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Beyond an instrumental approach to religion and development

Challenges for church-based
healthcare in Tanzania

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Abstract

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This dissertation serves as a contribution to the larger ongoing debate on the role of religion in development in an effort to move beyond an instrumental approach. The aim is to study the role of religious agents in development through the prism of contractual partnerships between church organisations and the Tanzanian state in healthcare delivery. Three Christian denominations are included in the study: the Roman Catholic Church in Tanzania (Tanzania Episcopal Conference), the Evangelical Lutheran Church in Tanzania and the Free Pentecostal Church of Tanzania.

Three theoretical perspectives are applied to the study of religion and development: (1) an *instrumental perspective*; (2) a *bottom-up perspective* and (3) an *integral perspective*. In order to operationalise the three theoretical perspectives to function adequately for health sector development research, three analytical concepts are included in the framework, namely *resource dependency*, *linking social capital* and *intangible religious health assets*. The methodology is based on an abductive qualitative approach with the use of case studies on the three church organisations (Catholic, Protestant and Pentecostal). Three key methods have been used for collecting data: policy analysis, semi-structured interviews and participant observation. Each organisation is analysed in terms of their Public Private Partnership (PPP) agreements and collaborative models, their relation towards the state, their internal health policies and their motives for delivering health services. Moreover, by including one local hospital per organisation (Turiani, Selian and Mchukwi), it is also possible to integrate the local implementation level into the study. In order to capture the views of public authorities, interviewees from the national Ministry of Health and local Council Health Management Teams have also been included.

By entering into PPP health agreements, church organisations have moved to centre stage and gained more influence following the latest political and economic reforms. Their attraction as service providers follows from their existing infrastructure and previous experience and capacity in the health sector. The analysis shows that faith is a key motivator and a central factor in the running of church health services. However, the fact that church organisations are becoming increasingly dependent on the state has implications in terms of their role as a critical voice in the public debate and could potentially threaten their independence as faith-driven civil society actors. Church organisations are also becoming more vulnerable financially, as they are not compensated according to the PPP contracts. The current situation where church organisations are dominating the PPPs in health has implications on both the Tanzanian model of secularism, with its emphasis on Muslim and Christians being treated equally, and the local governments' strive towards national ownership with their favouring of public healthcare over private alternatives. It is therefore necessary to further study the role of religion beyond an instrumental approach in order to get a deeper understanding of the religious dynamics in the PPPs in health in Tanzania.

Keywords: Religion, development, church organisations, public private partnerships, healthcare

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Abbreviations

AACC	All African Conference of Churches
AIDS	Acquired Immunodeficiency Syndrome
ALMC	Arusha Lutheran Medical Centre
AMREF	African Medical and Research Foundation
APHFTA	Association of Private Health Facilities in Tanzania
ARHAP	African Religious Health Assets Programme
ATR	African Traditional Religions
BAKWATA	Baraza Kuu la Waisilamu la Tanzania
BRICS	Brazil, Russia, India, China and South Africa
BTF	Burns Turiani Foundation
CARITAS	Catholic Relief Systems Organisation
CBO	Community Based Organisations
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CCHP	Comprehensive Council Health Plan
CCHPG	Comprehensive Council Health Planning Guidelines
CCM	Chama Cha Mapinduzi
CCT	Christian Council of Tanzania
CDH	Council Designated Hospital
CHA	Christian Health Assets
CHADEMA	Chama cha Demokrasia na Maendeleo
CHMT	Council Health Management Teams
CSSC	Christian Social Services Commission
CTF	Christian Forum of Tanzania
CUF	Civic United Front
DANIDA	Danish International Development Agency
DDH	Designated District Hospital
DED	District Executive Director
DFID	Department for International Development
DMO	District Medical Officer
DPG	Development Partners Group
ELCA	Evangelical Lutheran Church of America
ELCT	Evangelical Lutheran Church in Tanzania
FBO	Faith-Based Organisation
FPCT	Free Pentecostal Church of Tanzania
FrTH	Foundation Friends of Turiani
GA	Grant-in-Aid

HBF	Health Basket Fund
HBG	Health Block Grants
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
IFBO	International Faith-Based Organisation
IMA	Inter-Church Medical Assistance
IMF	International Monetary Fund
INGO	International Non-Governmental Organisation
IRCPT	Inter-Religious Council for Peace, Tanzania
KCMC	Kilimanjaro Christian Medical Centre
LGRP	Local Government Reform Program
LHRC	Legal and Human Rights Centre
LMC	Lutheran Mission Cooperation
LWF	Lutheran World Federation
MDGs	Millennium Development Goals
MMC	Medical Missionary Committee
MMH	Mchukwi Mission Hospital
MoHCHGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOI	Muhimbili Orthopaedic Institute
MoU	Memorandum of Understanding
NCA	Norwegian Church Aid
NCD	North-Central Diocese
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Funding
NORAD	Norwegian Agency for Development Cooperation
NSGRP	National Strategy for Growth and Reduction of Poverty
OECD	Organisation for Economic Co-operation and Development
PaRD	Partnership on Religion and Sustainable Development
PCAT	Pentecostal Churches Association in Tanzania
PCT	Pentecostal Council of Tanzania
PEPFAR	United States President's Emergency Plan for AIDS Relief
PFRPL	Pew Forum on Religion and Public Life
PHRAA	Private Hospitals Regulation Amendment Act
PMO	Prime Minister's Office
POW	Health Sector Reform Programme of Work
PPP	Public Private Partnerships
PRS	Poverty Reduction Strategy
RCH	Reproductive and Child Health
REDET	Research and Education for Democracy in Tanzania
RHA	Religious Health Assets
RMO	Regional Medical Officer
SA	Service Agreement
SAP	Structural Adjustment Programme

SDGs	Sustainable Development Goals
SFM	Swedish Free Mission
SLH	Selian Lutheran Hospital
SRHR	Sexual Reproductive Health and Rights
SWAP	Sector Wide Approach
TACOSODE	Tanzania Council for Social Development
TAG	Tanzania Assemblies of God
TANU	Tanganyika African National Union
TBC	Tanzania Broadcasting Corporation
TCMA	Tanzania Christian Medical Association
TEC	Tanzania Episcopal Church
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VA	Voluntary Agency
WCC	World Council of Churches
WHO	World Health Organisation

1. Introduction

This dissertation is a contribution to the ongoing debate on the role of religion in development (Beckford 2017; Tomalin 2012; Bompani & Frahm-Arp 2010). It links directly to the research field of welfare and religion. Globally, the role of religion in social service provision has undergone a radical reassessment in recent decades. Faith-based organisations (FBOs) have experienced increased visibility, financing and growth (Beckford 2017; Tomalin 2012). Furthermore, studies linking religion and public life in development contexts have multiplied, often explicitly highlighting how religious issues are involved in health, politics, policy dialogues and other dimensions of development programmes (Kaag & Saint-Lary 2011; Bompani & Frahm-Arp 2010; Lunn 2009). At the same time, religious studies drawing on sociology and theology have increasingly focused on contexts outside the West (Beckford 2017; Pallant 2012), and the relationship between religion and development is currently considered an important area for future research.

This change has come about recently (Tomalin 2012). In 2000 sociologist Kurt Alan van der Beek declared that religion was a “development taboo”. His conclusion was based on an analysis of three leading development journals from 1982 to 1998: *World Development*, *Journal of Development Studies* and *Journal of Developing Areas*. He found that there was only a very small number of references to religion and that the references he found tended to focus on religion as a descriptive, rather than analytic, category (Ver Beek 2000).

My principle argument in this dissertation and in my earlier work is that religious agents constitute an integral part of social, cultural and political processes of change in development contexts (Sundqvist 2016). This means that the increased visibility of religion in development contexts is not primarily a result of religious mobilisation or new forms of revival. Instead, this change has rather taken place at the analytical level, through changes in our interpretation and approaches to the study of religion and development (Kaag & Saint-Lary 2011). These changes are also to a high extent related to transformations in the global political economy and in development cooperation (Beckford 2017; Boulenger & Criel 2012).

Development scholars and social scientists in related disciplines are today more open to the fact that conventional boundaries between religion, health, politics and culture need to be re-drawn in order to improve our current understanding of development contexts (Beckford 2017). Under the influence

of globalisation, there is also a growing need to develop new approaches on how to handle tensions between religion, culture and civic political life, as societies grapple with the issue of how to accommodate religious and cultural differences (Casanova 2011; Herbert 2003). Instead of being studied as an isolated factor in religious studies, it is necessary to include religion as an integral part of development studies more broadly (Tomalin 2012; Gary & Cochrane 2012). This is necessary in order to grasp the real complexities and challenges of development processes related to religious change and not least in order to grasp the role of FBOs.

This trend of an increased interest in the study of religion and development, where religion in service provision and development research has once again become more visible, is sometimes referred to as a “religious turn” in development studies (Sundqvist 2016; Jones & Petersen 2011; Kaag & Saint-Lary 2011).

Aim and research questions

In order to explore the role of religion in development, this study uses an interdisciplinary approach based on the field of sociology of religion. Here, the role of religious agents in development is studied through the prism of contractual partnerships with the state (Public Private Partnerships) between Christian church organisations and Tanzanian public authorities.

The focus is on the role of religious agents in development in Tanzania. I have chosen to focus on the health sector, since this is the development sector where religious agents play the most significant role in Sub-Saharan Africa and in East Africa in particular (Olivier & Wodon 2012; Dilger 2010). FBOs have traditionally played an important role in promoting health and in running health institutions. Around half of all health institutions in Sub-Saharan Africa are still today run by Christian FBOs (Nordstokke 2016). I have also decided to explicitly focus on Christian churches and church-based health services. These choices are explained below.

I have applied three theoretical perspectives to the study of religion and development (Beckford 2017). (1) The first being a *rational/instrumental perspective*, primarily looking at religious organisations instrumentally from a financial/organisational point of view in their role as service providers and implementers of development cooperation. (2) Secondly, a *bottom-up perspective* addressing the social and political role played by religious organisations in relation to public authorities and the development process at large. (3) Thirdly, an *integral perspective* approach looking upon religious organisations more holistically, in terms of the values and beliefs they promote, where faith is believed to be strongly integrated into the understanding and motivations for why church organisations deliver health services. By studying church organisations in Public Private Partnerships (PPP), beyond their

role as service providers (*instrumental perspective*), I try to shed new light on our understanding of the role of church organisations in healthcare delivery.

Empirically, the study examines healthcare delivery by three church organisations within the framework of Public Private Partnerships (PPP) in Tanzania. These partnerships are defined and understood as an arrangement between the public and the private sector (Itika 2009). The focus is on the pooling of resources (financial, human, technical and information) from the public and private sector in order to achieve a commonly agreed-upon social goal, such as healthcare delivery and the realisation of health rights at large. FBOs are in this study included in the private sector as a private not-for-profit type of agent (Bandio 2012).

The Public Private Partnership (PPP) policy was initially introduced in the Tanzanian healthcare sector already in 1991, through the Private Hospital Regulation Amendment Act (Boulenger & Criel 2012). The current national framework and PPP policy was launched in 2009 and turned into law in 2010. Through this piece of legislation, government agencies were empowered to enter into PPPs with the private sector, including both for- and not-for-profit actors (World Bank 2013; Itika et al. 2011). The background of the PPP policy in Tanzania is discussed further in Chapter 5.

The study looks into the strategies of the chosen church organisations with regard to these partnerships: financing strategies, their relation towards public health authorities, their internal health policies and theological base. The study seeks to identify how the respective church organisation and the public health authorities perceive these partnerships. Including one local hospital per organisation in the case studies enables the integration of the local community level into the research design. In the local contexts, relationships are studied between church-based hospitals and the local health authority, and also how the hospitals are related to the church leadership as well as to the respective local congregation. Voices from public health authorities at the national and local level are integrated into the study in order to broaden the analysis and to find out how public health authorities perceive the role of church organisations in health sector development.

Aim

The aim is to study the role of religious agents in development through the prism of contractual partnerships between Christian church organisations and the Tanzanian state in healthcare delivery.

Three Christian denominations are included in the study: The Roman Catholic Church in Tanzania (Tanzania Episcopal Conference), the Evangelical Lutheran Church in Tanzania and the Free Pentecostal Church of Tanzania.

Research questions

There are five primary research questions in this study:

1. How are contractual partnerships (PPPs) with church organisations in the health sector constructed?
2. How do church organisations and public authorities perceive the contractual partnerships from a financial and organisational perspective?
3. How do church organisations and public authorities perceive the contractual partnerships from a political and social perspective?
4. In what ways does religion appear as a significant factor in the contractual partnerships?
5. What does the study tell us about the role of church organisations in Tanzania in terms of development, beyond an instrumental perspective?

Delimitations

This study only includes the PPPs that are negotiated and implemented in the health sector at hospital level. Health dispensaries and health clinics have not been taken into specific consideration. The study was conducted between 2011 and 2014, and is therefore limited both in time and geographical coverage. From the public health authorities' side, I have limited my study to the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCHGEC) at the national level and the Council Health Management Teams (CHMTs) at the local level. Formally, I have not included the President's Office Regional Administration and Local Government, apart from one key informant interview conducted as part of the pilot study. At the district level, I have included the District Medical Officers (DMOs) in all three districts.

The three local cases are all based in the rural areas of Tanzania, based on the notion that partnerships between church organisations and local governments are mainly entered in rural areas. The main reason for this is that missionary societies primarily and by tradition established church-based hospitals in rural areas. Some of these areas have today grown into peri-urban areas. It is also based on the fact that most rural areas have been unable to attract private for-profit actors, as people in these settings depend on cheaper services from the church-based hospitals. PPPs in urban centres, on the other hand, have turned out to be more successful compared to rural areas. Identified success factors here include better access to information, networks and a better educated population with a higher income and coverage of health in-

surance. Having said that, there are also health institutions, both for-profit and non-profit, situated in urban areas facing severe problems (Itika 2009).

