing the word of God and providing health care services to the sick. Consequently, clinical encounters (registration, clinical consultation, laboratory tests and medication) focused not only on patients' illness, but also on their social, cultural, and spiritual wellbeing. Healthcare workers used both medical and religious approaches to interpret the nature of the patients' illness and the medication they provided (including medical treatment and spiritual healings). The UMEC was located in an area predominantly inhabited by poor Muslims, thus providing an opportunity for proselytizing in the context of medical processes.

Apart from that, every year the BRT organizes charity events and thanksgiving week accompanied with thanking God and supporting the community in different areas, including the provision of healthcare activities for free. The charity events and thanksgiving week is connected to many social activities, like visiting the sick admitted in different hospitals as well as homes of patients known with chronic diseases, supplying the target groups with different necessities and organizing free medical check-ups and medication. Others activities include visiting prisons and orphanage centres. The BRT has been organizing the week in question since 2008 up until 2020, they had already reached 7856 beneficiaries (BRT 2020).

In 2020, BRT in collaboration with the department of voluntary testing and counselling of Morogoro Region Hospital organized medical checkups and medication to the sick. In that particular week, a good number of people both from the church and outside the church attended and received healthcare services. Apart from healthcare services, they were provided with other necessities including but not limited to clothes which were donated by the members of the church and other touched segment of the population. Through the researchers' engagement in an informal conversation with the head of

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<sup>3</sup> Go ye therefore, and teach all nations, baptizing them in the name of the Father, and of the Son, and of the Holy Spirit

<sup>4</sup> And He said unto them, Go ye into all the world, and preach the Gospel to every creature

medical services, it became apparent that a total number of 69 patients had been attended in that week. All the services that they received were provided free of charge, and the whole exercise was accompanied by sharing the word of God from different pastors and choirs that were singing all the time.

Furthermore, during the 2020 charity events and thanksgiving week, a good amount of money was contributed by the church followers, which reached Tanzanian shillings six million, along with clothes, food, and household items. The special committee was identified and assigned a task to coordinate the event. The committee drafted the timetable and identified the areas that were planned for visitation. The areas for visitation identified included *Mama wa Huruma* orphanage center, Morogoro Region prison and Morogoro Region hospital.

The anthropologist/researcher joined the team that visited patients admitted at Morogoro Region hospital. Among others, this team distributed second hand clothes, conducted prayers and shared some few bible verses. On the same occasion, the team supported few patients with some funds especially those who were recognised to face a challenge of either lacking support from relatives or those who were without relatives. After the end of the charity event week, the women members of the BRT kept on visiting and supporting the patients at Morogoro Region hospital that were identified to lack relatives to take care of them. They were visiting them every Sunday they used to wash their clothes, utensils, and paid for their medication upon the proof of being discharged from the hospital.

Another healthcare intervention conducted by BRT is blood donations campaign. Each year BRT in collaboration with the safe blood department of Morogoro District hospital conducts three sessions of blood donations. The aim of the blood donation exercises is to save the lives of patients admitted in different hospitals over the country who needed blood as part of their treatment but they are not in a position to meet the costs of buying it. The followers of BRT used this exercise as a unique opportunity for them to participate on what they called and regarded as part of showing the fruit of the spirit. In this sense, the exercise was interpreted as an avenue for doing

God's job of evangelization and spreading the love of Jesus and or acting like Him as narrated in the book of Galatians verse 5:22<sup>5</sup>.

The BRT followers were guided by the belief that in Christ's love, one chooses to set aside everything of his or her own preferences and needs to put others first. To achieve this interpretation and meaning attached to the blood donation exercise; a comprehensive set of players were directed to the exercise for seven days. For the BRT followers, healthcare workers of UMEC and the general management, blood donation was interpreted to mean saving the lives of others, evangelizing the world, sharing the love of Jesus Christ, giving people another chance of living so that they can see the God's miracles in their lives and be saved.

In 2020, the blood donation exercise was proceeded by a week of extensive campaigns, announcement as well as advertisement were made almost in all premises of the BRT. In that particular week, all prayers at BRT were directed towards the exercise. The Senior Pastor one Dr. Mtokambali used to remind the followers on the importance of their participation in the event. He repeatedly referring to the book of Galatians which call for the believers' conscious to practice the spirit of fruit like love, joy, peace and kindness for them to truly become sons and daughters of Christ. During the first day of the blood donation exercises, the Senior Pastor made an encouraging prayer to his followers. While crying loudly and speaking in tongues; he prayed as follows;

*'Our father who art in heaven, observe our blood donation exercise where it will be initiated, we plead to you Jehovah King, protect it, give your children strength and courage of total participation so that blood that will be donated here will be very important in saving other people's lives and make your disciples wherever they are.'*

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<sup>5</sup> 5:22 But the fruit of the Spirit is love, joy, peace, longsuffering, gentleness, goodness, faith,

After the prayer, the Senior Pastor accompanied with the management team of Bethel Revival Temple proceeded to donate blood when they were allowed to do so by medical experts following the conclusion of minor health check-up to see whether they medically qualified to participate in the exercise. At the end of the 2020 blood donation exercise (which the researcher participated), a total number of 131 followers and non-followers were recorded to have participated.

