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Character and content dynamics in healthcare interventions by emerging faith-based organizations: *An ethnographic perspective in urban Tanzania*

Mussa Said Muhoja[1*]

[1]*Department of Economics and Social Sciences, School of Spatial Planning and Social Sciences, Ardhi University, Tanzania, mussa.muhoja@aru.ac.t / muhoja2020@gmail.com*

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*Corresponding author: *mussa.muhoja@aru.ac.tz*

Abstract: Faith-based organizations (FBOs) have a long history of providing healthcare services in Africa dating back to the 19th century. In recent decades, the emergence of new FBOs, including Pentecostal and Muslim revivalist organizations, has significantly influenced healthcare provision amidst evolving socio-economic, political, and technological developments since the 1990s. This article presents findings from a primary research study that explored the character and content of healthcare activities conducted by these new FBOs in response to these changes. The study investigates how religious values shape the character and content of healthcare activities undertaken by new FBOs within dynamic socio-economic, political, and technological contexts from the 1990s to the present. Ethnographic methods, such as participant observation, key informant interviews, and focus group discussions, were employed to gather insights. The findings demonstrate that healthcare interventions by new FBOs are infused with moral values, impacting both beneficiaries and healthcare workers. These interventions contribute to generating social capital for beneficiaries in the context of weakened social ties since the 1990s, leveraging international connections for funding and utilizing social media to expand their reach and gain public recognition. The study concludes that, the character and content of healthcare interventions by new FBOs have been significantly influenced by socio-economic, technological, and political changes since the 1990s. The study recommends policy initiatives that acknowledge the importance of healthcare social support and non-clinical services in strengthening the overall health system.

Keywords – Christian, Faith based organisations, Healthcare, Muslims, Religion

1. INTRODUCTION

The history of faith-based organisations (FBOs) healthcare interventions can be traced back to the colonial period when the FBOs provided almost 40-50 percent of the healthcare services in Africa (Oden, 2016; Olivier et al., 2015: 5–6). In recent decades (since the early 1990s), the incapacity of African states to provide healthcare services to the people has provided a room for the donors to focus their funding away from the state but towards FBOs (Benn, 2017). Statistics have shown that until 2010, FBOs in Tanzania were owning and running up to 50 percent of all the hospitals and 20 percent of all healthcare centers in the country; hence, making them important players in the health and

wellbeing of the people (Green et al., 2010: 15). A study by Avert (2016) further revealed that more than 40 percent of the population in Tanzania received their medical treatment from FBOs by 2016.

The characteristics and focus of FBOs healthcare interventions have evolved over time and can be traced back to the time of colonial rule in Tanzania (Muhoja, 2020a: 214). During the Germany colonial rule, Christian organisations from Germany expanded their activities to Tanganyika which, among others, involved the establishment of healthcare facilities that saved both religious and colonial masters' interests (Nyanto, 2014). After the First World War, Tanganyika was placed under the trusteeship of the British whereby the British missionaries replaced the Germans' organisations. The British colonial government funded some of the FBOs healthcare interventions, especially those located in rural and marginalised areas where there were no government healthcare facilities (Jennings, 2013: 948–950).

In both the colonial periods of the British and the Germans, religious-based healthcare services were very common particularly in rural and marginalised areas (Dilger, 2014a). The Christian missions used healthcare services and religion as one of the powerful tools in the colonisation of the people by reducing hostility as well as resistances from the local communities (Olivier, 2011). In some parts of Tanzania such as Kigoma and Tabora, FBOs' religious healthcare interventions were very vital in regulating Muslim-Christian relations (Nyanto, 2018: 125). Furthermore, Nyanto (2018: 126) reveals that some of the FBOs healthcare services like those provided by White Sisters in Western Tanzania (Tabora and Kigoma) were highly valued by the local communities owing to their efficacy in improving the health conditions of the local people.

2. LITERATURE SURVEY

2.1. The character and Content of Faith Based Organisations' Healthcare Interventions in Tanzania- A historical Analysis

The health of the citizens of any nation is extremely important in the attainment of sustainable development and economic growth (Mobosi et al., 2022: 22). The FBOs healthcare services during the colonial era were designed to help the poor African people (Muhoja, 2020b: 49), specifically as a way of convincing the local population to abandon their social and cultural lifestyle that were considered unscientific practices, values and altitudes with regard to diseases and medicines (Lyimo, 2014: 98). They focused on eroding the African concepts and interpretations of diseases and medicines that were viewed as being regressive, outdated, irrational and barbaric (Lyimo, 2014: 97–98). Additionally, the missionaries' healthcare services were used to reduce resistance against Christianity and to provide a pathway towards conversion of local communities (Cleall, 2012). Existing literature have further revealed that, during the colonial period, the local communities had strong ties based on family and kinship, mostly in rural areas as compared to the community of believers (Ranger, 1981, p. 268). Furthermore, most of the Christian healthcare services functioned as part of the colonial project politically, economically and socially (Green et al., 2010: 143–144). On the part of Muslim organisations, some of them were able to establish healthcare facilities mostly in urban areas. Until 1961, the Ismailites communities were able to establish 12 non-communal healthcare centres that were used to provide healthcare services to the Ismsilites themselves and other few people of Asian origin, hence, becoming discriminatory in its approach (Kaiser, 1996: 62).

After independence in 1961, Christian healthcare facilities provided around 50 percent of hospitals in Tanganyika (Dilger, 2014a: 57). They worked as an arm of the new independent government by supporting their policies and programs (Boulenger & Criel, 2012); the most notable being accessibility and availability of primary healthcare to all people in urban and rural areas (Jennings, 2013: 69–70). After the Ujamaa policy in 1967, the government of President Nyerere nationalized FBOs' healthcare institutions and other welfare facilities like schools and colleges. However, the favoured colonial system of using FBOs healthcare facilities to run as district hospital in the name of Designated District Hospitals prevailed. The government funded these healthcare institutions to operate as district-level hospitals (Ludwig, 1999: 90). At the end of this era, the Ujamaa policy weakened the private healthcare services and the state assumed the role of the sole provider of these services which were then provided for free (COWI et al., 2007).