I have chosen to focus on contractual partnerships between church organisations and the public health authorities, which is why the study has not included other religious organisations in PPPs in the health sector. The main reason for this choice is that the majority of private and religious agents involved in PPPs are church organisations with traditional links to the corresponding missionary societies (Olivier & Wodon 2012; Itika 2009). However, despite that they are less prominent and not included in this study, both Muslim organisations and private-for-profit actors are part and parcel of the PPP reform. Within Tanzanian Christianity, there are numerous vital church organisations. Some of these are leading stakeholders in the health sector, but not included in the study, for instance the Anglican Church of Tanzania, the Baptist Church and the Moravian Church (Boulanger & Criel 2012). The selection criteria behind the choice of specific church organisations and denominations is discussed further in the methodology chapter, Chapter 3.

The study is entirely focused on the Tanzanian mainland. Zanzibar is excluded due to the peculiarities of the Zanzibar culture, as well as its political and religious landscape. Since Islam is the majority religion on Zanzibar (approximately 95%), churches on the island do not engage in PPPs in the health sector to the same extent (Utrikespolitiska Institutet 2017; Olsson 2016).

Background to the choice of topic

Public Private Partnerships have become increasingly common in global health and national health policy. It looks as if FBOs are benefitting from this development and are given increasing space in policy-making and access to contractual agreements for accessing public health funding (Williams et al. 2012). Since health systems in development contexts tend to be weak and fragile, they are still dependent on receiving contributions from FBOs (Pallant 2012). However, despite the growing visibility of church organisations in global health and national health policy, religion has until recently been overlooked in health sciences and development studies (Tomalin 2012). But this is changing and religion is increasingly becoming a factor to consider in both disciplines (Sundqvist 2016; Clarke et al. 2008).

In fact, we have in recent decades seen a growing research interest in the study of social service provision in general and health delivery in particular, as performed by church organisations in development contexts (Olivier & Wodon 2012; Hackworth 2012; Itika 2009). We see several examples of this increasing interest at a global level. Encouraged by the launch of the global Development Dialogue on Values and Ethics in 2000, the World Bank drew attention to FBOs and church organisations and their key role in poverty

reduction in development contexts (World Bank 2017). The World Bank has continued to publish series of different studies on the topic, and continues to support this agenda through a comprehensive series of studies focused on FBOs and healthcare provision (Olivier & Wodon 2012). Recently the World Bank together with key UN agencies established the World Bank and UN Interagency Task Force on Religion and Development (United Nations 2017b).

Similar developments are also noticeable in health policy-making within European government aid departments in terms of an increasing interest in the delivery of health services by FBOs, such as the membership of the Swedish International Development Agency (Sida) in the PaRD initiative as well as recent studies on the role of religion in development cooperation (Sundqvist 2016). In February 2016, at the Berlin conference *Partners for Change – Religions and the 2030 Agenda*, the global donor community established the first global donor coordination mechanism for religion and development under the secretariat International Partnership on Religion and Sustainable Development (PaRD). Furthermore, since the beginning of the new millennium, the United Nations has more actively advocated cooperating with FBOs in the areas of health through the United Nations Population Fund (UNFPA).

In development contexts, faith-based health providers have historically often been the first to establish health facilities based on scientific medicine and then continued to partially operate as contractually recognised entities, but without being fully integrated into the public health systems (Flessa 2005). However, since PPP has come about in its current form, most donor agencies have increasingly come to support the development of FBOs as key partners in the realisation of Sustainable Development Goals (United Nations 2017a). At the same time, a growing number of critical scholars are asking whether a further integration and promotion of FBOs into public health systems is the result of a search for ideological legitimisation of a global agenda aiming at privatisation of health service delivery (Gauthier & Martikainen 2013; Hackworth 2010).

When studying religion and health, the role of FBOs in healthcare mainly tends to be studied from a rational/instrumental perspective, where FBOs and church organisations are primarily viewed as service providers (Beckford 2017). In most of these studies, scholars focus on the infrastructure, the wide geographical coverage and the institutional capacity in health service delivery of FBOs (Boulanger & Criel 2012). The integration of FBOs into national health systems is said to be cost-effective and crucial in order to achieve Sustainable Development Goal number 6 “to ensure healthy lives and promote wellbeing for all at all ages” as agreed in the Global Development Agenda 2030 (United Nations 2017a). This can also be seen in several development policies, where the international donor community tends to

argue from an instrumental perspective by providing evidence for faith-based engagement in development (Sundqvist 2016).

With the aim of studying the role of religious agents in development through the prism of contractual partnerships, I seek to get a more comprehensive understanding of how church organisations in a specific development context are influenced by and respond to the current transformations in global health policy; both in their current role as service providers, but also beyond this role. This is done drawing on inspiration from scholars from several other academic fields: human geography, political science and theology (Williams et al. 2012; Pallant 2012; Mallya 2008).

On the one hand, PPP as an institutional mechanism has provided the space for FBOs and church organisations to step in as key actors in comprehensive health planning and service delivery (Itika 2009). On the other hand, however, the concept of PPP has also resulted in increased vulnerability and uncertainty at the organisational level, since church organisations have become increasingly dependent on public funding through these partnerships with public health authorities (Pallant 2012). Hence, some scholars suggest that further integration of FBOs into current health systems, through PPPs, might lead to a financial and organisational collapse of the private not-for-profit health entities (Olivier & Wodon 2012). One reason for this is said to be that many private not-for-profit FBOs are not fully compensated according to the contracts and thus risk running their health services with a deficit after signing the PPP agreements (Boulanger & Criel 2012; Itika 2009). Additionally, donor organisations tend to phase-out their funding once the PPP agreements are signed, even if the public authorities are not able to provide the financial support needed (Boulanger et al. 2009). It is evident that even though many scholars seemingly portray FBOs as effective service providers, they nevertheless face severe challenges, as they are still dependent on their international partners, while frequently lacking a sense of real ownership and long-term sustainability (Pallant 2012). This complex situation forms the background of this study.

Previous research

A constantly shifting research landscape in the field of church organisations and health service delivery in Sub-Saharan Africa makes it difficult to provide a comprehensive overview of this research field. Oliver and Wodon have perhaps published one of the most prominent overviews (Olivier & Wodon 2012). They concluded that around 2000, there was a sudden increase in evidence-based research on FBOs in health and religious responses to HIV/AIDS in Sub-Saharan Africa. As part of this move towards stronger recognition of FBOs in health, several scholars also started to show an interest in individual health-seeking behaviour, in particular surrounding condom

use and how religiously informed decisions influenced different sexual and reproductive practices. In Sub-Saharan Africa, several studies have provided evidence and pointed to the fact that FBOs seem to be more important in weak health systems in rural and marginalised communities, and that on several occasions there are higher satisfaction levels of the health services provided than in most public health facilities (Olivier & Wodon 2012).

Through the PPPs, church organisations are able to forge stronger collaborations and subsequently a more coherent voice and presence in the development discourse in the African context, increasingly framed within the context of Religious Health Assets (Gary & Cochrane 2012). There is an emerging body of research in this area, particularly from South African scholars. The South African International Religious Health Assets Programme has served as a great source of inspiration for this study (International Religious Health Assets Program 2017).

The framing of an emerging faith sector

A current challenge in this field of research, as addressed by Oliver and Wodon, is the search for a common and more coherent terminology in terms of defining and conceptualising the faith actors in health sector developments. Although a few standard labels are applied to the “faith sector”, there is no shared typology or classification of “Faith Based Organisations” (FBOs). A variety of labels and abbreviations exist, such as Faith-Based Health Providers (FHPs), Mission Based Providers (MBPs), Christian Health Assets (CHAs), Religious Health Assets (RHAs), Faith Inspired Institutions (FIIs), Religious NGOs (RNOGs), Congregations or Community Based Organisations (CBOs). This makes it difficult to compare and synthesise research and also to cross-examine studies (Olivier & Wodon 2012).

A common distinction is often made between FBOs and secular NGOs. However, Tanzanian national surveys of NGOs do not always differentiate between FBOs and NGOs, or civil society at large for that matter (Boulanger & Criel 2012). I argue that more research is needed on the particularities of different types of FBOs. To limit the definition of FBOs to formally registered organisations resembling NGOs could be problematic, since it risks excluding a large number of religious organisations, such as congregations, missionary organisations and religiously based socio-political groups. Thus we need a definition including all religious organisations that derive “inspiration and guidance for its activities from the teaching and principles of the faith” (Clarke & Jennings 2008a, p. 6). It is, of course, an ambiguous boundary, as some FBOs truly resemble NGOs and others could not be considered NGOs at all, such as cults, individual churches, mosques, temples, etc. (Jennings 2013).

Several studies on development work with Christian FBOs reveal that faith and faith affiliation may influence the organisations at many different

levels and in many different ways (Petersen & Juul 2011). This scenario makes it impossible to generalise with regard to the underlying strategies, values and structures of FBOs (Clarke 2007), which is why some scholars argue that it is not even meaningful to study all FBOs from a broad perspective, since they differ so much. Tomalin argues that identifying different types of FBOs is beneficial, as it helps recognise their character and inform potential donors concerning potential opportunities for engaging with them (Tomalin 2012). Clarke also argues in favour of this and suggests five main types of FBOs relevant to their roles as development agents: (1) representative organisations; (2) charitable or development organisations; (3) socio-political organisations; (4) missionary organisations; and (5) radical organisations. He argues that donors in development contexts have mainly engaged with the second type of FBOs (charitable or development organisations), which are mainly Christian, suggesting that they express their faith identity in a more passive way. Still, many organisations play down their religious label, fearing that it would potentially restrict their capacity for obtaining international funding (Clarke 2007).

In other academic disciplines, such as third sector studies, several scholars have started to call for giving more attention to the special nature of not-for-profit alternatives in relation to business organisations in service delivery (Ballou & Weisbrod 2003). For example, Burton A. Weisbrod has even found substantial differences between not only for-profit and non-profit organisations, but also between FBOs and other non-profit alternatives, in particular in terms of managerial behaviour and financial compensation schemes (Ballou & Weisbrod 2003). Nevertheless, within the scope of this study, I limit my theoretical discussion primarily to the concept of FBO. Empirically, I limit my study even more specifically to the concept of church organisations as one form of FBO, and within the analytical framework, I have included the concept of intangible religious health assets with the purpose of broadening my analysis beyond an instrumental perspective (Gary & Cochrane 2012).

More specifically with regard to the Tanzanian context, most faith-based charitable, relief and development organisations are registered as NGOs or societies (Leurs et al. 2011). In Tanzania, it is therefore difficult to grasp the concept of FBO outside the context of civil society. In principle, this means that FBOs should be regarded as part of the wider civil society. However, Tumainimungu also brings forward that fact that there are some FBOs that he does not consider part of the Tanzanian civil society. As an example, he mentions those exclusively operating in the interests of the adherents of the faith tradition with which they are associated (Tumainimungu 2007). In public policy, FBOs are sometimes labelled voluntary agencies or religious organisations (Ministry of Health 2015).

FBOs as social agents of the state

The ways in which FBOs and church organisations relate to the public sector in Tanzania and globally have changed over time (Bompani & Frahm-Arp 2010; Mallya 2008). Ernest Mallya has analysed these dynamics over the last decades in Tanzania. He argues that while the Tanzanian state has set the rules, the state has been lacking the resources required for sustaining its legitimacy, mainly by its failure to provide the needed social services since the economic crisis in the late 1970s (Mallya 2007). Due to a global structural shift, the Tanzanian state has later been pushed to rethink not only the state-market relationship, but also that between the state and FBOs, in order to pay more attention to market logics and the role of the third sector (Mkandawire 2011; Mallya 2008). By fulfilling the services of the state, FBOs have tended to move towards the centre stage and gain even more power following the latest political and economic reforms. At the same time, traditional NGOs such as cooperatives and trade unions have lost power and influence in the privatised economic domain (Mallya 2008).

This change has resulted in a dilemma for FBOs. While entering into collaborative partnerships with public authorities, they are collaborating with a state that is to some degree both authoritarian and corrupt. At the same time, if FBOs want to influence governmental actions and policies, or access public funding, entering into formal partnerships with public authorities may be the most effective strategy (Mallya 2008).

It is clear from previous research that FBOs can act as service providers in different ways and take on different roles in relation to public authorities (Williams et al. 2012). Several typologies have been developed for the specific purpose of analysing these different roles. In Hackworth's view, FBOs and church organisations can relate to the governmental public authorities in five major ways: as (1) extensions; (2) enhancements; (3) catalysts; (4) regressive alternatives; and (5) progressive alternatives (Hackworth 2010). Hackworth has built his framework on earlier typologies developed for similar purposes. Kramer was among the first to enter the scholarly debate in this area, while others followed in the stormy political climate and tight economic situation of the early 1980s, when enthusiasts of a limited government area and reduced public funding were trying to do more with less by encouraging the non-profit sector to play a larger role. The political discourse of that time in many ways resembles the current global political economy debate on the relative effectiveness of markets, governments and non-profit organisations when it comes to addressing social challenges. It is interesting that Kramer already in 1981 argued that the end of an era of welfare state expansion was reached and that he, at such an early stage, was able to predict the transition within global political economy from welfare states to welfare societies. He refers to non-profit organisations as welfare agents by four main functions and contributions: (1) a vanguard role; (2) an improver

role; (3) a value-guardian role; and (4) a service provider role (primary, complementary or supplementary) (Kramer 1981).

Despite the fact that all of these principal typologies have been developed for late-modern Western societies, they are still relevant for the Tanzanian context; partially as policy-making is to such a high extent influenced by global policies and New Public Management ideas originating from the West. Kramer's typology has proved particularly useful in my study when discussing the political and social dimensions of the PPPs and also when analysing the different roles church organisations are able to adopt in the Tanzanian context. However, there are also unique particularities in the Tanzanian context. Tanzanian scholars like Bakari and Mallya argue that the particularities in the FBO-state relationship characterising the Tanzanian context need to be studied to a much greater extent (Mallya 2008; Bakari 2007). Health rights are yet to be realised, health infrastructure is not developed comprehensively and many diseases are not combated. Thus, I consider it important to study the contractual partnerships with particular consideration to the political and religious context, while simultaneously relating this analysis to the transformations taking place at the global level.