*The Shemasi*<sup>6</sup> healthcare support system is another informal healthcare interventions conducted by BRT. Through the *shemasi* system, Bethel Revival Temple has developed a mechanism for members who live close to each other in defined boundaries to help and support each other during hardships like ill health and other related social problems. Mama Jeremiah, the chairperson of Mkwajuni Shemasi explained to the researcher that the sense of cooperation and support goes beyond supporting a sick member to access healthcare support and services but to take care of the close relatives in case of hospitalization. Mama Jeremiah provided a number of several practical examples of members that were offered a full support at the time the close relative of one of the members fall sick or was facing some other known social problems. Mama Jeremiah was once supported by the members of the Mkwajuni Shemasi when her son fell sick and become admitted at Morogoro District Hospital for four days. Apart from providing material support like cooking and washing clothes for the sick, they also paid the final medical bill amounting to Tshs 197,000 (equivalent to 80 USD).

Another live scenario is that of Justina Mwombeki, a woman aged 43 years and an active member of a *shemasi* at Nyalikungu area. In a key informant interview, Justina explained that in 2019, she delivered a baby boy through operation. Justina was then admitted at Tengeka Hospital for more than 14 days. While admitted, Justina enjoyed constant support and visits of her fellow *shemasi* members and other members from different *shemasi*. The continuous visitation was accompanied with constant prayers, washing of her clothes, giving her food and fruits on rotational basis. The support of the BRT

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<sup>6</sup> It is the smallest administrative unit at BRT composed of 5 to 10 households that live close to each other



followers to Justina (*not only shemasi members*) persisted even after she was discharged from hospital. Furthermore, the members of the Shemasi used the opportunity of being together to cooperate and support each other in prayers, reading and learning the bible, sharing information as well as exchanging ideas, opportunities and advice.

The healthcare activities of the FBOs described herein were designed as alternatives for the organization's beneficiaries as well as the general public to access healthcare services, particularly those from socioeconomically weaker and who lacked and or missed sufficient, clan and family support (Dilger, 2014:55). Findings revealed that many communities especially from the growing urban areas lack important healthcare services. This in turn may be due to either government-limited budget or increased demand from population against available health institutions (Muhoja, 2020:198). Despite Tabata and Mwembesongo Streets being located in urban areas of Tanzania (Dar es Salaam and Morogoro), both areas were characterised by a lack of healthcare services, both Government and privately owned. The mobile clinics conducted by AMA targeted areas lacking healthcare services and the same have not been claimed or occupied by other private or government organizations in the struggle for claiming urban space and influences (Dilger, 2014:55-56)

For example, the selection of the places for the mobile clinic services were influenced by a number of factors, including the socio-economic status of people in those particular areas. The level of poverty in communities that Direct Aid targeted were very high to the level that some community members failed to afford and access healthcare services both in government and privately owned healthcare facilities as exemplified in the case study of Zuhura and Amina. In 2017, Afro Barometer conducted a study which revealed failure of the majority poor to access and afford healthcare services as one of the most burning issues facing Tanzania's health systems in the recent years. The findings further noted that, 40 percent of the interviewees said they went home without getting medical services after seeking for the same in both government and private facilities. The literature has further noted the Tanzanian health system face a number of serious challenges one

of them being lack of and or shortages of medicines and supplies (Binyaruka et al., 2021:3).

The situation has been associated with several scholars to the changes in healthcare policies and increased level of poverty among the people in Tanzania (Hasu, 2012:69). The situation has, therefore, resulted in dynamics in both religious ideas and practices for the followers of the FBOs, healthcare workers, funders and the general management connected to the FBOs under this study. These changes affected their role as believers/followers towards the fulfilment of their religious duties as stipulated in holy books – Qur'an and the Bible, in relation to supporting the sick, the need and the poor. In that context, they employed their religious resources (Ndaluka et al., 2020) that motivated them to engage in the provisions of healthcare services both informal and formal depending on the socio-economic context of the communities under study.

Another issue worth noting from the findings of this study is that religious ideas and practices influenced the meanings the followers/believers attached to their engagement in healthcare interventions (Geertz, 1973:96). For example, the provision of healthcare services by following people in their places was interpreted at DA as an act of reaping countless rewards nicknamed as reward '*mutaed*'. The study noted that religious ideas, practices and motivations were subjected to religious meanings and interpretations that induced moods for both FBO followers, healthcare workers, management and funders.