From late 1970s and early 1980s, Tanzania entered into an economic crisis that forced it to accept the conditions and terms contained in the Structural Adjustment Programs (SAP) prescribed by international monetary institutions most notably being the World Bank (WB) and International Monetary Funds (IMF) to revamp the economy (Lugalla, 1995; 1997). One of the key conditions that were attached to this agreement was the unconditional retrenchment of public officials, reduction of government expenses, free trade and commercialization of healthcare services (Mujinja & Kida, 2014: 1–2). The changes in the socio-economic policies employed from the SAP were believed to be the necessary instruments for poverty reduction. However, despite adaption of the SAP, the situation worsened due to increased living costs and unemployment in both urban and rural areas in Tanzania (Dilger, 2009: 63; Hasu, 2012: 69). In the context of these challenges, the government of Tanzania enacted a policy that introduced a cost-sharing system (user fee) on healthcare services, a practice which had not been witnessed during the Nyerere's Ujamaa Policy from 1967-1993 (Mujinja and Kida, 2014: 1-2). SAP led to the privatization and commercialization of healthcare services making the poor unable to access and afford these services (Mamdani & Bangser, 2004: 1–2).

In that context, the government needed for an immediate intervention and support from private healthcare providers (Havnevik, 2010), hence, FBOs emerged again as an alternative healthcare providers that became important actors in the provisions of healthcare services (Sundqvist, 2017: 24). The Civil society institutions including FBOs increased in number during that period as a response to the requirements advanced by the international neoliberal institutions in an attempt to improve the functioning of the civil society organisations (Shivji, 2006).

The FBOs including the new FBOs (Pentecostal and Muslim Revivalism) became famous during this period as they started to introduce coping tactics, one of them being restoration of healthcare services to the urban poor who had found themselves crippled by the socio-economic and political changes that occurred from the late 1980s and early 1990s (Dilger, 2007, 2014a; Hasu, 2007, 2012). Championed by the Pentecostal organisations, the new FBOs devised several ways in their effort to enable their followers and the surrounding communities to get healthcare services and support (Dilger, 2009: 90–91; Hasu, 2012: 83). In big cities like Dar es Salaam, Dilger (2014: 63) notes that the new FBOs started to offer both spiritual, social, material and healthcare support and services to their members, particularly those coming from the middle and poor backgrounds who had already been affected by the effects of globalisation and SAPs. In the process of making their intervention known to the people, and easily reach and attract new beneficiaries, the new FBOs started to use social networking sites such as Facebook, Twitter, Instagram, and WhatsApp. The use of social media platforms was intended to attract the segment of the population which was considered as being weak, and faced some challenges in meeting their daily healthcare needs (Muhoja, 2020a: 189–190).

Furthermore, the development activities of the new FBO that emerged from 1990's were much more concerned with the conduct of civic life in which they became eager to address both moral and spiritual aspects of their beneficiaries and the general public (Dilger, 2017). In contrast to FBOs healthcare interventions during the colonial rule and immediately after the independence which focused on providing services and support the poor emerge from savagery, the new FBOs combined proselytization with healthcare intervention strategies to improve spiritual matters and impart in them the new religious and moral ideologies (Dilger, 2007: 78, 2017: 514–515).

Dilger (2007: 61) found that the healthcare interventions conducted by the new FBOs in the light of changing socio-economic, technological and political contexts arising from neo-liberal policies aimed at alleviating suffering and afflictions caused by immorality and anti-social lifestyle of individuals due to advancement in urbanization and modernity. Therefore, the new FBOs that emerged in urban areas like Dar es Salaam promised people relief from the suffering and afflictions, consequently, becoming more attractive to those groups strongly affected by these changes. The new FBOs, and particularly the Pentecostal ones started to offer healthcare social support and material goods. However, there is scarcity of literature on the engagement of new FBOs in healthcare interventions since 1990s to date. This study aim to fill this gap by focusing in two areas; firstly, to exprole the nature and character of the new faith-based organisations' healthcare interventions since 1990s; secondly, to examine the role of religious values in

shaping the nature and character of the new FBOs healthcare activities in the context of the changing socio-economic, technological and political environments since 1990s.

2.2. Conceptual application

The concept of faith-based organisations has raised a number of contentious debates on what is actually the meaning and content of the term. However, scholars agree on the basic characteristics of the FBOs to include the use of religious faith, values, norms and meanings as a catalyst for the execution of their healthcare interventions. They are both embodied in the their religious teachings (Berger, 2003: 16). A study conducted in Cameroon by Wees et al. (2021: 4) revealed that there were six forms and types of FBOs working in the health sector. These types and forms included but not limited to the international faith-based non-governmental organisations, faith-based networks and forums, faith-oriented healthcare providers, faith-oriented centres of excellence, faith-based healthcare schools and colleges, and faith-based leaders and social support (informal) church networks that promote health, healing and wellbeing of their congregates and the local communities in general.

Olivier et al. (2015: 5–6) present a comprehensive range of different types of FBOs that work in the health sector in the African countries. Her analysis included faith-forming entities like churches and mosques, religious-based NGOs, community-led religious institutions, religious networks and forums as well as healthcare centers. In this study, the concept of FBOs is used to include churches and mosques (engaging in some sort of healthcare activities and support; both formal and informal, clinical and non-clinical), community-based religious healthcare support and services, religious-oriented groups and networks engaging in healthcare interventions, social support to the sick and charity (faith based), healthcare related services and support to their members and the general public. In the context of this study, the term healthcare interventions has been used to include medical and non-medical services, healthcare-related support, voluntary blood donations and charity events conducted by members who belong to certain religious traditions as part of meeting their religious obligations and teachings.