The role of FBOs in health sector developments

Church organisations, as one type of FBOs, have been involved in the development agenda for a much longer period of time compared to secular NGOs (Olivier & Wodon 2012). Health service delivery by FBOs in East Africa takes its starting point already in the 19th century colonial period (Flessa 2005). Following national independence, church organisations faced many changes as national health systems were introduced and promoted. At this time, the research carried out mainly focused on concerns such as the transition from mission-based hospitals to independent church facilities. However, the colonial legacy was only discussed to a limited extent (Olivier & Wodon 2012).

In the struggle to break with the colonial legacy, many development scholars saw religion as an obstacle. The secularisation paradigm based on the modernist model of the progressive exclusion of religion from the public sphere dominated development theory, and religion was mainly seen as an obstacle to progress (Bompani & Frahm-Arp 2010). Even though communities in developing contexts could hardly imagine life without religion, development scholars and Western philosophers believed that as the state flourished, development would lift people out of religious dependency (Lunn 2009). Hence, religion would eventually diminish in importance (Clarke et al. 2008).

This conclusion does not come as a surprise, considering that early development scholars were seeking a break with the colonial heritage, including the missionary societies, which played a central role as development agents

(Clarke 2007). As state-led development programmes were replacing former colonial institutions at the national level, the social service delivery of FBOs was considered less important. Since outsiders, such as international faith-based organisations and Western missionary societies, were still in charge of the healthcare, church-based healthcare delivery was also considered lacking a component of national ownership (Boulanger & Criel 2012).

Despite this critique, missionary societies and independent church organisations continued their work in rural areas and stayed at the margins of development policy for a few decades following independence (Bompani & Frahm-Arp 2010). It is important to note that although they were disregarded at the central policy level, some of the religious agents, mainly Christian FBOs, were at the same time becoming more incorporated in the architecture of development cooperation by participating in development dialogues and by receiving development funding from the West (Boulenger et al. 2009; Clarke et al. 2008).

In the late 1980s, the privatisation of the global economy aimed at minimising the state's influence also led to a stronger inclusion of FBOs, which were requested to fill the gaps left by the state (Reychler 1997). This transformation was facilitated by the introduction of structural adjustment programmes, which promoted the privatisation of social services of what later came to be labelled New Public Management (Gnan et al. 2013; Thorsen & Lie 2006). This was also true for countries such as Tanzania (Mallya 2008). The weakening of the nation-state led to an identity transformation away from the nation-state as the foundation for identity to the reinforcement of religion and ethnicity as a basis of identity (Ellis & Ter Haar 2004). The fact that these identities were multiple and transcended national borders meant that they were better suited for a globalised context (Reychler 1997). Religion and religious beliefs started to become recognised as factors influencing poor people's priorities and shaping concepts of life in their identity formation (Rakodi 2012). As part of this transformation, FBOs became more visible and important in development initiatives. However, it is worth noting that research initiatives on religion and health sector developments mostly took on an instrumental perspective, studying to what extent FBOs were capable of promoting certain common global health goals from a perspective of efficiency.

During the 1990s, the interest in partnering with FBOs increased along with a higher interest in collaboration between public and private health actors (Boulenger et al. 2009). A comprehensive literature review by Olivier and Wodon brings forward four main characteristics of the literature from this period: (1) recognition of the role historically played by FBOs in health provision; (2) "market share" estimates indicating FBOs providing a high share of healthcare; (3) reports of weaknesses of FBOs, such as their dogmatic resistance to particular health strategies, lack of management capacity or resistance concerning the evaluation of their finances; and (4) statements

of possible “added value”, such as unique reach, trust and access into communities (Olivier & Wodon 2012).

With a shifted focus from the state as a leading development actor towards the promotion of a market economy, the civil society was suddenly brought into the spotlight of development policy (Beckford 2017). This global transformation included a growing emphasis on stakeholder engagement in participatory governance in the policy process. Given the opening of the development space, development scholars started exploring the question concerning the ownership of the development agenda (Rees & John 2010). Religion was not considered a key factor, although more participatory approaches fitted in nicely with the neoliberal paradigm and its focus on privatisation and citizen participation (Kaag 2004).

Under the current global health governance framework, shared public and private health governance was to replace the government as the single guarantor of health promotion (Itika et al. 2011). Through this new paradigm, FBOs and church organisations were recognised and promoted as efficient actors in the development sector. At the same time, governments acknowledged the fact that they could not achieve broad-based, sustainable development on their own (Woolcock & Narayan 2000). FBOs were said to bring the capacity of long-established networks of grassroots congregations and organisations dating back to the pre-colonial era. Suddenly, the colonial legacy brought along benefits rather than being a burden. A growing number of new theories on human development and capabilities offered more holistic and people-centred views on development (Sen 1993). Even some counter-theories benefitted FBOs, as they questioned neoliberal economic policies by instead emphasizing social and cultural factors integral to the concept of development (Kaag & Saint-Lary 2011). In spite of this, a more narrow and instrumental understanding of religion was still dominant (Pallant 2012).

FBOs in the current framework of global health

Since the turn of the new millennium, there has been an increasing emphasis on trying to understand the local context and referring to country-specific evidence in order to avoid excessively broad generalisations concerning FBOs and health service delivery (Olivier & Wodon 2012). As argued by Gerrie ter Haar, earlier attempts to achieve development objectives have sometimes failed as a result of trying to change people’s worldviews rather than building on them (Haar 2006). Increasing numbers of scholars have shown an interest in the complexity of the effect of people’s religiosity in relation to the transformation of the global political economy (Gauthier & Martikainen 2013; Williams et al. 2012). Some scholars have argued in favour of the need for further recognition of the multifaceted behaviours of health-seeking patients who simultaneously access traditional and science-based medical facilities (Boulenger et al. 2009; Clarke 2007).

It is important to note that the current PPP agenda with an emphasis on the integration of established faith-based facilities in public health systems leaves less room for religions with few formal contractual partnerships, in particular African traditional religions (Boulenger et al. 2009). It is also important to note that the number of Muslim organisations having entered into PPPs is significantly smaller. The National Muslim Council of Tanzania, Baraza Kuu la Waisilamu la Tanzania (BAKWATA), operates more than 50 dispensaries and health centres. There are, however, no official statistics on the total percentage of Muslim health facilities, even though all scholars agree that they represent a significantly lower figure compared to church organisations. The Aga Khan Foundation is the most predominant Muslim organisation, operating hospitals in all the major cities, and other Islamic organisations have several health facilities scattered all over the country. But the Christian church organisations are dominating the PPPs at the local level, delivering around 40 percent of all health services nationwide (National Muslim Council of Tanzania (BAKWATA) 2017).

Most studies on strengthening health systems have been guided by an instrumental approach and often originated in health sciences. For this very reason, there is more written on Christian health providers than on health activities and services emerging through other communities of faith (Dilger 2010).

In African regional studies, the understanding of public and institutional relationships between church organisations and public authorities is still evolving (Gary & Cochrane 2012). One of the leading actors in this research field is the African Religious Health Assets Programme, an international research collaboration working on the interface between religion and public health, with a focus on the African region (ARHAP 2017). In the Tanzanian context, studies on FBOs and health provision share many characteristics with other development contexts in Sub-Saharan Africa. One of the reasons is that policy-making has been internationalised, where local policy-making institutions have played a relatively passive role when discussing and adopting new directives from the donors (Bakari 2012; Mallya 2008). This, however, has started to change in the last years. With economic diversification, the emergence of the BRICS and increasing tax collection, African states and not least Tanzania's policy-making have ended up being less dominated by the donors (Paget 2017).

Still, significant research has been conducted in aid-dependent contexts and funded through development cooperation (e.g. World Bank, IFBOs, INGO) (Olivier & Wodon 2012). However, this is changing and an increasing number of scholars have started to examine externally driven policy development more critically, and also how it has influenced FBO-state relationships and the broader relationships between religion and politics in Tanzania. Wide-ranging development research initiatives with a particular focus on social capital, human development and human rights have started to in-

clude religion as an analytical category within a larger development context: cultural, social and political. In 2006, the organisation Research and Education for Democracy in Tanzania (REDET) initiated a national research programme on religion and service provision entitled *Justice, Rights and Worship – Religion and Politics in Tanzania* (REDET 2017). Another good example is the Religions and Development Research Programme. In 2015, a follow-up on the REDET programme was carried out and published under the title *Religion and State in Tanzania Revisited*. In addition to these larger national research programmes, there are numerous books and empirical studies on the intersection between FBOs, service provision and development in Tanzania. It may come as a surprise, however, that the Religions and Development Research Programme found little evidence of the distinctive use of religious language by FBOs in their development work in comparison to secular NGOs. It was concluded that they were unable to identify a particular, religiously informed view on development as well as a distinctive approach to development (Green et al. 2010).

Gaps in knowledge and relevance of the study

A key conclusion from the literature review is that contemporary research and policy initiatives on FBOs as health service providers is characterised by a focus on the instrumental role of FBOs, often with the purpose of providing evidence for their contributions. This is evident in both studies with an institutional focus as well as in studies with a community-level focus on healthcare (Boulanger & Criel 2012; Olivier & Wodon 2012).

The research overview shows an increased interest in considering religion as a factor and in studying the role of church organisations in healthcare provision in Tanzania (Boulanger & Criel 2012; Itika 2009). A set of four case studies were carried out in 2007–2009 with the purpose of evaluating PPPs in health between FBOs and public authorities, Tanzania included. These studies were focused on the health system as such and health systems being strengthened and guided by an instrumental perspective, and did not take much of the faith identity and church leadership into consideration, even though the study identified important challenges facing FBOs in PPPs and related health policy gaps in Tanzania (Boulanger et al. 2009). The authors pointed towards a crisis in the current contracting landscape in Tanzania, and based on their case studies they saw the need to dramatically improve knowledge and expertise in designing, implementing and monitoring contractual arrangements. Itika conducted a similar study during the same years on the PPPs in health in Tanzania, except that he did not consider FBOs specifically. However, he identified similar challenges facing the current PPP reform in Tanzania (Itika 2009). The main research gap identified

for this study therefore concerns the need to comprehensively study church organisations in PPPs beyond an instrumental approach (Beckford 2017).

Bottom-up aspects – such as the partnership relationships and embedded values such as culture, politics and religion – are less visible in the studies, even though Mallya, based on a political science approach, has conducted some studies in this regard on FBO-state relationships (Mallya 2008). These studies are not carried out explicitly with regard to the health sector, but rather at the general policy level. Integral dimensions in the form of values, beliefs and ethics are frequently absent, since theologians and scholars of religion generally do not participate in most health research programmes (Pallant 2012). However, the International Religious Health Assets Programme constitutes an exception in this regard, since it has managed to merge health sciences with religious sciences in impressive ways (International Religious Health Assets Program 2017). Several Tanzanian scholars have also started to argue for the need to better integrate the factor of religion in social science research, and a few have even claimed that development policy and development practise in Tanzania have ignored the role of religious values and religious teachings (Kipacha et al. 2015). Clearly, there is a need for empirical research in this field, in particular research covering more specific aspects of faith-based values and religion that may also engage with church policy without having to support a particular faith doctrine.

A challenge is that church organisations are often framed and analysed similarly to secular NGOs and other private actors, such as private for-profit and social enterprises. Hence, the unique organisational structure, identity and related values that characterise FBO actors are not taken into consideration when designing studies (Green et al. 2010). Nor are their faith-identity or Christian ethics, often stressed as the basis of their engagement in health sector development, taken into account. In conclusion, there is a lack of studies covering the views of the leadership of church organisations and their strategies in relation to contractual partnerships from both an ideological and theological perspective. Several authors have argued that more research is needed on faith-inspired engagement in the health sector (Boulenger et al. 2009; Clarke 2007). There is still a lack of shared understanding on how the direct and indirect impact of religion and religious organisations should be interpreted (Olivier & Wodon 2012). Even though some previous empirical studies have looked into the relationship between religion and development in Tanzania, few studies have focused exclusively on the strategies of church organisations in relation to PPPs in the health sector and in particular with a focus on integral aspects.

In this particular study, the PPPs are explored from both the public and the private side, thus attempting to contribute to a more comprehensive understanding of these partnerships in comparison with some other studies (Itika 2009). Within the scope of this study, the concept “public” is considered to be the Tanzanian state and the related public health authorities and

public health institutions. Private is considered both market contribution to health service delivery in the form of for-profit health companies as well as non-profit healthcare delivered by church organisations and other FBOs and NGOs. Several other studies on church organisations in Tanzania and health delivery tend to focus on particular denominations instead of identifying larger trends and ecumenical perspectives, or have simply conceptualised church organisations as “private not-for-profit”. A key theme in this study is to gain deeper insights concerning the existing gaps between public-private, policy implementation, national-local public health authorities, churches’ national level dioceses, values performances and contractual partnerships-partner relationships. Critical dimensions, such as embedded values and the nature of the partnership relationships, have not been in focus in previous studies. The core and structural question also remains unanswered: how we should understand the developmental role of religious agents in Tanzania, in particular church organisations? Several studies contain overly encompassing and generalised descriptions of FBOs and religious agents. Therefore, there is a need to conduct more specific contextual studies in order to study the practical embodiment of religious discourse in the health sector performance of church organisations.

Outline of the following chapters

Chapter 2 provides the theoretical and analytical framework of the study. The analytical framework consists of three perspectives regarding the study of religion and development. Chapter 3 introduces fieldwork method and data, epistemological starting point, research design and methodological choices. Chapter 4 is a description of the research context, where I provide some background on the role of religion in Tanzania and how the developmental role of church organisations has changed over time. Chapter 5 gives an overview of the PPP policy, where I trace the roots of these health collaborations in Tanzania. In Chapter 6, I present the three case studies of church organisations at the national and local level, as well as the respective local church-based hospital. In Chapter 7, I discuss how the partnerships between the state and the church organisations are constructed and how these are perceived by church organisations and the public authorities at both national and local levels. In Chapters 8–10, I analyse the partnerships from the three perspectives: rational/instrumental, bottom-up and integral. The results are discussed in Chapter 11, where I also return to my theoretical starting points, discussing the results in relation to the analytical framework and how my findings fit into the larger context of the development debate in Tanzanian society. Finally, I draw some more general conclusions and present suggestions for further research.