The study argues that the healthcare activities conducted by DA and BRT function to reduce the gap between the rich and the poor as well as material and spirits. The mobile clinics, charity events, blood donation, *shemasi* support system, and financial support provided an avenue for the poor to access healthcare services and hence played a remarkable role in bridging the gaps and or inequalities with regards to healthcare services. Based on these observations and interviews, the health care interventions of the FBOs played a double role, introducing religious beliefs to the beneficiaries and meeting their healthcare needs. This can be exemplified by the fact that in each of the healthcare interventions that the FBOs engaged, the same were accompanied

by serious prayers and sharing of their religious teachings and ideologies. This type of interventions, which focus on both the material and spirit, are the ones referred to by Bornstein as holistic development (2005:48-49).

The findings suggest that a lack and or weakened social ties, especially in the urban contexts due to socio-economic and political changes since the 1990s (Sigalla, 2015:173) have left a big segment of the society vulnerable and without any, or with minimal social support in times of hardship like illnesses (Hasu, 2012:67-70) (Refer to the case of Zuhura and patients at Morogoro Hospital). This called for an immediate intervention from FBOs like BRT and DA to restore the situation. The healthcare interventions of the FBOs discussed in this study came as an alternative for both followers and non-followers of their organisations. The findings suggest that the execution of the healthcare interventions of both DA and BRT reflected the vision, mission for which they were established (Freeman, 2018; Ware et al., 2016). They were both developed to target disadvantaged groups of individuals and communities reflective of their religious teachings, duties and obligations. Such practices have been installed to the FBOs followers, healthcare members and the general management through prayers and other religious practices and sharing of the religious teachings to the beneficiaries.

The blood donation exercise at BRT was conducted in order to help poor Tanzanians who suffer or die from failure to afford the cost for buying it both in Government and privately owned healthcare facilities. According to Bates et al. (2008:11334), 184 of 713 hemorrhage deaths in Mainland Tanzania were caused by lack of an effective blood supply and transfusion in the year 2008. Another study done by Kapologwe et al. (2020:9) noted that 17.4 percent of the sampled 115 health centers had no facility for offering blood transfusion and those with the facility lacked sufficient blood in stock. Therefore, the FBOs healthcare interventions like blood donation and the informal healthcare interventions like charity events and *shemasi* support systems aimed at integrating the disadvantaged segment of the population or community that ascribed to an increase in suffering and affliction caused by urbanization and modernity as well as changes in socio-economic and political circumstances (Dilger, 2007:61).

Generally, the findings noted that religious ideas, practices and meanings play a crucial role in informing the believers' understanding of healthcare services and needs in specific contexts and time. They are much alive and dynamic, influencing the nature and character of the FBOs' healthcare interventions. The institutionalized healthcare activities (UMEC and PSHC) were provided in areas that lacked a health facility, and there was a high demand for and needs from the nearby communities. The monthly mobile clinics conducted by DA, charity events, and thanksgiving week were designed to meet the needs of those who were not in a position to meet their healthcare needs or problems. Financial support at Direct Aid and Shemasi healthcare support system at the BRT targeted individuals in which the traditional and public social support system failed to provide for the same in times of need. As clearly noted by Dilger (2014:64) the location of the FBOs' healthcare activities can be associated with the desire for appropriating and reconfiguring urban spaces occupied by individuals and or communities with certain social, material as well as spiritual needs easily making them targets of their religious activities.

The dynamics of FBO healthcare interventions as explained in this study can be seen in a number of ways. One, the dynamics on target areas and groups of their healthcare activities. During colonial era and post-independence period; Faith Based Organisations' healthcare interventions targeted rural areas and especially the rural poor (Dilger, 2014:457). The new generation of both Christian and Muslim pay much focus on urban areas that seems to be underserved. The nature and character of the FBO healthcare interventions have been critically influenced by the socio-economic and political changes since the 1990s (Hasu, 2012; Dilger, 2014; Muhoja, 2020). These changes which resulted in increased social and economic inequalities among the people in urban areas necessitated FBO interventions as urban service hubs responding to the challenges (Beaumont, 2008a:2011-2014).

## **Conclusion**

The overarching conceptual and empirical finding of this study is that the health interventions of the Christian and Muslim FBOs in Tanzania are highly dynamic and adaptive to the specific historical and urban contexts in which they became established. Accordingly, FBOs healthcare interventions have

been shaped by both local and transnational religious ideas, practices, experiences, and meanings and the existing socioeconomic, cultural, and political changes that influenced their establishment in urban Tanzania since the mid-1990s. Contrary to the strategies employed by FBOs during the colonial and post-colonial periods, the new generation of the FBOs provided health care and support to their followers and non-followers in order to improve both material and spiritual well-being, turning them subjects of their religious ideologies.

Furthermore, this study sheds light on the concept of development. The findings showed that the conceptualisation of development and well-being cannot be defined independently of the religious background of FBO staff and their beneficiaries, nor can it be considered in isolation from other aspects such as spirituality or religious observance and experience. In the context of this study, the meaning of development among FBO healthcare workers, management and beneficiaries included both material and spiritual aspects.

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