The study use the concept of religion as a model for, and model of lived reality by Geertz (1973) to interpret the findings from this study. Geertz (1973: 90) defined religion as a system consisting of symbols that works together for the purpose of establishing powerful and pervasive long-lasting moods coupled with motivations to human being (belonging to a particular religious tradition) by framing ideas of a general order of their existence and at the same clothing these ideas (in form of conception) with such an atmosphere of factuality that the mood and motivations seem exclusively realistic. Based on the above concept of religion by Geertz (1973), this study argues that, religious values, teachings, norms, ideas and meanings are alive and dynamic constantly informing the character and content of the new FBOs healthcare interventions in the light of changing socio-economic, political and mass media technology since 1990s. Furthermore, religious values, teachings, norms, ideas, meanings and practices (derived from religious rituals) emanating from FBOs' healthcare activities bring to FBOs' members, healthcare workers, and FBOs' management and funders/supporters certain dispositions that instill specific characters which dictate the direction, flow and means of their engagement in healthcare activities/interventions.

3. PROBLEM STATEMENT

The history of faith-based organisations (FBOs) healthcare interventions can be traced back to the colonial period when the FBOs provided almost 40-50 percent of the healthcare services in Africa (Oden 2016; Olivier et al., 2015: 5–6). The nature and character of FBOs healthcare interventions have evolved over time and can be traced back to the time of colonial rule in Tanzania (Muhoja 2020a: 214). Studies on the involvement, character and content of FBOs' healthcare interventions in Tanzania have been conducted by a number of scholars (Dilger, 2007, 2009, 2014; Hasu 2012; Nyanto, 2018; Green 2005; Sundqvist 2017, Jennings, 2008). However, little is known about the engagement of new FBOs in healthcare interventions since 1990s to date. This study has focused on two areas; firstly, to exprole the nature and character of the new faith-based organisations' healthcare interventions since 1990s; secondly, to examine

the role of religious values in shaping the nature and character of the new FBOs healthcare activities in the context of the changing socio-economic, technological and political environments since 1990s.

4. RESEARCH METHODOLOGY OR METHODS

This study is grounded in ethnographic tradition. The rationale for choosing ethnographic approaches was meant to enable the researcher to gain an in-depth understanding (from emic perspective) of how religious values, teachings, norms, ideas and practices informed the character and content of the new FBOs' healthcare interventions in Tanzania's socio-economic, political and technological advancement since 1990s (Carroll, 2013: 42–43). The study was conducted in two regions of Tanzania namely Morogoro and Dar es Salaam. The regions were selected purposively based on the fact that they had the biggest number of new faith-based organisations in Tanzania (Jamal, 2017); hence, provided a wider choice of the FBOs in the two regions that engaged in healthcare interventions compared to other regions in the country.

The study targeted urban areas because previous studies had noted that the transformation of urban areas through religious healthcare interventions was an urban phenomena (Dilger, 2014b: 55). These were linked to the increased role of religious institutions as urban service hubs that were responding to urban challenges in the context of neoliberal policies (Beaumont, 2008: 2011). The selection of the case studies was done purposively in order to include two religious traditions; Christian and Islamic religions that predominantly had majority people in Tanzania. The selection of the two religious traditions aimed at making a comparative analysis of the two. A Bethel Revival Temple (BRT) was selected purposively on the side of Christian-based organisations while Africa Muslim Agency (AMA) represented the Islamic religion.

The population of the study included members of the FBOs in question, religious leaders, FBOs management, healthcare workers in the healthcare facilities owned by the FBOs, healthcare officials from Ilala and Morogoro Municipals, beneficiaries of the new FBOs' healthcare interventions and officials from the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGC). The sampling of interlocutors was done using purposive and snowball sampling. Purposive sampling was used to select the members of the FBOs in question, religious leaders, FBOs management, healthcare workers in the healthcare facilities owned by the FBOs, healthcare officials from Ilala and Morogoro Municipals, beneficiaries of the FBOs' healthcare interventions and officials from the Ministry of Health, Community Development, Gender, Elderly and Children. Snowball sampling was used to get beneficiaries of the FBOs' healthcare interventions.

Data were collected through the use of participant observations (where the researcher participated in a number of FBOs healthcare activities like mobile clinics, blood donations, charity healthcare related events, facility based healthcare services, religious teaching, prayers and events of the FBOs under study), in-depth interviews, key informant interviews, focus group discussion and documentary reviews. Data was analysed using comparative approach used in grounded theory as well as content, thematic and narrative analysis. NVivo11 software was used to organise the bulk density of ethnographic materials collected for 13 months on the two FBOs under this study.

5. DATA ANALYSIS AND DISCUSSIONS

5.1. Background of the Faith Based Organisations under the study

Africa Muslim Agency (AMA) (currently known as Direct aid Society) is a Muslim based charity organization which was brought into existence in 1981 by a Kuwait-based citizen, Dr. Abdurrahman Sumayt (Ahmed, 2009). AMA focused on empowering the less privileged individuals and communities through the provision of, and support in socio-economic issues, education, development projects, healthcare provisions, social care and water programs. AMA in Dar es Salaam operated a healthcare facility called Prince Saudi Health Center (PSHC). The center offers subsidized health consultation services and medical staff who are available on a 24/7 basis. It conducted free monthly mobile healthcare clinics mostly in underserved areas of Dra es Salaam. Lastly, AMA provided financial support for selected beneficiaries to access specialized healthcare services in big hospitals and covered medical needs for selected

beneficiaries who suffered from chronic illness.

The second faith-based organisation studied in this study was Bethel Revival Temple (BRT). This was a Pentecostal organisation established in 1987 at the outskirt of Morogoro region in an areas known as Mwembesongo. BRT owned and ran a health facility called Uzima Medical Centre (UMEC). Furthermore, after every six months, BRT often organized charity healthcare related events which among others includes the provision of free healthcare services to its congregate and the community in general, conducted blood donations and operated the shemasi (neighborhood) healthcare support systems.

5.2. The character, content and the role of religious values in the New FBOs' Healthcare Interventions in Urban Tanzania

The study findings revealed that the nature and content of the new faith-based organisations' healthcare interventions included appropriation of morals, social capital generation, international collaborations and extensive use of social media as part of the medical care and support.

5.2.1. Morality and Dressing Etiquette in the Healthcare Interventions of BRT and AMA

The following quotations from the interview conducted sums the issues of morality and dressing etiquette as being among the concerns of the faith-based healthcare providers.