2. Theoretical and analytical framework

In this chapter, I present the theoretical and analytical framework of the study. By using an interdisciplinary approach based in the field of sociology of religion, I explore the role of religion in development. It is an attempt to bridge the gap between sociology of religion and other related disciplines in the social sciences including, but not limited to, development studies, human geography and global political economy. I seek to contribute to the larger area of welfare and religion studies at the Uppsala Religion and Society Research Centre. The study builds further on previous research conducted through the Welfare and Religion (WREP), the Welfare and Values (WaVE) and the Welfare and Religion in a Global Perspective (WRiGP) projects, but I limit my focus to the role of Christian churches as agents of welfare in the area of healthcare (Molokotos-Liederman et al. 2017, Pettersson & Middlemiss Lé Mon 2012; Bäckstöm et al. 2011; Bäckström et al. 2010).

I start the chapter by discussing the concept of religion, followed by a broader theoretical reflection on the relationship between religion and development in order to show how sociologists of religion and development scholars have approached this shifting relationship. Two tendencies are critically discussed: (1) A tendency to originate from a Eurocentric worldview and (2) a tendency to relegate religion to the private sphere. I then discuss how discursive transformations have led some contemporary scholars, including myself, to believe that we are currently witnessing “a religious turn” in development cooperation, whereby religion is becoming more visible in development policy, development practice and development research (Sundqvist 2016; Jones & Petersen 2011; Kaag & Saint Lary 2011).

Based on this background, I discuss how transformations in the global political economy, due to the increased influence of New Public Management, have contributed to religion becoming increasingly visible, with a particular focus on the promotion of the social service provision of FBOs. I critically examine how this change could be interpreted in a given social, political and religious context, and how the role of church organisations in the health sector can be understood more broadly.

The concept of “religion”

As long as the field of sociology of religion has existed, there has been an ongoing debate on how to understand and research religion as an academic concept and unit of analysis (Furseth & Repstad 2006; Woodhead & Heelas 2000). Over the last decades, sociologists of religion have raised concern and criticism against generic and fixed definitions of religion. A growing number of sociologists have developed wider and all-encompassing understandings of religion (Casanova 2011; Beckford 2003). As tends to happen all too frequently, theorists have perceived religion as a relatively homogeneous phenomenon that may be analysed and compared across time and space without properly considering its multi-faceted and socially constructed character. Instead of continuing the search for generic qualities of religion, or generalisations about religion “as if it were a single, invariant object that operates independently of human agents and agencies”, Beckford suggests that it is preferable to analyse the various situations in which religious meaning or significance is constructed, attributed or challenged (Beckford 2003, p. 17). Such a social constructivist approach to the study of religion reveals that collective agents (the state, health authorities, FBOs, etc.) may construct the notion of religion for different purposes. I agree that the conventional boundaries between religion, politics and ideology need to be redrawn, as they are more complex and dynamic than we tend to think.

In search for a deeper conceptual understanding, several scholars have developed typologies to provide a better understanding of church organisations and FBOs, as well as how and when faith is part of the social services they provide (Clarke et al. 2008). One element missing in many of these studies is an understanding of the importance of studying religion contextually in each social setting. Depending on the historical, cultural, socio-political and economic realities, religious actors will construct different meanings and beliefs, and also take on various roles in society (Murindwa-Rutanga 2011; Lunn 2009). Even the term FBO itself fails to capture the reality of some religious bodies in Africa, as the term excludes many religious agents without a fixed organisational status (Olivier & Wodon 2012; Pallant 2012). For this particular reason, the African Religious Health Assets Programme opted for the term *religious entity* instead of FBO (Gary & Cochrane 2012).

In order to stress the importance of developing an understanding of the concept of religion contextually, Carole Rakodi’s framework for analysing the links between religion and development has proved helpful. She highlights key areas where religious beliefs, religious language, symbols and activities influence societies, specifically in development contexts (Rakodi 2012). Since social and historical processes have led to a particular embodiment of religion, she argues that religion redefines itself in light of changing social, economic and political contexts. In order to grasp the practical em-

bodiment of religious discourses, one needs to pay particular attention to religious organisations, religious leadership and the nature of power relationships within a religious community. For example, the official ban on contraception in the Catholic Church means that the power and legitimacy of the religious leadership is a crucial element when interpreting religious teaching (Deneulin & Rakodi 2011).

In African regional studies, several anthropologists and scholars of semantics have highlighted the significance of the linguistic context by pointing to the fact that in many African languages, including Kiswahili spoken in Tanzania, there is no equivalent to the Western notion of religion as a concept (Kipacha et al. 2015). “Religion” as used in the English language does not necessarily translate directly into other religious traditions and languages outside the West (Ellis & Ter Haar 2004). In Kiswahili, religion as a concept is most frequently translated into *Dini*, which primarily refers to institutionalised forms of religion. The Kiswahili word *Imani* refers to belief and covers a broader spectrum of meaning constructions. This word is sometimes more useful when researching religious beliefs in the Tanzanian context, as it captures more of the entire web of beliefs, myths and spirituality. However, in politics and in the Tanzanian constitution, religion in most cases translates into *Dini*. In current research, international scholars also often refer to the activities of religious organisations in Tanzania by applying the concept of FBO, which risks becoming overly instrumental, just like the *Dini* concept. In this way, religion is mainly addressed in organisational terms and risks excluding both holistic elements and specific non-formal religious agents, such as African independent churches and adherents to African traditional religions (Makaramba 2006). Another important and complex concept to consider is “African traditional religion(s)”. In the Tanzanian context, it is both defined and operationalised as a concept in singular and plural. I have chosen to define it in line with two leading Tanzanian scholars in plural as African traditional religions in order to put emphasis on the diversity of beliefs, symbols and practices (Lawi & Masanja 2006). However, it is also important to define the meaning of the word “traditional”. I have here chosen to use Omosade Awolalu’s definition of traditional as “indigenous, that which is aboriginal or foundational, handed down from generation to generation, upheld and practised by Africans today. This is a heritage from the past, but treated not as outdated but as that which connects the past with the present and the present with eternity” (Awolalu 1976).

With regard to this study at large, I limit my study on religion in the Tanzanian context to church organisations, their faith doctrine and the practical embodiment of religious discourses. Hill (1973) defines religion as: “The set of beliefs which postulate and seek to regulate the distinction between an empirical reality and a related and significant supra-empirical segment of reality; the language and the symbols which are used in relation to this distinction; and the activities and institutions which are connected with its regu-

lation” (Hill 1973, pp. 42–43). Even though his definition risks excluding discourses rejecting the core distinction between sacred and secular, spiritual and material, I find it relevant for capturing the way I understand religion within the scope of this study.

In this study, I have chosen to address and label the three faith-based organisations in my study as *church organisations* and their health institutions as *church-based hospitals*. My choice is primarily a result of me wanting to highlight the role of the religious identity of these church organisations in relation to the partnerships. Nevertheless, I situate the three church organisations in my study within the larger theoretical discussion on FBOs and the relationship between FBOs and the state when discussing analytical dimensions of the PPPs.

With the choice of emphasising the practical embodiment of religious discourses and beliefs through the study of religious organisations, I understand the concept of religion as a phenomenon redefining itself in light of the changing social, economic and political context of Tanzania. I thereby limit my analysis of religion primarily to specific situations where religious meaning or significance is highlighted, constructed, attributed or challenged (Beckford 2003). In this regard, the analytical concept of intangible religious health assets has been useful in order to analyse in what ways religion appears as a significant factor in the contractual partnerships.

The concept of “development”

The concept of development is as complex and multifaceted as that of religion. I have chosen to define development in line with Beckford’s understanding of development as it captures “discourses, policies, strategies and practices aimed at sustainable improvement of the material wellbeing, health, education and life-chances of people living in conditions of significant deprivation relative to standards of living in countries with high levels of Gross Domestic Product” (Beckford 2017, p. 3). This elaboration of the concept is a good representation of what I have come to include in my own understanding of the concept within this study.

Long before the term “development” entered scholarly debates, questions about relations between economic life and religions were discussed in the field of sociology of religion. The founders of sociology shared a longstanding interest in the concept of modernity and modernisation (Deneulin & Rakodi 2011). Consequently, in the late 1950s social scientists began to more explicitly equate development in the Western world with the condition of modernity (Beckford 2017; Rakodi 2012; Kaag & Saint-Lary 2011). Modernity was defined as a condition of social existence and economic order radically different from all past forms of human experience. Modernisation was

seen as the transitional process of moving from the traditional towards this new condition (Jones & Petersen 2011). Rostow's modernisation thesis in the 1960s serves as a clear illustration of how Europe was initially seen as the ultimate norm for how low-income countries ought to develop (Rostow 2013). Theoretically, European societies were presented as the preferred paradigmatic example for the rest of the world, where modern rational values would replace traditional worldviews and religious beliefs. A decline in religious beliefs was only one out of many processes that would follow in the wake of modern development processes (Rostow 2013).

The secularisation thesis informed development theory in profound ways. Religion was defined as a traditional social element leading to its eventual loss of influence and visibility in public life as part of social progress towards an increasingly modern society (Jones & Petersen 2011). Appearing primarily as a phenomenon in the shape of "manners and customs" and "tradition", religious agents were not identified as agents of social change in the larger social transformations (Beckford 2003). Instead, development was embedded in a larger narrative of top-down state interventions (Bakari 2012). In fact, the secularisation thesis came to legitimise the marginalisation of religion not only in academic development studies, but also in development theory, policy and practice (Kaag & Saint-Lary 2011; Jones & Petersen 2011; Kaag 2004).

A "religious turn" in development cooperation and research

Based on the notion that modernity leads to religious decline, several sociological theories based on the secularisation thesis were developed and became very influential from 1960 and onwards. Many sociologists took the division between the public and the private spheres in the Western world for granted and considered it a key feature of modernity (Clarke et al. 2008). The legacy of Christianity in Europe was a common central theme and the public performance of religion was seen through the prism of the church as a symbol of religious authority (Davie et al. 2003). The emergence of secular states, the functional differentiation of social systems and the reduced influence of the church in the rest of society was interpreted as religious decline and the marginalization of religion at large in the public sphere, where it was reduced to the private sphere (Casanova 2006). It is evident that the secularisation thesis traditionally tied the description of religious decline to the public spheres in Europe through social and public significance (Davie 2006); a process by which religious institutions lost their social significance (Wilson 1982). Arguing that religion had become a matter of personal choice, scholars like Bryan Wilson and, later, Steve Bruce came to support a relegation of religion to the private sphere (Bruce 2006; Wilson 1982). In his book *The Structural Transformation of the Public Sphere* (1989), Jürgen Habermas

offered a key starting point for both the notion of the public sphere itself and later the place of religion in the public sphere (Habermas 1989).

In the field of sociology of religion, scholars like Grace Davie came to challenge this reasoning by arguing that “secularisation” was a typical Western phenomenon and that Europe constituted more of an exception than a global rule (Davie 2006). In fact, David Martin was one of the first sociologists of religion to reach this conclusion already in the 1990s (Martin 1993). Other scholars, such as Casanova, have argued that the trend towards increased individualism in the West has not necessarily resulted in religion losing its influence in the cultural and political arena (Casanova 2006; Casanova 1994). Religion is still a unifying force in a global pluralistic society expressed between the private and public, which means that any theory of modernity systematically ignoring the public dimension of modern religion is in fact an incomplete theory. He has further pointed out that religion can and should have a public role in the modern world, particularly via entry into the discursive space of civil society (Casanova 1994). Casanova defines public religion based on a three-part division of modern democracies. Ultimately, mainly the public religions at the level of civil society are in line with modern and universalistic principles, as well as with contemporary diverse structures (Casanova 2006). Habermas, in his later thinking, has come to argue that religion has not disappeared from the public sphere in Western societies, as he first assumed (Habermas 2010; Habermas 2008a; Habermas 2008b). Through the discussion on religion in the public sphere and the patterns of religious decline or resurgence, the secularisation thesis has taken a new turn within the framework of a more critical secularisation paradigm (Joas & Wiegandt 2009; Berger et al. 2008; Taylor 2007).

Today, the notion of incorporating religion into the academic study of development has become more acceptable due to a transformation in the study of social sciences at large. Since the turn of the 21st century, religion has started to appear in both development theory and development policy. The discussion on a “religious turn” in development studies is a reflection of this wider growth of interest found in the social sciences with regard to religion and the social role of religious organisations (Sundqvist 2016; Jones & Petersen 2011; Kaag & Saint-Lary 2011; Bäckström et al. 2010). At the same time, a few critics of the religious turn question whether we have in fact witnessed a structural shift in changing something as embedded as a powerful secular or modernist framing within the development sector (Olivier 2016).

Simultaneously, an entire body of research has evolved within development studies with more constructive “postmodern” ways of conceptualizing culture and religion, including post-developmentalism, post-colonialism, post-structuralism and post-traditionalism (Salehin 2016). These theoretical frameworks reject visions that are overly Eurocentric and generalised, pointing at the crucial role of cultural and religious ideas and institutions in de-

velopment contexts (Kaag & Saint-Lary 2011). On the basis of more multi-dimensional alternative theoretical frameworks, it is possible to raise one's sensitivity to the cultural context, including religion, in a sociological analysis without necessarily imposing secular Western categories on development contexts (Lunn 2009). The gradual understanding of poverty as a multi-dimensional phenomenon with a stronger emphasis on cultural aspects and creating meaning has rendered the notion that religion is an important dimension in many people's lives in developing countries explicit (Beckford 2017). Shifting and more heterodox interpretations of the development concept with elements such as human development, social capital and participation have opened up for both increased attention to religion in development cooperation and easier access to the development space (Jones & Petersen 2011).