> *The provisions of healthcare services and support to the needy is an Islamic prayer embedded in holly books; however, for one to reap the intended rewards by helping or giving healthcare services and health-related support to others, the services should be provided while taking on board all Islamic morals. For healthcare services to be meaningful, they have to be provided while reflecting the Islamic values, norms, teachings and meanings (Shehe Majuto Mtuguto, AMA)*
>
> *Our healthcare activities and support are guided by the teachings from the Bible. Immoral practices of whatever nature ranging from corruption, cruelty in service provisions, cheating and unacceptable wearing style render the intended services (blessings) meaningless. We know that the healthcare services that we provide aims to reap intended blessings and consequently to inherit the Kingdom of God. We have, therefore, to embody the above moral issues as they are part of our covenant with God (Pastor Joshua, BRT).*

The AMA office was located at Al-Farouq centre, the headquarters of AMA in Dar es Salaam, and Tanzania in general. PSHC, Orphanage Centre and Al-Farouq Primary School were among the development interventions of AMA at Alfarouq Centre. On arrival at the centre, I was interested, in the wearing styles of female employees at the Prince Saud Health Center. Without considering their religious faith, female employees of PSHC wore the popular Islamic dressing style known as *'Stara'* that covered all parts of their bodies. Dr. Gulahman, the head of medical services at PSHC, explained the rationale behind that dressing code. He explained that it was AMA's policy, which instructed women and girls to adhere to Islamic wearing style in order to inspire the beneficiaries of their healthcare services to embrace the same conduct and invite Allah at the health center or during mobile clinic sessions by protecting others, particularly men and boys, from falling into temptation for sexual desires, the action he termed as *"tamaa za ngono"* in Kiswahili.

The issue of dressing style at PSHC or during the mobile clinics was not only a prerogative of the women employees, but also the beneficiaries of the services that were being attended. The researcher noted that some women were denied healthcare services in both mobile clinics and at PSHC for wearing unacceptable type of clothes, particularly those that exposed some parts of their bodies. They were denied services and asked to return home to dress accordingly and come back for treatment. In one occasion, the researcher witnessed female employees of PSHC struggling to cover with their *khanga* (a piece of cloth usually kept on women bags for emergencies) one woman who was brought for medical services after she was engaged in a bodaboda accident. That woman was dressed in a tight trouser that showed clearly the morphology of her body.

At BRT, the dressing etiquette was interpreted as an act that glorifies God. Etiquette of dressing at BRT, specifically at UMEC was much more dynamic for the employees and patients who sought healthcare services. All employees at UMEC were born again Christians and despite the absence of strict guidelines to dictate on their dressing style, they were guided by Jesus Christ's teaching on self-discipline. The dressing style aimed at demonstrating their identity (*as opposed to other Christians*) as born again coverts; something they wanted to share with their beneficiaries as being a good example.

The way UMEC dealt with patients who wore indecent clothes differed greatly from that of AMA as explained above. At BRT, patients who sought healthcare services and support at UMEC and during charity events were given the required services even if their dressing style was controversial or indecent. However, at the end of the medical session all the women who were dressed indecently were advised to talk to the matron who counselled and convinced them to desist from putting on such kinds of dresses. In the end, the matron prayed for each patient whom she talked to and invited God's power to compel them to wear clothes that glorified rather than provoked God.

During an interview with a nurse in charge at UMEC, she narrated that the healthcare services provided at BRT were not meant to generate any kind of profit but performed as part of God's job; hence, adherence to moral issues including the dressings etiquette were of great concern. She provided a number of moral issues that were greatly considered in their healthcare interventions as including but not limited to avoiding corruption, acts of hating of others, failing to take care of the needs of the poor such as providing support to their healthcare problems, discrimination in service provision and being involved in unjust practices. She further narrated that it was quite a challenge for one to embody all those moral aspects until one had the guidance of the Holy Spirit.

The findings from the study revealed what constituted as the dynamics of the character and content of the new faith-based organisations' healthcare interventions as explained in the foregoing sections. As compared to the traditional FBOs, the new FBOs healthcare interventions were executed in the context of increased immoral practices due to the impact of globalisation and advancement of communication technology since 1990s (Dilger, 2017). That, the findings demonstrated that the learning, appropriation and embodiment of moral and ethical standards (defined in the specific religious context) in the new FBOs healthcare interventions were influenced by the relationships that existed between different actors (both FBOs healthcare workers, management, and healthcare beneficiaries) and their socio-economic and religious environments in which they belonged (Dilger, 2017: 514–15). Therefore, in the execution of their healthcare interventions, the new FBOs decided to include other public issues that seemed to be growing rapidly. The situation since 1990s provided a room for the FBOs to use their religious resources such teachings, ideas and practices, to address moral issues including unethical dressing style. For instance, the issue of dressing etiquette as part of the moral guidance started from the FBOs healthcare workers to the beneficiaries of these services was enhanced.

The findings demonstrated that the dressing etiquette was an important factor to the FBOs healthcare interventions as they were interpreted as one among the requirements for these services to achieve the intended meanings which includes reaping of rewards and blessings. For instance, at African Muslim Agency, for the healthcare interventions and support to obtain the anticipated rewards from God, the services in question had to be provided in the way that could attract the presence of Allah as contained in the Quran and other Islamic books. At Bethel Revival Temple, decent dressing meant one's celebration and glorification of God as well as being a good example to others. The appropriation and embodiment of morals including the dressing etiquette at BRT and AMA were done for specific purposes of reaping rewards and blessings from Allah/God (Dilger, 2017: 514–515; Lambek, 2015: 309).

Furthermore, the study revealed that religious values, teachings, norms, ideas and meanings were much more dynamic and adaptive to the context of the changing socio-economic, political and mass media development since 1990's. It is in this context that, the new faith-based organisations' healthcare interventions included the issue of morality such as the dressing etiquette in the context of increased acculturation worldwide due to the effects of globalisation and media technology that resulted in increased rates of immoral practices since 1990s (Schulz, 2006:

248; Smith, 2012: 148). Therefore, the new FBOs' healthcare interventions also addressed moral issues as part of critical contemporary issues that increased along the changing socio-economic, political and mass media development since 1990's.

As clearly argued by Dilger (2017: 514), the process of learning and appropriation of morals and ethical standards are practices that orient faith-based organisations' healthcare workers, congregates, management and beneficiaries' minds in their surroundings. In this context, the surroundings referred to here are the ones provided in the context of their religious traditions through rituals, prayers, teachings, values and belief vis-à-vis the existing socio-economic, political and technological advancement. In addition to what Dilger (2017) argued above, this study support the arguments brought out by Lambek (2015: 309) who sees moral and ethical obligations as being dynamics; hence, can evolve over time subject to the changing socio-economic, political environments as well as the interests of the actors involved including the FBOs healthcare providers, members, religious leaders, and the general management of the FBOs under study (Throop, 2012).

5.2.2. The Use of Social Media in the New FBOs' Healthcare Interventions

Both BRT and AMA used a number of social media networks to inform the public about their healthcare interventions which included Instagram, Facebook, WhatsApp groups, and YouTube. At UMEC, photos, quotations and video taken at the waiting lounge from previous patients and other healthcare events were shared on their social media networks. At the time of this study in 2020, the BRT's YouTube channel displayed a video clip that introduced UMEC to the public. This video received 34500 views since it was posted two years prior to the time of this study. The video showed a service provider singing. The singing service provider introduced himself and narrated the history of Uzima Medical Center. Later on, a senior pastor appeared imploring both BRT followers and the wider community to visit the medical centre in case of ill health because they would receive miracles of Jesus Christ not only during the course of the medical treatment but also in their entire lives.

On the Instagram page of Bethel Revival Temple, the researcher saw a testimony from Rachel, a member of the Mji Mpya Shemasi. The post attracted 249 likes and 107 comments within two weeks and it had the following quotation from Rachel;

> *My stomach had problems for more than four years and I used all the money I had saved earlier in meeting the medical expenses. Through WhatsApp group, the members were able to contribute TZS 1, 966, 000 that enabled me to get my full medication including undergoing surgery. With their support, I got all the medication I needed and I thank Jesus for this miracle because now I am healthy.*

Every year, Bethel Revival Temple organized charity health related occasions and thanksgiving week for the sake of thanking God and supporting the needy including the sick. During the time of this study in March 2020, BRT organized a medical check-ups and free medication to its attendees. The whole event was broadcast live through YouTube channel. In their Instagram page, they posted short clips advertising their healthcare services and showed every event that were taking place. In his closing remarks after the event, a senior pastor addressed the mass. His speech was broadcast live through YouTube and Instagram platforms. The speech was watched live by more than 282 viewers on Instagram and 118 viewers on YouTube.

In the YouTube channel of AMA, there was a short video clip of a healthcare provider in charge of PSHC at the time of the study in 2020. This officer explained that prior to the founding of Prince Saud Health Center in 1998, the community members around were supposed to travel for about twelve kilometres to the city centre in order to get medical services. The video clip further explained that PSHC was opened to provide healthcare services to the poor and the disadvantaged groups in the nearby communities. When the researcher asked the head of medical services why they posted this video on their YouTube channel, he replied that they did so in order to invite people to their services because in doing so they would reap the rewards of Allah.

Another healthcare intervention conducted by BRT is blood donations campaign. Each year BRT in collaboration with the Safe Blood Department of Morogoro hospital conducts two sessions of blood donations. The blood donation

exercises was proceeded by a week of extensive campaigns, announcement as well as advertisements were made in all BRT social networks such as YouTube, Instagram and Facebook accounts. In the YouTube channel, there was a short clip of the Senior Pastor urging and reminding followers on the importance of their participation in the event. He repeatedly referring to the book of Galatians (5:22) which calls for the believers' conscious to practice the spirit of fruit such as love, joy, peace and kindness for them to truly become sons and daughters of Christ. In this event, BRT prepared a separate budget, which was used as fare refund to other social media networks that were invited to cover the event. When the researcher talked to the owner of Mlimani YouTube account, the owner reported receiving an invitation letter from BRT two weeks earlier to cover the events and that all the costs were borne by BRT.

Two weeks prior to the blood donation event, Millard Ayo Instagram account, Mwananchi online television, Makinda YouTube Channel, Mlimani Instagram account, and YouTube channel started to advertise the event. They shared the advertisement in their social media platforms for inviting, informing, and calling the mass to participate in the exercise. During the last day of the blood donation, the Senior Pastor delivered closing remarks, which were broadcasted live by the abovementioned social networks accounts. In his remarks, the Pastor urged the people to obey their government and maintain peace. Furthermore, the Senior Pastor urged the people not to engage in witchcraft beliefs, altitudes, and practices including the killings of people with albinism and the elderly. Lastly, he shared the word of God and called the people for deliverance so that they could live happily in the hands of Jesus Christ.

On the other hand, Africa Muslim Agency conducted free monthly mobile clinics in selected areas. In their Instagram page, there was a statement indicating that between 2016 and 2019, the mobile clinic attended 54,214 recipients in more than 16 parts of Ilala Municipal and 17 parts of Temeke Municipal in Dar es Salaam region at the cost of US Dollar 79,520,118. In 2020 when the researcher visited the mobile clinics in Zogowali, MpijiMagohe, Kiwalani, and Chanika, the introductory part of the services was broadcast live through Instagram and YouTube platforms. The introductory part started with an invitation of a leader who talked from the Islamic teachings perspective on what were the genesis of the provisions of healthcare services in mobile clinics which involved following people in their areas of residence.

During the mobile clinic at Zogowali, the AMA media team made a short video testimony of a lady called Amina. The video was shared in their YouTube channel two days later. This video clip showed Amina, who suffered from amoeba for quite long time but could not afford the cost of medication both in private and government hospitals which amounted to TZS 130, 000 (equivalent to 56 US Dollar). In that case, Amina lived with the disease for more than two months until the AMA mobile clinic visited her, diagnosed her and provided her the required medicine free of charge. The video received 346 views and 112 comments within two days after it was posted on the YouTube.