A critical secularisation paradigm

It is clear that sociologists of religion have continued to influence the scholarly debate on religion and development. At the more global level, different elements of the secularisation thesis have been questioned and further debated through a number of arguments and counter-arguments; in particular the notion that secularisation is the inevitable by-product of modernisation (Davie 2007). Using the notion of *multiple modernities*, S. N. Eisenstadt stresses the need for conceptualising modernity in plural, as modernities are not "static", but continually changing, and since the Western patterns of modernity are not the only "authentic" modernities (Eisenstadt 2000). The concept of "multiple modernities" has been central to the critical secularisation debate ever since. It is worth noting, however, that some contemporary scholars still defend elements of the traditional secularisation thesis. As an example, using data from the World Value Surveys, sociologists like Norris and Inglehart continuously provide support for the hypothesis that life insecurities lead to increased demands for religion (Norris & Inglehart 2006). At the same time, other sociologists, such as David Herbert, see more of global contradictions and tensions occurring "between religious resurgence and decline [...] and between religion as a source of social integration and social division" (Herbert 2003, p. 5). By arguing that a unitary public sphere is no longer evident, he suggests that one should start accounting for multiple contesting public spheres through the development of a global civil society. In this process, a discursive analysis of religion is absolutely crucial for developing our understanding of religion's relationship with the public sphere (Herbert 2003).

Globally, outside Europe, there are several examples of religious change contradicting the secularisation thesis. Brazil, Russia, India, South Africa, the Middle East and the United States are all examples of countries and re-

gions where religion at the societal level has remained strong when combined with economic growth and increased wealth. These regions and countries, according to some scholars, have served as the ultimate proof against the secularisation thesis (Casanova 2006; Asad 2003). Following the global revitalisation of political Islam and the global development of Pentecostal forms of Christianity, several sociologists have reworked previous assumptions on the secularisation thesis and reached new conclusions (Beckford 2017). At the same time, many anthropologists and religious studies scholars have started emphasising that the boundaries between religion in the public and private spheres are much more dynamic in non-Western contexts (Mkandawire 2011; Clarke et al. 2008). Therefore, any attempt to separate religion from the private and public spheres risks becoming irrelevant, as religion is frequently deeply rooted in the cultural, political and social domains (Ellis & Ter Haar 2004).

In Europe, the critical secularisation debate continues to be in focus in the field of sociology of religion, albeit challenged by globalisation and migration processes transforming the religious, cultural and social relations of Europe. In the critical secularisation paradigm, some scholars are increasingly pointing towards a condition of tensions (Casanova 2011; Herbert 2003). Other scholars argue for a condition of “post-secularity” consisting of peaceful dialogues and coexistence, a negotiation between the secular and the religious (Williams et al. 2012; Habermas 2008a). And some stress that in a post-secular age, religious language is said to carry semantic potential speaking to existential needs that have been uniquely compromised amidst the hyper-individualism of a neoliberal world order (Bahram 2013; Habermas 2008a).

Still, it is evident that the true challenge to the secularisation paradigm comes from globalisation. From a post-colonial perspective, Michiel Leezenburg argues that even the notion of the term post-secular, as defined by Habermas, risks being ethnocentric. According to his critique, post-secular is not a globally applicable analytical category, but a normative notion carrying deep secularist and modernist assumptions, since it uses the Western European liberal nation-state as a self-evident framework. Leezenburg instead suggests an approach more empirically refined, where the history of religion and secularism is traced against a background of changing meta-discursive global regimes, involving the reconfiguration of spheres, such as those of the religious and the secular or the political and the moral (Leezenburg 2010).

It is clear that José Casanova’s analysis of social and religious change in relation to the global world order has taken transformations beyond Europe into greater consideration based on the recognition of the increased relevance of the world religions for the emerging global order (Casanova 2011; Casanova 2006). More recently, sociologist James Beckford has also introduced substantial critique by applying more of a global perspective in the

sociology of religion, shedding light on the intersection between religion and development, and shifting the focus away from the West (Beckford 2017; Beckford 2010; Beckford 2003). He argues that the increased visibility of religion “is actually associated with the state’s interpellation of selected religions as partners in the delivery of public policies for managing diversity, combating inequality, and promoting social enterprise” (Beckford 2012, p. 1). This study serves as an empirical example of how one may study religious and social change in the field of sociology of religion in a context beyond the late modern societies in the West and the post-secular paradigm.

Renewed visibility of religion in light of PPPs

I argue that the renewed visibility of religion is partly due to current transformations in the global political economy (Tomalin 2012; Kaag & Saint-Lary 2011; Lunn 2009). Development agencies have come to support the development of non-profit alternatives in the third sector, in particular FBOs, as a supplement to government efforts (Gauthier & Martikainen 2013). Williams has argued that since private entities have been given more room in the public systems, health systems are thereby filled with both spiritual and market-orientated values (Williams et al. 2012). In these processes, some scholars acknowledge new opportunities for collaboration between previously more separate religious, humanist and secularist interests, in order to work together towards common development goals, such as the UN 2030 Agenda (Williams et al. 2012). They see a change in the secularist self-understanding of states, where they accept FBOs in government-led partnerships (Williams 2012). It is also possible to interpret this change as a strategy for governments to build relationships based on the work of moderate religious groups in order to avoid legitimising or collaborating with radicalised religious movements (Davis & Robinson 2012). The UN Agenda 2030 is the most obvious example of a global framework stressing the importance of Public Private Partnerships (United Nations 2017c).

Theoretically, this emergent trend has had, and continues to have, profound consequences for how we perceive FBOs and the role of religion in development. Opening up for a renewed role for FBOs is part of the re-organisation of the role of the state in social service provision in the public realm. In the global quest for better health for the world’s poorest, FBOs in particular are receiving increased attention. There is undoubtedly a significant influence from the market and external donors in terms of shaping health systems and a global consensus around the fact that FBOs can be important contributors in the realisation of global health rights (Pallant 2012). In this process, the donor community is faced with the dilemma of taking a stand to what extent they should involve the religious sector in the process of

privatisation and service delivery when the third sector gets increasing space (Erasmus et al. 2009).

As for the Sub-Saharan African context, several scholars argue that FBOs, and in particular church organisations, are important agents in the development of the health sector. As a clear example of this, the World Bank recently published evidence supporting this development entitled *Strengthening the Evidence for Faith-Inspired Health Engagement in Africa* (Olivier & Wodon 2012).

The new Global Health Governance framework stresses shared public and private health governance in terms of universal human rights, where a full knowledge and a mutual understanding of the global health objectives is a prerequisite for the realisation of health justice (Ruger 2012). Health rights are further emphasised in the Sustainable Development Goals of the UN 2030 Agenda. This document serves as a contributor to development as well as a key indicator of what the proponents of people-centred, rights-based, inclusive and equitable development seek to achieve, while promoting greater synergies between public and private actors. Furthermore, the new Sustainable Development Goals are framed in such a way that their attainment calls for policy coherence and shared solutions across multiple sectors in line with PPP policies (United Nations 2017a).

FBOs, in particular Christian church organisations, appear to be inextricably inter-connected to these trends as they have expanded their health service delivery in order to fill the gaps (Gauthier & Martikainen 2013). Pallant has critically examined the impact of contractual partnerships, and found that on the one hand, FBOs are encouraged by this new willingness to partner-up after years of struggling to find funding. On the other hand, there is a potential risk of isomorphism, as partnerships might affect both the organisational character and identity of FBOs when adapting to public policies or setting priorities according to global funding criteria. Therefore, in matters of faith, FBOs should determine their own direction and charter, even though the actions of the state and the market inevitably assert influence through their power to set the agenda (Pallant 2012).

Contractual partnerships – an externally driven global agenda

At the core of the on-going globalisation process, we find economic policies pushing for market solutions to social service provision. This has signalled a fundamental shift in the principles of public sector management, a general reinvention of the role of government, its agencies and the means through which services are delivered within public sector organisations. It is clear that there has been a global ideological shift at the structural level from a pro-development state, through market conforming, to a more market-friendly paradigm (Williams et al. 2012). This is a gradual shift to a system of contractual delivery due to universal consensus among the global eco-

conomic and political elite, such as the so-called Washington Consensus and the joint agenda of the G8. Even though international aid agencies acknowledge the importance of a strong national health policy, they still influence policy development, whereby partner countries are obliged to adopt “approved” approaches in order to receive funding (Pallant 2012; Evangelical Lutheran Church in Tanzania 1994). In this study, the PPP policy in Tanzania is partially regarded as a product of this policy shift considering social service delivery related to New Public Management. (Gnan et al. 2013; Thorsen & Lie 2006).

Moreover, in this study PPP as a policy is defined as a mode of governing, where non-state actors, such as church organisations, participate in both the formulation and implementation of public policy (Fiszbein 2000). In the implementation of these partnerships, FBOs need to find a “common ground” with an increasing number of partners, both public authorities and private donors (Pallant 2012). By entering into these collaborations, some scholars argue that FBOs are being co-opted into the wider governmentalities of neoliberal politics as inexpensive resource providers serving to legitimise a market-based model in service provision (Gauthier & Martikainen 2013; Hackworth 2012; Hackworth 2010). Other scholars, on the contrary, argue that ideological and theological responses to this transformation are more multifaceted and complex in nature (Bielefeld & Cleveland 2013; Williams et al. 2012). Dean Pallant stresses that FBOs carry the potential of operating as counter movements to market-driven development in their role of promoting the value of social relationships and emphasising intangible religious health assets and faith and not only acting as an effective distribution network for secular initiatives (Pallant 2012).

Analytical framework

When discussing the dynamics between religion and development in relation to contractual partnerships between church organisations and public authorities, I use the recent work of Beckford. He has highlighted the significance of three particular perspectives; namely the rational/instrumental, the bottom-up and the integral perspective (Beckford 2017). In these three perspectives, the role of religion in development is stressed, but for different reasons and under different conditions.

Beckford highlights the importance of integrating religious organisations in the larger schemes of societal development, as “far from being necessarily deviant or marginal, [religious movements] are an integral part of social and cultural change” (Beckford 2003, pp. 9–10). This is particularly true in the Tanzanian context, where development scholars are striving to be more compatible with people’s realities and reflect their values, including religion and culture at large.

In order to operationalise Beckford's three theoretical perspectives on religion and development, I have included the following key analytical concepts.

For the rational-instrumental perspective, I have included the critical concept of resource dependency, as developed by Jeffery Pfeffer and Gerlad Salancik. The concept of "resource dependency" has been helpful when critically examining the instrumental perspective and how the external resources and partnerships of a church organisation affect its behaviour under the current PPP reform. When analysing religion and development from a bottom-up perspective, the concept "social capital" offers a way to bridge sociological and development perspectives, thereby providing new understandings of social development. Linking social capital is here defined as to what extent the social capital generated by church organisations in health sector performance in the local and national context is linked vertically to local governments in order to facilitate sustainable societal development (Swart 2010; Woolcock & Narayan 2000). In the analysis from an integral perspective, I have included the concept of "intangible Religious Health Assets" (RHAs). The concept has helped me shed light on when religion appears as a factor of significance in the contractual partnerships, and thus as a phenomenon not normally "counted" or measured in health data (Gary & Cochrane 2012).

(1) Rational/instrumental perspective

In the first perspective, the *rational/instrumental perspective*, religion is primarily viewed instrumentally in terms of religiously affiliated organisations. The focus is on the role of FBOs as service providers and implementers of development cooperation and the economic and politic factors constituting boundaries and room for manoeuvre for FBOs (Gauthier & Martikainen 2013). This perspective acknowledges that FBOs are profoundly conditioned by the external political and economic power "exerted by formal organisations subject to rational and instrumental criteria of efficiency and accountability" (Beckford 2017, p. 21).

It relates to how the international and national agencies, in order to use their contributions more efficiently, have increasingly started promoting FBOs as effective implementers of development programmes. It acknowledges that governments are encouraged to collaborate with FBOs in achieving domestic and foreign policy objectives. International organisations such as the World Bank, the International Monetary Fund, the World Health Organisation and the United Nations Family Planning Agency, together with NGOs accredited by the UN, have thrived in the field of religion and development in recent decades. They have jointly promoted FBOs as co-donors and implementers of development initiatives.

However, while acknowledging that religious actors cannot afford to ignore the broader context of political reforms and economic power in which

they have to operate, there is also a risk of portraying FBOs as simply being the effect of external forces (Beckford 2003). The prominence of FBOs in development cooperation has increased in the past decade, but this is to a lesser extent based on an increase in the vitality of religions, but rather based on contextual factors such as the place of faith-based organisations in social service delivery (Beckford 2017). Those who favour an increased religious presence in public systems often argue that FBOs are superior to state organisations due to their history, distribution networks and organisational capacity (Clarke et al. 2008).

As part of the rational instrumental perspective, I have chosen to include a discussion on to what extent the utilisation of the existing health infrastructure of FBOs (buildings, hospitals and institutional capacity) inherited from missionary societies is considered an asset in the realisation of national health policy (Flessa 2005). This due to the fact that the incorporation of church-based hospitals into public health system is increasingly considered a critical and important step towards the realisation of comprehensive national health planning and effective health systems (Ruger 2012). Once integrated into public health systems through contractual partnerships with public authorities (PPPs), church-based health institutions are supposed to be less dependent on international aid, in addition to having secured a long-term funding mechanism (Pallant 2012).

Church organisations depend on both self-generated and external resources for their survival. The concept “resource dependency” can be helpful when examining how the external resources of a church organisation affect its behaviour. Focusing on the dependency of church organisations with regard to their external partners means that their struggle in securing financial and human resources is taken into consideration. This concept might also tell us why some church organisations when entering into PPPs become more commercialised in their health service delivery than others (Pfeffer & Salancik 2003). The concept is also useful when explaining why the outcome of PPPs to such a high extent depends on how different church organisations understand and relate to these partnerships.