In July 2023, the AMA YouTube channel ran video clips that showed the inauguration of their new healthcare facilities. The first video showed the inauguration of a health facility constructed and owned by AMA in Unguja. In the video clip, the President of the Revolutionary Government of Zanzibar was seen inaugurating the facility. The second video clip showed the inauguration of a dispensary constructed and owned by AMA at Kisarawe District. The video clip, which ran for 5 minutes was posted on YouTube channel and for the period of five days, it received positive reactions from the 433 viewers and 201 comments. The clip started with the official speech from the AMA Country Director who explained that since the area had no health clinic, residents were forced to travel more than 5 kilometres to the neighbouring villages making infant and maternal mortality rate a common problem in the area. Therefore, the health facility was meant to give people health services within that area.

The development of mass media technology, particularly the flourishment of the use of the internet services since the 1990s, had enabled the execution of the new FBOs healthcare services and support public events as the same are shared through the use social media such as Instagram, WhatsApp groups, Facebook and YouTube (Ng'atigwa, 2013). The new FBOs healthcare interventions under this study made an effort to engage with new information technologies through the inclusion of social media in their communication plans in a more systematic and

professional way, as confirmed in interviews with FBOs healthcare workers, members, religious leaders, and the general management.

Additionally, the FBOs healthcare interventions continued to generate considerable attention and interest through online contents. BRT and AMA had integrated the use of social media and networks into their own institutional structures while aligning with the institutions' vision and missions. The results indicated that the use of social media in the execution of the FBOs healthcare activities was one of the strategies that reflects the desire of the FBOs to reach more people with the message they intended which in most cases carried religious content as one of the mission in achieving the objectives behind the establishment of these healthcare activities. This mission is well reflected in the contents of the messages that the FBOs shared with the public through their social media network accounts in the course of executing their healthcare interventions (Muhoja, 2020c).

The topics covered by the FBOs on their social media platforms include those linked to social challenges facing the larger community since 1990s, religious messages, and obligations, in addition to those relevant to their healthcare events. FBOs' creative use of social media reflected their dynamism in pursuing their political, social, economic, and religious goals since the 1990s. Thus, this study concludes that FBOs' use of social media in their healthcare interventions was one way of going public and providing a platform for advancing their moral, spiritual, and political interests while capturing the population's attention; hence, gaining the public recognition of their religious and non-religious services like healthcare provisions activities (Meyer, 2011). For instance, the new FBOs' use of social media in their healthcare interventions was used as a public forum to communicate their views and concerns to the government. This was necessitated by the fact that the new FBOs missed a direct working relationship with the government as opposed to the mainline churches which had collaborated with the government since colonial period and proved their support to the people (Sundqvist, 2017: 17).

Therefore, this paper argues that, the development and the provisions of healthcare activities by the new FBOs and the appropriation of social media in their execution provided the opportunity for them (FBOs) to continue to raise issues and concerns of public interest. The new FBOs used the opportunity behind the development of social media in linking their healthcare activities to communication on their main agenda (for example, gospel and Islamic teachings) in order to be easily recognized and to win both new souls and public visibility as religion was highly valued in Tanzania (Sundqvist, 2017: 219).

5.2.3. Social Capital Generation from FBOs' Healthcare Interventions

On the part of the capacity of the new FBOs to generate social capital in their healthcare interventions, findings from this study showed that thirteen (13) beneficiaries from the African Muslim Agency had been integrated into its long-lasting healthcare services support scheme as per the time of this study in 2020. These beneficiaries were sponsored to get free medical services at PSHC' and were given social support services that included food and other necessities during Islamic festivals. They were regularly visited by AMA officials to review the development of their health conditions and be advised accordingly. Some of those beneficiaries were suffering from prolonged health complications such as diabetes mellitus, stroke, blood pressure, HIV/AIDS. These diseases required regular clinic attendance. Through regular clinic attendance and other opportunities organised by AMA that used to bring them together, the beneficiaries of AMA healthcare support scheme were able to establish their own social network groups whereby they would help each other on a number of issues like regular visitation when one was sick, supporting each other during social events like funerals, encouraging each other to take medication on timely basis as well as adhere to regular clinic attendance. The beneficiaries under AMA healthcare support schemes had also developed a social network system which each member could rely upon in case of need for social and psychological support arose.

For Bethel Revival Temple, the beneficiaries from their healthcare interventions, most notably the health-related charity events, were made part and parcel of the family of believers. They were included and accorded membership in the Shemasi support groups. Under Shemasi support groups, members used to support themselves in terms of

financial, material, social and psychological aspects during the time of need like sickness and other social hardships. In the Shemasi support system, when a member and or his/her relatives fell sick, it was the responsibility of the other members to meet his/her medical bills including that of hospitalisation (as the case may be), taking care of the patient which included but not limited to cooking, and washing the clothes and member's utensils.

At the time of this study in 2020, the researcher witnessed the SUA Shemasi group taking care of their member (named Victoria) who was hospitalised at Morogoro Hospital for 5 days. The fellow Shemasi members contributed a total of TZS 330,500/= (US $ 150) that was used to meet her medical bills and other necessary expenses. Also, fellow members were responsible for preparing food for her, and washing her clothes. They used WhatsApp groups to coordinate their activities monetary contributions, and prayers for the needy, sick member and or relative.

It was noted that, when the Shemasi member encountered a serious healthcare problem that was not within the capacity of his/her fellow members, BRT had a separate budget to help people of this kind in collaboration with one's respective shemasi. For example, at the time of the study in 2020, Jamila encountered a pregnancy-related complication that needed intensive care at a referral hospital in Dar es Salaam, and the BRT supplemented the Shemasi contributions that were used to meet her healthcare costs that amounted to TZS three (3) million.

The new FBOs healthcare interventions had been found to have the capacity to develop social capital among the beneficiaries, healthcare workers and the management. The findings from this study revealed that both Bethel Revival Temple and Africa Muslim Agency healthcare activities function as a basis for solidarity with their healthcare beneficiaries. The FBOs under study provided a medium for protecting their supporters and the general public against life uncertainties emanating from the deteriorated societal ties due to the failure of community, family and clan support systems that performed the same function in the previous days (Dilger 2007:61; Hasu, 2012: 9). The increased social networking, trust and support in the context of the faith-based organizations' healthcare interventions have the potential to expedite social development in the context of weakened social institutions due to changes in the social-economic and political environments since 1990 (Beckford, 2016).

Previously, the healthcare activities of the FBOs did not generate social capital because it was the responsibility of the community, family and clan members to cater for the sick. Hence, they were able to take care as well as support their fellow members during hardships such as sickness and ill health complications (Ranger, 1981, p. 268). As a result of the socio-economic, technological (mass media technology) and political changes since 1990s, which in turn have increased the rate of urbanisation and poverty; social ties became strong to the group of believers who had been at the frontline in helping their members and the general public access healthcare services and support after the same were commodified and privatised following the healthcare reforms of the 1990s (Dilger, 2007, 2009; Hasu, 2007, 2012).

5.2.4. International Collaboration and Funding of the New FBOs' Healthcare Interventions

BRT and AMA healthcare interventions were characterised by extensive collaborations and funding from international organisations. For example, AMA worked in collaboration with international organizations that originated from Muslim countries like Kuwait and Saudi Arabia. When the researcher went through a number of reports and documents at the Africa Muslim Agency (specifically the documents related with Prince Saud Health Center), he found that AMA had previously cooperated with Al-Baser International and Makahh Eye Complex from Sudan. They worked together in 2010 in what they referred to as the Big Eye Camp where specialised eye services, operations and grasses were provided for free to the attendees. In an interview with the AMA Country Director in Tanzania, he revealed that these organisations funded the camp at the tune of up to USD 16,207 and sent 26 eye specialists from Sudan to take part in the event. They further donated special equipment like eye glasses that were disseminated free of charge to those who were in need of them, either at PSHC or during the monthly mobile clinics. The establishment of maternity ward and reproductive health centre at AMA was also facilitated by funding from Al-Jabr Commercial, a Sudanese company.

Apart from funding of AMA activities (including healthcare activities and support) in Tanzania, AMA in Kuwait had been donating a number of healthcare related equipment to AMA in Tanzania. The equipment donated included walking aid and wheelchairs that were distributed to the disabled persons at PSHC and during mobile clinics. AMA in Kuwait funded all the costs of the mobile clinics in Tanzania and the general management of PSHC. For example, between 2016 and 2018, AMA in Kuwait transferred a total of TZS 75.5 million to AMA in Tanzania to enable the provision of mobile clinics in 68 areas of Ilala and Temeke in Dar es Salaam. AMA in Kuwait had also been funding the capacity building sessions for AMA staff in Tanzania as well as government officials and all other important stakeholders working on the health sector. In 2013, AMA in Kuwait coordinated and organised a three-days training to AMA staff in Tanzania, officers from the Ministry of Health and other stakeholders including CSOs who worked in the health sector. The training was fully funded by AMA in Kuwait whereby a total number of 25 international experts were brought to Tanzania to facilitate the training.

Since early1990s, there had been an increased inability by the Sub-Saharan African states to provide healthcare services to their people. While the government was the major recipient of donors' funds for implementation of various social services, from late 1980s and early 1990s, donors started to channel their funding to the FBOs as alternative healthcare implementers (Benn, 2017). In the contexts of the state being incapable of meeting the social needs of the people including provision of healthcare services, AMA and BRT became involved and were supported by global networks of faith-related institutions all over the world (Jennings, 2013) to deliver healthcare services to the affected people as a result of the ineffectiveness of the African states due to the changing social, economic and political environments since 1990s (Muhoja, 2020b: 121).

While the new FBOs depended on globalized world of faiths and international donors to deliver their healthcare interventions since 1990s, in the previous era, FBOs depended much on networks with their mother organisations or support from the state to deliver healthcare services in the areas of their interest and particularly in rural underserved areas (Jennings, 2008: 65–66; Kaiser, 1996).

6. RESEARCH IMPLICATIONS

The study calls for policies that recognise the role of healthcare social support and non-biomedical services on the overall health system. The study has revealed that the informal healthcare systems and support, and other non-clinical healthcare services contribute significantly to meeting the healthcare needs not only of the members belonging to a certain religious tradition but the community at large; and particularly the majority urban poor not covered by different healthcare insurance schemes existing in Tanzania.

7. CONTRIBUTIONS TO SCIENTIFIC COMMUNITY AND FUTURE RESEARCH

This study has made contributions in two main areas: knowledge and theoretical contributions as well as policy and practice contributions. On knowledge and theoretical contribution, the study has shown the importance of paying attention to the meanings that religious people attach to their actions in specific socio-economic and political contexts. Furthermore, the study has contributed by showing how religion and religious beliefs are dynamic and alive to the extent that they change ad make necessary adjustments in helping their members and the general public to respond to various events and environments. On policy and practice contribution, the study has shown the importance of including non-clinical healthcare services and support in the context of increased rate of urbanisation and erosion of social ties.

Further research is needed to establish the magnitude to which the FBOs healthcare workers, followers and management observe to and embody practical moral and ethical issues expounded in this study for a longer period of time. In addition to that, more studies should be done to establish the impacts of the use of social media in the norms, values and practices of both Christians and Muslims in the context of executing their social services projects including but not limited to education and health ones.