An important aspect of resource dependency is power relations, since access to resources is seen a basis of power. Actors controlling power are the ones holding the resources that lead to dependency. Once integrated into PPPs, FBOs might on the one hand move their resource dependency away from international FBOs but, on the other hand, increase their dependency on the state and private donations of a more ad hoc nature as complementary means. To be able to adapt to the future, FBOs need the capability and discretion to alter their actions in order to manage both cooperation and compromises with the state and the surrounding donors and partners so that they may access funding and survive in the environment. There are also strategies for decreasing interdependence. If one actor in the partnership has more resources, then the other actor becomes a more dependent partner in their co-

operation, causing power inequalities between the participating parties, often framed as an asymmetric relationship. On the other hand, power equality and mutual interdependent relationships occur when both cooperating actors possess valuable resources and when managing these resources meets mutual needs. It is hard to achieve power equality and mutual interdependent relationships in PPPs, but they may still occur when the partners themselves possess valuable resources. However, it looks as if church organisations sometimes act in contradictory ways, trying to be independent while seeking certainty and stability through secure and stable finances. This risks leading to increased dependency (Pfeffer & Salancik 2003).

(2) Bottom-up perspective

The second *bottom-up perspective* sheds light on the role of religion in political and social mobilisation all the way from the grassroots level up to the state. The key question concerns who has real influence over people's values and behaviour? To what extent is the social capital generated by church organisations in health sector development linked vertically to local governments and public health authorities? In this perspective, local activities and experiences are important as "a deliberate strategy of favouring methods of study, policies and professional practices which start from the vantage point of people in developing countries other than elites or experts" in the West (Beckford 2017, pp. 14–15).

Some Western models of development have tended to neglect the voices of the poor, including their religious messages (Beckford 2017). Inclusive development should be more compatible with people's realities and reflect their values, including religion and culture (Kurfi 2013). Since there are rural areas that the government has a hard time reaching, religious leaders may in these settings influence the moral-political climate by mobilising the members in their congregations (Wuthnow 2003; Coleman 2003; Reychler 1997). Even in the poorest and most remote areas, people organise themselves for religious practices and are offered opportunities to enhance their human and social capital (Olivier & Wodon 2012). In some of these cases, religious leaders are also said to represent local institutions with the potential of challenging and counter-balancing injustices by enabling political participation (Beckford 2017). Religious actors often qualify as legitimate representatives of the people, since they work in remote areas, while secular NGOs often work more from the other end – "as both urban-based and single-issue based, and requiring the services of the educated" (Mallya 2008, p. 148).

Within this perspective, I have chosen to look into social and political mobilising factors by focusing on the social capital that is generated through church organisations health engagement in public private partnerships. Such as the notion that when FBOs deliver social services on behalf of the state, they can also serve to inspire political change or, even more radically, serve

as a replacement for the public sector (Gauthier & Martikainen 2013). In this perspective, service delivery (scale, scope and nature) influences the accountability and legitimacy of both the state and religious authorities. It is therefore important to discuss to what extent FBOs risk giving up parts of their identity or even replace their holistic approach when entering into contractual partnerships with public health authorities. One way of doing so is by studying internal struggles in church organisations and discussions among the church leadership to see to what extent they ensure that they come out clean when it comes to anti-corruption and transparency. In order for FBOs to promote active citizenship, stand with the poor and safeguard health rights, they similarly need to protect their autonomy and independency towards the state (Mallya 2008).

As a sociologist of religion, I also consider the concepts of representation and power in church organisations as part of a bottom-up perspective. In the analysis, I have tried to identify to what extent the religious leadership is legitimate as stakeholders in terms of healthcare performance. This is important, as the church leadership (bishops, priests and pastors) in most cases appear as representatives of the studied church-based hospitals.

In areas where the public health infrastructure is weak, healthcare services delivered by church organisations are said to have good outcomes since they are close to the poor (Green et al. 2010). Social networks, norms and trust have increasingly proven to have the potential to facilitate social development when middle-level public institutions are weak. Beckford uses the fact that Pentecostalism often flourishes against the background of failed states or failed programmes of state-funded welfare and economic development as an argument for concluding that religious denominations are well-suited to fill the gap between states and individuals (Beckford 2017). However, critics argue that while social capital in the form of ties within religious groups locally provides communities with a sense of religious identity and common purpose, without the necessary crosscutting ties to transcend religious, ethnic, social and geographic divides, they can also lead to the pursuit of narrow self-interest and to the rejection of outsiders (Woolcock & Narayan 2000). In fact, the very capacity of FBOs and church organisations to act in their collective interest is crucially dependent on the quality of the formal institutions under which they operate and on how well the health services may be linked to vertical levels between government and communities (Erasmus et al. 2009; Woolcock & Narayan 2000). The success of social capital for development will depend on how well social capital can be linked between government and communities and whether it creates new opportunities and increases access to resources that can facilitate social transformation (Swart 2010). Having broader ties in the form of linking social capital is essential in order for church organisations to reach out to the poorest and turn their existing social capital effectively toward broader civic engagement and public policy (Coleman 2003). When analysing the partnerships from a political

and social perspective, it is crucial to identify the conditions under which “linking” social capital can be generated and built up from the many positive aspects of “bonding” and “bridging” social capital, hence enabling the socially marginalised to gain access to formal health institutions and government support. It is about looking at church organisations as potential generators of social capital.

Closely linked to the question on linking social capital is the notion of church-state relationships, which is also affected by the scale, scope and nature of health services provided by church organisations. Embedded in the church-state relationship is the danger of church organisations becoming “domesticated” by the state. For this reason church organisations should pay more attention to the risks of institutional isomorphism (Pallant 2012). Otherwise, contractual partnerships between public authorities and church organisations risk influencing the potential of church organisations to be independent and able to speak out against social injustices (Swart 2010). If churches wish to promote active citizenship and safeguard health rights, they need to protect both their autonomy and their independency vis-à-vis the state (Mallya 2008). In this perspective, I find Kramer’s typology on different relations implemented by welfare agents towards the state to be useful when discussing the church-state relationship in a Tanzanian context (Kramer 1981). This typology is discussed further in chapter 9.

(3) Integral perspective

The third perspective, the *integral perspective*, acknowledges that development is likely to be successful and sustainable if it is informed by religious worldviews and practices (Beckford 2017). This perspective stands in contrast to the rational/instrumental perspective, as an integral perspective “regards development as intrinsic to religious traditions – not just an ‘add on’ to secular projects” (Beckford 2017, p. 14). Religion and development are treated as categorically interlinked phenomena. Ellis even regards religion in general and Christianity in particular “as the historical point of departure for the modern concept of development” (Ellis & Ter Haar 2004, p. 354). Religious ideas are relevant in diverse aspects of development, including governance and health. The spiritual dimension of life is necessary to take into account if one wishes to empower people in the developing world (Ellis & Ter Haar 2004). Instead of becoming less relevant, religion and religious beliefs are increasingly recognized as factors influencing people’s priorities and shaping their concepts of life with dignity. Religion is thereby recognised as potential moral capital and a motivating force in community development, potentially mobilised for transformational development (Beckford 2017).

Religion therefore needs to be given more attention when designing development policy, since religion plays such a central role in the lives of peo-

ple in local communities. From an integral perspective, religion contains some of the keys to successful development and, conversely, that “development is only likely to be successful and sustainable to the extent that it is informed by religious worldviews and practices” (Beckford 2017, p. 12).

A challenge, however, is that the integral approach carries a tendency of conceptualising religion in highly inclusive and possibly homogenising terms, thus lacking a more critical dimension on religion. Hence, research needs to carefully examine not only the things shared by different religions, but also the things that distinguish each of them and possibly make them incompatible with each other. This also means that religion can be destructive (Beckford 2017). For example, religious values and principles can stand in direct conflict with the realisation of health rights in public health. In these circumstances, religion constitutes an obstacle rather than a solution. Shedding light on the underlying function of religious values in these processes is therefore necessary in order to gain a deeper and more comprehensive picture of the role of religion in development (Gary & Cochrane 2012). This is why Rakodi highlights the importance of also understanding the ways in which religious teachings are used (Rakodi 2012).

In this perspective, I have chosen to study the religious dimensions of PPPs in the context of beliefs, understood as an integral part of life as it informs people’s material, moral and spiritual activities (Beckford 2017). I consider the concept of intangible Religious Health Assets (RHAs) useful in this perspective. In Sub-Saharan Africa, the notion of Religious Health Assets (RHAs) has been developed as a concept in order to operationalise and take better account of religious beliefs and values in health performance (Gary & Cochrane 2012). RHAs alert us to the crucial role of religion in the context of health; phenomena normally not “counted” or measured in health data, such as the internal sources of beliefs and practises and more holistic approaches to health (Gary & Cochrane 2012). The term itself focuses on how assets can be both mapped and evaluated. As Nordstokke brings forward, the importance of such a measure can be seen in the shift from a needs-oriented to an asset-oriented approach in development work, particularly in community development, and in a parallel move from needs-based to rights-based development work (Nordstokke 2016). Religious language frequently contains more useful concepts for talking about wellbeing and healthy humans in comparison to the language of health sciences applying more of a one-dimensional view on humans (Pallant 2012). RHAs have been increasingly recognised as potentially crucial components of a comprehensive, sustainable strategy for advancing health (Gary & Cochrane 2012). From this perspective, I have strived to consider to what extent religious beliefs and practises are used as resources, but also how they may impede church organisations from adopting health rights.

This study complements other studies originating from the health sciences, since it takes the special value system of church organisations in health

systems into consideration in order to create increasing awareness of church-based healthcare at a deeper level; for example to better understand under which conditions religious resources and volunteers are mobilised and health-seeking behaviour promoted. In order to gain these insights, I have considered if and to what extent church-based hospitals are linked to local congregations in their health performance within PPPs. It is clear that if one wishes to utilise intangible RHAs in health performance, then one needs a new, more holistic understanding of faith and health as well as an embodiment of religious discourse. For this purpose, Gary and Cochrane have developed an RHA matrix. By highlighting intangible RHAs, they suggest that one may consider faith an important resource in health (Gary & Cochrane 2012). In other words, when assessing what contributes to health and healing, a far broader variety of intangible elements, such as church services that include prayer and blessing, should be considered assets than what is normally the case in health science or development research, as many of these assets are often ignored when health work is planned and evaluated. Uncovering more knowledge about these assets is particularly important in a country like Tanzania where, as already mentioned, church organisations play a central role in healthcare (Nordstokke 2016).

3. Method and material

This chapter starts with a description of the methodological approach of the study, followed by a description of the pilot study and the three case studies, including an overview of the specific qualitative methods used in the fieldwork. Finally, I discuss the interpretation and analysis of the data with specific reference to gender, language and ethical considerations.

An abductive qualitative approach

This study is based on an abductive qualitative approach (Timmermans & Tavory 2012). This type of approach was chosen as a consequence of the overall character of the aim and the analytical framework for the study, which is of a qualitative nature, exploring experiences, attitudes, values, beliefs and motives (Kvale 2007; Pettersson 2000). By arguing for the importance of moving beyond a single narrow instrumental analysis of religious organisations, I try to shed new light on our understanding of the performance of church organisations in health sector development. The study moreover contains unique extensive fieldwork conducted in Tanzania over a number of years.

Abduction proved to be a useful methodological approach to validate previous knowledge as well as to make new discoveries in logic, systematic and explorative ways. The development of the analytical framework, the empirical fieldwork, as well as the analysis of the case studies have been done in a qualitative way (Timmermans & Tavory 2012).

The position and reflexivity of the researcher

I undertook the research in the Tanzanian health sector during the period of 2011–2014, and it is built on a decade of previous personal experience from the Tanzanian context: coordination of development programmes and participation in networks in academia, civil society and religious networks. As I developed a deeper understanding of the country's political, cultural, social and religious spheres, I became more self-aware, which proved very useful when managing a study of this kind. Throughout the research process, I prioritised extensive presence in the field, as the length of time a researcher spends engaged in data collection influences the kind of findings he or she

may discover (Mikkelsen 2005). In order to expose existing gaps and to get meaningful feedback on the findings, I discussed my results with a team of Tanzanian sociologists of religion at the University of Dar es Salaam, in particular at the beginning of the data analysis phase.

Who I am as a researcher, and also my level of critical and conscious introspection, has clearly to a high extent affected the type of data I have been able to collect, as well as my individual interpretation of the material (Clissett 2008). However, I am aware of the fact that neither researchers nor the people being researched have fixed identities (Geleta 2014). The “insider” or “outsider” positions are contextual, changing from time to time and place to place. Since I have lived and worked in East Africa, mainly Tanzania, for more than a decade, it is also hard to draw a clear line between the two positions, even though I primarily considered myself an outsider throughout the study. I have been a participant in the social reality I have studied, while at the same time being a critical outsider, observing and reporting on the same reality. Reflexivity, understood as my awareness of possible implications and biases (values, prejudices and assumptions), has been my strategy in the process of generating knowledge. In this context, my interviews are means of knowledge exchange and construction in ontological and epistemological ways (Kvale 2007; Mikkelsen 2005).

Since the empirical study was conducted in a developing context in Sub-Saharan Africa, my position as a white European researcher at times proved both complex and challenging. The social distance created by wearing a “researcher hat”, however, was a welcoming space for reflection (Lichterman 2002). It contributed to a safe space for the church leadership and the government officials, since I worked in accordance with certain required ethical principles. As I occupied different positions and a number of attributes, such as sex (female), professional status (i.e. academic/development professional), ethnic background (i.e. white/European Christian), it is hard to analyse which personal attributes influenced the study most. Nevertheless, my background obviously coloured my vision to some extent and also influenced my access to the research field (Timmermans & Tavory 2012; DeWalt & DeWalt 2011).

Throughout the research process, I strived to reflect upon my position in the midst of complex, shifting and overlapping religious, political, economic, cultural, social and gendered contexts. As part of this reflection, I reached the conclusion that several interviewees presumably perceived me as a development expert, probably due to the Western dominance over the global agenda for global health and Public Private Partnerships (PPPs) in health. It also seems as if some interviewees mistakenly associated me with the Lutheran majority church, the Church of Sweden, due to my affiliation with the Department of Theology at Uppsala University.

However, I tried to move beyond the obvious “race-class-gender trifecta” and to consider more of what I had brought to the table as a researcher in

terms of life history and underlying theoretical and ideological assumptions, considering that my analytical and ideological assumptions and the theoretical lens I applied likely influenced the study more than my personal attributes. For this very reason, an abductive qualitative approach has proven very suitable.

In order to avoid too many misinterpretations due to cultural and language barriers, I have validated key results with a selection of key interviewees and stakeholders after the study was completed (during the period of 2015–2017). Furthermore, with the aim of broadening my insights, I used multiple verification methods, often referred to as triangulation of methods (Mikkelsen 2005). Combining more systematised methods of data collection (qualitative policy text analysis and semi-structured interviews) in conjunction with less systematised methods (such as participant observation) improved both the quality and the consistency of the study (DeWalt & DeWalt 2011).

As a development researcher in the field of sociology of religion, I have strived to contribute to the development context in Tanzania by relating my findings to the larger policy picture and by engaging myself as a researcher in stakeholder meetings and ongoing national and international dialogues, including ongoing policy forums within the respective church organisations studied, as well as at international academic conferences.

There is a risk, however, that development researchers increasingly find themselves in the same category as the development practitioners, discovering that they have adopted their vocabulary and development buzzwords. The recognised need for research to enhance the preparation, performance and sustainability of aid interventions, projects, programmes or policy support has fostered a profession of “development specialists”, who are increasingly intersecting the roles of development researchers (Mikkelsen 2005). I tried to keep a good balance between the roles, and to keep a measure of both integrity and distance, while still making development research relevant in terms of policy. At the same time, I acknowledged that research is crucial and can make a great contribution to poverty reduction and recognition of health rights, not least in the realisation of the Global Sustainable Development Goals (United Nations 2017c).

Pilot study

A pilot study was conducted over two months in order to set the research design, identify key stakeholders and obtain a research permit. During the pilot study, I became an affiliated researcher at the Department of Sociology and Anthropology at the University of Dar es Salaam. The university assisted with the application to the Tanzanian Commission for Science and Technology to obtain a research permit and a work/residence permit, including an ethical approval for this study. My knowledge and former experiences from working in Tanzania and East Africa helped me overcome some of the

methodological challenges faced in this process. Key tasks during the pilot study were the identification and choice of case studies and the selection of policy documents and secondary sources for the main study.

Ten interviews were conducted during the pilot study, which later served as a base for developing the four interview guides (Appendix 1: A-D). The first six interviews were carried out with official representatives of a few selected organisations: Senior Social Scientist Sustainable Development, World Bank Tanzania; Lead Health Policy Specialist, World Bank Tanzania; Public Official, the President's Office Regional Administration and Local Government; External Health Sector Adviser, Christian Social Services Commission; Technical Support Service Officer (Health Unit) and Christian Social Services Commission and External Health Adviser, Free Pentecostal Church of Tanzania. The other four interviews were conducted with scholars at the University of Dar es Salaam. The interviews proved beneficial, allowing me to familiarise myself with the research context and the PPP policy. Among other things, the pilot study taught me how the PPP framework is structured and implemented at the general level in Tanzania, and also how church organisations collaborate with each other and public health authorities in general. I also gained insights into the latest transformations related to the PPP framework in health.

Case study methodology

I apply a case study methodology as I wish to grasp both the interaction between the phenomena in focus as well as the context, and at the same time the particularity and complexity of the three single cases (Bennett & George 2005; Gillham 2000; Stake 1995). In sociology of religion, case study methodologies are appropriate when the aim is to build an increased understanding rather than predicting outcomes (Leavy 2014). I managed the three case studies with the overall purpose of getting insights into the research questions (Stake 1995). The aim has not been to emphasise representation within the religious landscape or Christianity, but rather to find the conditions under which certain strategies, positions, beliefs and values occur and also to identify potential variations between the different cases.

Selection of the three case studies

The three case studies are not representative of all religious organisations in the health sector, but represent a good spectrum of different types of Christian denominations in Tanzania. It is, however, important to stress that not all major Church organisations are included in the study. The aim is not to compare the single case studies with each other as belonging to different Christian denominations. The aim is instead to study the role of religious

agents in development through the prism of contractual partnerships between Christian church organisations and the Tanzanian government in healthcare delivery, by identifying larger patterns occurring in all three cases as well as unique insights from each of the individual case studies.

There is a great deal of diversity among Christians in Tanzania with respect to denominational affiliation and neither Catholics nor Protestants form a clear majority. According to the Pew Forum on Religion and Public life, about 51 percent of all Christian Tanzanians are Catholics and 44 percent Protestants. The Catholic Church in Tanzania is united and diverse at the same time. On one hand, the church is centrally structured under the Tanzania Episcopal Conference (TEC), but at the same time the TEC it is made up by several diverse Catholic orders. Protestantism in Tanzania is in itself diverse, with a unique blend of denominational affiliations, such as Lutherans, Anglicans, Pentecostals, African Independent Churches, Baptists, Seventh-Day Adventists, Presbyterians, Methodists, etc. Within the protestant group of Christian denominations, the Evangelical Lutheran Church in Tanzania (ELCT) is the largest protestant denomination, representing 13 percent of all protestant Christians.

Three church organisations were strategically selected for the case studies, based on their status with regards to membership, levels of institutional public partnership, healthcare provision, number of members and theological doctrines (Esaiasson et al. 2007). This was done in order to cover the broadest spectrum of church organisations; namely, Catholic, Lutheran and Pentecostal (Afrobarometer 2008). However, it is important to note that the selected church organisations do not serve as a statistically representative sample, and also that there are other prominent church organisations in the health sector, such as the Anglican Church, not included in the study.

I selected the church organisations with support from the Ministry of Health and the Christian Social Services Commission's (CSSC) database for Church Health Facilities. This resulted in the selection of three identified church organisations, namely the Tanzania Episcopal Conference (TEC), the Evangelical Lutheran Church in Tanzania (ELCT) and the Free Pentecostal Church of Tanzania (FPCT). Together these church organisations account for about 35 percent of healthcare services in Tanzania (Ministry of Health 2016).

For each church organisation, a corresponding church-based hospital is included as part of the respective case study at the local level. I visited additional stakeholders, including the National Public Private Partnership Unit and the Prime Minister's Office of Regional Administration and Local Government, several non-governmental organisations, international FBOs and the World Bank (Health Unit). These formal and informal consultations resulted in the first selection of the three church-based hospitals and corresponding local governments. In the case of the Roman Catholic Church (TEC), St. Francis Referral Hospital in Ifakara was initially selected as the

local case study. After the first field study was conducted in July-October 2011, it occurred to me that the hospital had a central agreement with the Swiss Embassy in Dar es Salaam. It was also clarified that it had special agreements and a direct partnership with the Ifakara Health Institute. A core international contract and a large portion of external funding would have made it hard to distinguish the unique role of PPPs in the local setting. For these reasons, the local case of the Roman Catholic Church (TEC) was in 2011 changed to the St. Francis Turiani Mission Hospital in Mvomero District.

All the selected hospitals were situated on the mainland, in the rural areas of Tanzania, namely in the Muslim dominated region of Pwani,¹ the Muslim-Christian mixed region of Arusha² and the predominantly Christian region of Morogoro.³ Church health facilities and Council Health Management Teams included in the study are (1) TEC – St. Francis Turiani Mission Hospital in Mvomero District; (2) ELCT – Selian Lutheran Hospital in Arusha Region; and (3) FPCT – Mchukwi Mission Hospital in Rufiji District. All of these cases illustrate relevant collaborative forms between local governments and church organisations: Grant-in-Aid, Council Designated Hospitals, Service Agreements and Health Basket Funds. The map below (Figure 1) serves to situate my three case studies; TEC, ELCT and FPCT and their respective headquarters in a geographical setting. I have also placed the three local church-based hospitals included in the study on the country map.

¹ At the time of the study, the region of Pwani included the following six districts: Bagamoyo, Kibaha, Kisarawe, Mafia, Mkuranga and Rufiji.

² At the time of the study, Arusha Region included the following seven districts: Meru, Arusha City, Arusha District, Karatu, Longido, Monduli and Ngorongoro.

³ At the time of the study, Morogoro included the following six districts: Gairo, Kilombero, Kilosa, Morogoro, Mvomero and Ulanga.

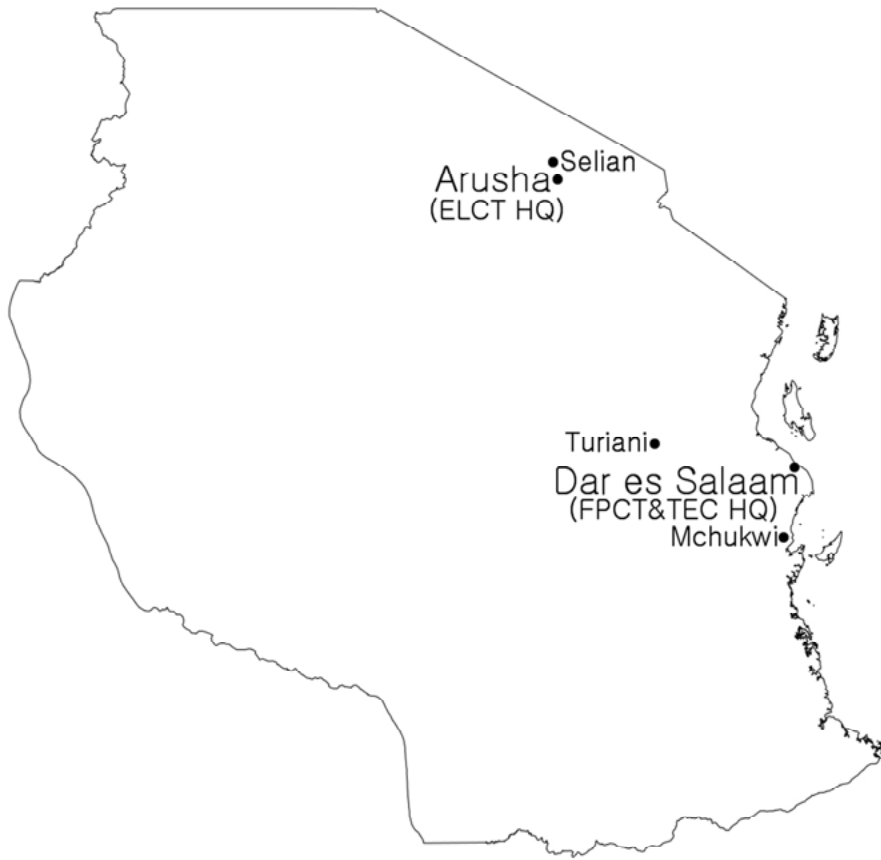


Figure 1. Map of Tanzania

Work plan for the case studies

The study includes national and local public authorities and their relationships to, and views on, the related church organisations, thereby capturing a mutual perspective and a more comprehensive understanding of the contractual partnerships (PPPs) in the health sector (Table 2). Furthermore, in order to ensure that the study captures Tanzania's unique institutional contexts, the Local Government Reform Programme is taken into consideration. Since contractual partnerships are now concluded at the local level, I have been open to the possibility of variances in local collaborative forms, subcontracting and informal stakeholder relationships. The financial policies and subcontracts concluded between the church organisations and the local government authorities are also analysed. The empirical results from the local case studies serve as a foundation for gaining deeper insights into the

public private partnerships in health. Relevant national policy documents and strategies on Private Public Partnership and positions adopted in health policy formulation are also analysed. In order to increase my contextual understanding of PPPs in health and how church organisations relate to other non-profit actors in the health sector, I have conducted interviews with representatives from the World Bank, the Tanzanian Council for Social Development, IMA World Health (Inter-Church Medical Assistance, Inc.) and the Christian Social Services Commission.

Table 1. Research design

	State	Church organisations
National	Public health authorities: Ministry of Health	The national secretariat of three church organisations: TEC, ELCT and FPCT
Local	Three local governments: Council Health Management Teams in Rufiji, Mvomero and Arusha rural	Three corresponding local church health facilities operated by TEC, ELCT and FPCT in the districts of Rufiji, Mvomero and Arusha rural

The case studies have been carried out in blocks (a few months at a time), starting with an initial four-month field study, July-October 2011. During the first part of this period, letters were submitted to the secretary-generals of the selected church organisations, where I formally requested the official approval of their participation in the study. Likewise, the interview guides were constructed and translated into Kiswahili with support from a Tanzanian linguist. The second period of fieldwork took place March-May and October-December 2012, with follow-up work in February 2013 and September-November 2014, which led to some preliminary data analysis. This was also integrated with periods of data collection at the local sites in Tanzania. Interview transcripts, policy texts and field notes have served as complementary documents. This work immediately followed the semi-structured interviews and observations, where the generated data was organised with completed notes facilitating the initial analysis.

The specific geographical sites are not in focus in the analysis, even though the different cultural, religious, social and political circumstances in the three selected local sites in Tanzania are important to some extent.

Methods

Triangulation has been applied through the use of multiple data sources and a qualitative method mix, comprising qualitative text analysis, semi-structured interviews and participant observations. These three methods are described and discussed in the following section.

Policy text analysis

The key issues in the study are examined through qualitative policy text analysis. Several policy documents have been reviewed as part of this process. The analysis focuses on three main types of documents: (1) government policies; (2) church policies; and (3) official statements. Qualitative policy text analysis also serves as an essential and valuable tool in the analysis of the transcribed interviews. The origins, purpose and original audience of any document were initially carefully examined. This was followed by overall policies, such as an analysis of the Tanzania Development Vision 2025 and the National Strategy for Growth and Reduction of Poverty. The qualitative policy text analysis also included the National Health Policy frameworks (2003 and 2007). Secondary data was included from the World Values Survey, the World Religion Database and the Afrobarometer, including different policies and statements from the respective church organisation. Sixteen policy documents have been included in the qualitative policy text analysis (Table 2).