8. CONCLUSION

Results from this article revealed that religious teachings, ideas, practices as well as the attached meanings define the character and content of the new faith-based organisations' healthcare interventions. The practical and moral concerns addressed within the new FBOs' healthcare activities such as dressing code are significant issues that form part of everyday life of the people as they also undergo some changes to reflect the existing situation. Therefore, the new faith-based organisations' healthcare interventions permeate the public to cub for the gaps created by the changes in socio-economic and political environments since 1990s. The growing mass media technology, and subsequently the coming into existence of social media networks have enabled the FBOs to use them in the context of executing their healthcare interventions as part of meeting their religious obligations, attracting new followers and gaining public recognition of both their religious and non-religious work. The new faith based organisations healthcare interventions are dynamic and adaptive in nature as they have been able to grab the opportunities emanating from the shifting focus in international funding (away from the state towards civil society) since 1990s' to solicit for funding opportunities and collaboration with other international institutions. The new FBOs used this chance to begin and enhance their healthcare activities and assume state's role in helping people to access healthcare services and support in the contexts of the financially-incapacitated poor majority who are unable to access healthcare services due to the impact of the neo-liberal policies that have been in place

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ORCID

Mussa Muhoja https://orcid.org/0009-0000-1828-9410

REFERENCES

Ahmed, C. (2009). Networks of Islamic NGOs in sub-Saharan Africa: Bilal Muslim Mission, African Muslim Agency (Direct Aid), and al-Haramayn. *Journal of Eastern African Studies*, 3(3), 426–437.

Avert, R. (2016). A closer look at the healthcare system in Tanzania. Retrieved from https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/tanzaniaBeaumont, J. (2008). Introduction: Faith-based Organisations and Urban Social Issues. *Urban Studies*, 45(10), 2011–2017. https://doi.org/10.1177/0042098008094870

Beckford, J. A. (2016). Hope and creativity: The shifting nexus between religion and development. In Death, Life and Laughter (pp. 153–172). Routledge. Retrieved from https://www.taylorfrancis.com/chapters/edit/10.4324/9781315404028-17

Benn, C. (2017). Guest introduction: Faith and health in development contexts. In Development in Practice, 27, Issue 5, pp. 575–579). Taylor & Francis.

Berger, J. (2003). Religious nongovernmental organizations: An exploratory analysis. *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, 14, 15–39.

Boulenger, D., & Criel, B. (2012). The difficult relationship between faith-based health care organisations and the public sector in sub-Saharan Africa: The case of contracting experiences in Cameroon, Tanzania, Chad and Uganda.

Carroll, J. J. (2013). Key theories from critical medical anthropology for public health research. Part I: Starting with Foucault: Cultures of medicine and meanings of illness. *Tobacco Control and Public Health in Eastern Europe*, 3(1), 39–46. Retrieved from http://journals.uran.ua/tcphee/article/view/6842

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

COWI, G. G. (n.d.). EPOS Health Consultants.(2007) Join External Evaluation of the Health Sector in Tanzania, 1999–2006. Ministry of Foreign Affairs of Denmark, Copenhagen, Denmark.

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

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

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

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

Dilger, H. (2017). Embodying values and socio-religious difference: New markets of moral learning in Christian and Muslim schools in urban Tanzania. *Africa*, 87(3), 513–536. Retrieved from https://www.cambridge.org/core/journals/africa/article/embodying-values-and-socioreligious-difference-new-markets-of-moral-learning-in-christian-and-muslim-schools-in-urban-tanzania/5CF88746C40526C1C701B06DA62CF56D

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

Green, M., Mercer, C., & Mesaki, S. (2010). The development activities, values and performance of non-governmental and faith-based organizations in Magu and Newala districts, Tanzania.

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

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

Havnevik, K. (2010). Postscript: Tanzania in Transition–summary and trends 2005-2010. Tanzania in Transition: From Nyerere to Mkapa (Dar Es Salaam: Mkuki Na Nyota Publishers, 2010), 274. https://www.researchgate.net/profile/Kjell-

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

Jennings, M. (2008). The spirit of brotherhood: Christianity and Ujamaa in Tanzania. Development, Civil Society and Faith-Based Organizations: Bridging the Sacred and the Secular, 94–116.

Jennings, M. (2013). Common counsel, common policy: Healthcare, missions and the rise of the 'voluntary sector'in Colonial Tanzania. *Development and Change*, 44(4), 939–963.

Kaiser, P. J. (1996). Culture, transnationalism, and civil society: Aga Khan social service initiatives in Tanzania. Greenwood Publishing Group.

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

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

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

Lyimo, F. (2014). Chapter Seven Religious Communities and their Participation in Development in Tanzania. Religion and State in Tanzania Revisited: Reflections from 50 Years of Independence, 7, 95.

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

Meyer, B. (2011). Going and Making Public. Some Reflections on Pentecostalism as Public Religion in Ghana.

Mobosi, I. A., Okonta, P. O., & Ameh, C. A. (2022). Socio economic determinants of demand for healthcare utilization in Nsukka Local Government Area of Enugu State Nigeria. *African Social Science and Humanities Journal*, 3(3), 22-35.

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

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

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

Mujinja, P. G., & Kida, T. M. (n.d.). The Economic and Social Research Foundation (ESRF).

Ng'atigwa, F. X. (2013). The media in society: Religious radio stations, socio-religious discourse and national cohesion in Tanzania [PhD Thesis]. Retrieved from https://epub.uni-bayreuth.de/id/eprint/1681/

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

Nyanto, S. S. (2018). "Waliletwa na kengele ya kanisa!": Discourses of Slave Emancipation and Conversion at Ndala Catholic Mission in Western Tanzania, 1896-1913. *Tanzania Journal of Sociology*, 2, 69–84. Retrieved from http://www.journals.udsm.ac.tz/index.php/tjsociology/article/view/1500

Oden, R. A. (2016). For Better for Worse: The Role of Religion in Development Cooperation. Swedish Mission Council.

Olivier, J. (2011). An FB-oh?: Mapping the etymology of the religious entity engaged in health. When Religion and Health Align: Mobilizing Religious Health Assets for Transformation, 5–6.

Olivier, J., Tsimpo, C., Gemignani, R., Shojo, M., Coulombe, H., Dimmock, F., Nguyen, M. C., Hines, H., Mills, E. J., & Dieleman, J. L. (2015). Understanding the roles of faith-based health-care providers in Africa: Review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *The Lancet*, 386(10005), 1765–1775.

Ranger, T. O. (1981). Godly medicine: The ambiguities of medical mission in Southeast Tanzania, 1900–1945. Social Science & Medicine. Part B: Medical Anthropology, 15(3), 261–277. Retrieved from https://www.sciencedirect.com/science/article/pii/0160798781900521

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

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