Table 2. Selected policy documents

Document/Policy	Publisher/Author
The Tanzania Development Vision 2025	The Government of the United Republic of Tanzania.
The National Strategy for Growth and Reduction of Poverty II 2010	The United Republic of Tanzania. Ministry of Finance and Economic Affairs.
National Public Private Partnership (PPP) Policy. November 2009	Prime Minister's Office.
Health Sector and Social Welfare Public Private Partnerships Policy Guidelines. Nov. 2011	Ministry of Health
United Republic of Tanzania: National Health Policy (2003; 2007)	Ministry of Health
Comprehensive Council Health Planning Guidelines. July 2011	Ministry of Health
The Second Health Sector Strategic Plan (2003–2008)	Ministry of Health
The Third Health Sector Strategic Plan (2009–2015)	Ministry of Health
Sample contract for Service Agreement. August 2007.	Ministry of Health
Sample contract for CDH agreement. 2011.	Prime Minister's Office and the respective church organisation.
Christian Sermon Guide for Reproductive and Child Health: A Toolkit for Tanzanian Religious Leaders	Ministry of Health and the Christian Social Services Commission.
The ELCT Health Service Charter. 2010.	Evangelical Lutheran Church in Tanzania.
Tanzania Catholic Church Health Policy. June 2008.	Tanzania Episcopal Conference.
Statement: "The Role of the Church in	Tanzania Episcopal Conference.

Providing Social Services – Special Attention to Health”. 25–27 June 2007.	
ELCT in Tanzania “The Bagamoyo Statement”. Arusha 1994.	Evangelical Lutheran Church in Tanzania.
Joint statement of the private health sector.	The private health actors in Tanzania (including FBOs, NGOs and purely private institutions).

Semi-structured interviews

I conducted 62 semi-structured interviews. All interviews were audiotaped and transcribed, as it is preferable to capture the real words of interviewees rather than recording the researcher’s annotated summary of the interaction (DeWalt & DeWalt 2011). All interviewees were informed and gave their permission for the recording and transcribing procedures.

I used semi-structured interviews for understanding the meaning of central themes related to the PPPs. Semi-structured interviews are known to give access to fragments of people’s ideas, thoughts and memories in their own words, but at the cost of a reduced ability to make systematic comparisons between interviewees (Taylor 2002). In this study, every interview included prepared questions and a sequence of themes to be covered. Still, it was possible to alter the sequence in order to follow-up the answers given.

An interview operates on two levels. On the one hand, it seeks to cover facts, in this case concerning the PPPs in the health sector. On the other hand, it aims to create meaning, even though it is usually more difficult to interview on a level of meaning (Kvale 2007; Mikkelsen 2005). Phenomena tend to have meaning in a given context and this meaning differs according to the prevailing contexts (Whiting 2008). One way of overcoming these difficulties was by having the position of a University of Dar es Salaam research associate, which enabled me to work in collaboration with a group of Tanzanian sociologists and development researchers. This enabled me to test my interview guides beforehand.

There are some specific factors to consider when conducting cross-cultural interviews (Kvale 2007). When conducting the interviews, I strived to demonstrate a sound knowledge of the interview topic, combined with sensitivity to the social relation between the interviewees and myself. However, I must admit that interviewing hospital directors and Council Health Management Team members during working hours offers its own sorts of limitations. There were frequent interruptions, which tended to reduce concentration and focus. As a result, I was in several cases forced to postpone interviews until the next visit. At other times, interviews changed into group discussions as some other staff member or representative entered the room, thus making it hard to refuse their participation, in particular when interviewing District Medical Officers.

The strength of semi-structured interviews is the opportunity to observe non-verbal indicators that may be used for evaluating truthfulness/validity as well as urgency (Kvale 2007). They may also potentially increase response rates in comparison to in-depth interviews (Whiting 2008). The main weakness was the fact that some particular groups, primarily women, were strongly underrepresented since the semi-structured interviews in this study were only conducted with interviewees holding certain official positions within public health authorities or church organisations. This is discussed below in a specific section on gender. Likewise, the interview guides did not consider the unique characteristics of the different interviewees.

Selection of interviewees

The identification of interviewees was carried out through strategic selection (Bennett & George 2005). Interviewees were selected from four categories: (1) public authorities at national level and related stakeholders; (2) church organisations and related NGOs/FBOs at national level; (3) public authorities at local level; and (4) church-based hospitals at local level. The focus was on people with specific information on PPPs in the health sector with regards to the role of church organisations.

The pilot study clarified the management structures at the hospitals and within the local government, while allowing for the identification of key individuals in the respective management groups. The selection of interviewees began after formulating the research questions, constructing the interview guides and selecting cases to study. Interviewees on policy and legal issues from the Ministry of Health were included. At the council level, Council Health Management Teams were included, as were District Medical Officers.

The official representatives from the church organisations or the public health authorities participating in the case studies were not considered the representative voice of the entire membership of these church organisations or the Tanzanian government, but rather as key individuals within these institutions. For a comprehensive overview of all the interviewees included in the study at the national and local level, as well as their function/position, see Appendix 2.

Interview guides

To facilitate the process of enquiry, four interview guides were constructed and used, one for each category of interviewees (Appendix 1). The questions in the guides focus on the collaboration between church organisations and public health authorities, church-based hospitals and health sector development at large. Each respective interview guide is based on results from the pilot study and the initial field study conducted in Tanzania during 2010–

2011. The interview guides are directly linked to the aim and research questions of the study, and each guide is designed to raise different types of questions with the overall aim of directing the interviewee in a clear but unobtrusive manner.

The questions have been constructed to fit the format of a face-to-face interview. The first interview guide is designed for interviews with representatives of health departments and health institutions within the church organisations at a national level. This guide also includes questions to the church leadership of each organisation, including the bishop and secretary-general, to examine their view on the relationship with the government with regards to healthcare delivery and related subcontracting. This guide was also used for interviews with the national representatives of the Christian Social Services Commission. The second interview guide is mainly designed for interviews within the Ministry of Health. This guide uses a structure similar to that of the first interview guide. The third interview guide is designed for interviews with representatives of church-based hospitals at the local level, for example hospital directors, hospital administrators, hospital accountants or/and hospital matrons. The fourth interview guide is designed for interviews with the Council Health Management Team members, including District Medical Officers. The interview guides follow a special structure as suggested by Leech (Leech 2002).

Participant observation at the local level

The participant observation mechanism was the most time-consuming element of the research process. The local cases included participant observation in the context of the three selected church-based hospitals. It gave me as a researcher a deeper understanding of the social challenges surrounding healthcare facilities and their relationship to the nearby congregation and the church leadership. Participant observation was crucial, since the small talk outside the formal interview setting both gave me a deeper meaning and a clarification of the material collected through the interviews. As a result of participant observation, I was able to better understand the range of perspectives in order to go beyond the broadest generalisations concerning the developmental role of the church organisations. In a similar way, I discovered some inconsistencies between what representatives of the church organisations said more formally and what they actually displayed in practice in the local cases.

In qualitative research in general, and in participant observation in particular, an in-depth understanding of the local setting is prioritised over an even distribution of variables across the studied population (Geleta 2014). Participant observation has the possibility of operating further at the level of meaning, beyond factual dimensions (Kvale 2007). With the help of participant observation, I was able to crosscheck the reliability of the initial findings

through both verbal and non-verbal expressions. Furthermore, living in the research context during longer periods forced me to place my particular focus of the study on the wider context (Geleta 2014). During my time in the field, I had the opportunity to include more voices and actors in the study; in particular nuns and other women serving at the church health facilities, as well as priests, pastors and evangelists leading the devotions at the church health facilities. In the fieldwork process, I strived to understand the underlying sources of diversity, primarily in terms of age, gender, income, ethnic identity and religious affiliation.

During the participant observation sessions, I was present at the church-based hospitals and participated in their daily activities, interactions and events with the purpose of learning both the explicit and the more implicit aspects of these hospitals. Several scholars argue that participant observation needs to be distinguished from both pure observation and pure participation in order to find a balance between the two as a way of handling the emotional involvement of researchers (DeWalt & DeWalt 2011).

After completing the participant observation in 2014, I analysed my own level of participation in accordance with an existing standard framework. The level of participation I thought best described my engagement at the time was *moderate participation*, defined as being present at the scene of the action, being identifiable as a researcher by most people, but not actively and more personally involved. In a few cases, I was encouraged to adopt a greater degree of participation; for example presenting myself in official devotions at the church-based hospitals or at Sunday services in nearby congregations. In these few cases, my participation was moved up more to the level of *active participation* (DeWalt & DeWalt 2011).

One of the challenges I encountered was the fact that neither the interaction between churches and their respective healthcare institutions, nor the theological reasoning, took place in a formalised way. Conceivably, these relationships took the form of informal social networks only observable through participant observation and personal conversations. Participant observation made it easier for me to capture the nonverbal expressions and gestures I was unable to pick up through the audio records of the semi-structured interviews.

My behaviour has clearly been affected by factors such as age, gender, ethnicity, religion, class and a number of cultural differences. My ideas and notions were continually challenged and met with some resistance from people within the different settings. I therefore tried to balance the interaction between observation and participation. My emotional involvement was to some extent adapted to the different sites depending on the level of trust reached and the type of relationship established. During the initial fieldwork (2011), these relationships varied between more formal and informal (DeWalt & DeWalt 2011). At the end of the study (2014), however, most of my relationships were more informal and personal in nature. There are dif-

ferent methods for writing field notes. The best description that matches the format of my field notes is *analytic notes*, as they include comments on notes, a summary of the evidence for a particular argument collected, preliminary interpretations and questions for future research (Schensul et al. 1999).

Corruption is widespread in the Tanzanian health sector (World Bank 2013). This situation made it difficult to map out some power relations and economic interests. However, the participant observation made it easier for me to access additional information on different funding strategies. In order to structure the analysis of the participant observation, I summarise the different forms of participant observation below (DeWalt & DeWalt 2011).

Table 3. Forms of participant observations at the church-based hospitals

Form/method	Comments
Living in the context for an extended period of time	Pilot study 2010–2011. Fieldwork 2011–2014. Validation of key results 2015–2016.
Learning and using the local language	Kiswahili
Actively participating in a wide range of daily, routine and extraordinary activities with people who are full participants in that context	Morning devotions at church-based hospitals, attending meetings with Council Health Management Teams and Hospital Management Teams, accompanying chaplains and evangelists in their daily work, visiting the private homes of hospital workers, engaging in dialogue with medical missionaries on site and with global partners.
Using everyday conversation as an interview technique	Entering into a dialogue with the interviewees rather than conducting a one-sided investigation. Trying to map network relationships, which were hard to grasp during semi-structured interviewing.
Recording observations in field notes	Written memos.

Interpretation and analysis

The data was reviewed and analysed in three main steps: (1) primarily, the 16 *policy documents*; (2) secondly, the 62 *interview transcripts*; and (3) thirdly, the *memos* from the participant observations. The next step in the content analysis was categorising the data. The highlighted statements from the three key sources were reduced into categories with a similar meaning or connotation.

The categories have been created thematically in response to the five research questions of the study. I attempted to identify substantive statements in relation to each of the five research questions and I strived to keep track

on how to trace the themes back to their original sources, policy text, interview transcript or memo from the participant observations. The data was compiled and analysed using the computer software Nvivo 10. The analytical framework, consisting of Beckford's three perspectives (instrumental, bottom-up and integral) also assisted in the process of structuring the categories (Beckford 2017). Below follows a description on how I have dealt with different elements in the content analysis (Hardy et al. 2004).

The meanings in this study are constructed in a particular context. In this process, I have played a key role as a researcher. The categories are based on the data, while I as a researcher have constructed the categories as such. However, the analytical framework is based on Beckford, who has provided ideas for what to look for. The research questions also provided initial guidance. The categories that emerged from the data allowed for coding schemes involving an analysis of the frequency and type of representation of different meanings in the text. The analysis was an interactive process of working back and forth between the policy texts, the interview transcripts and the memos in relation to the research questions and the analytical framework. The analysis located the meaning of the text in relation to the different social, religious, cultural and political contexts of the study. The results are reliable to the extent that they are understandable to researchers who wish to conduct a replication of the study. The results are valid to the extent that they show how patterns in the meaning of texts are constructed. In the analysis, I have tried to describe my role as a researcher.

By categorisation, the meaning of long statements was reduced to a few simple categories, which were supported with the help of quotes. The analysis proceeded by highlighting essential statements, after which the quotes were re-written in a readable style. The opinions were then compared with views from other interviewees to see whether they appeared in other interviews. When they are presented, I strive to contextualise the quotes to some extent, so that the reader is able to identify the question prompting the answer and the larger interview context from which the quote is extracted (DeWalt & DeWalt 2011; Kvale 2007). The process of analysis was interactive, although the design and implementation of the study took place in three main phases. This was an ongoing process with feedback into the research design. In order to increase reliability, the original data is available to reviewers of the study in accordance with ethical principles. After the study was completed in 2014, in the period of 2015–2016, I also organised feedback seminars with various stakeholders in Tanzania in order to validate my observations.

Significant methodological considerations

Gender

I consider the gender factor an important and relevant aspect to evaluate. For this study, I have considered the gender factor in two ways: (1) the ways in which my own sex (being a woman) has influenced the study; and (2) gender dynamics more structurally in, for example, the place, representation and participation of women within the health sector performance of the three church organisations.

Regarding the first factor, I have experienced that being a woman may represent an advantage in this type of field research, since access to social space is gendered. It is possible that I gained access to male research subjects by emphasising desexualized aspects of my femininity, such as being a mother, since I was pregnant twice during the fieldwork period. Regarding the second factor, I can conclude that women have been significantly underrepresented in the study, partly due to the research design with a focus on stakeholders and decision-makers in health. Due to the sampling method and the unique Tanzanian context, gender appears to be the most significant variable of underrepresentation in this study. The vast majority of the interviewees were men. However, it is important to point out that once the study moved beyond the formal structures of the church-based hospitals, the gender gap became less important. The inclusion of nurses, nuns, volunteers and international partners results in a different picture. This finding is congruent with other studies on welfare and religion (Edgardh 2004). These gender imbalances exist in the local governments. As an example, all District Medical Officers in the case study areas were male, just like the church leadership included in the study: bishops, secretary-generals and heads of the church health departments, as well as all hospital directors. Using participant observation enabled the addition of the experiences, attitudes, values, beliefs and motives of women, even though the data collection was less formal. In the case of local governments, I decided to ask all the representatives of the respective local Council Health Management Teams to participate in the study in order to allow for an opportunity to relate to and observe the dynamics and the different voices in the team, including women.

Language

This study was conducted in English and Kiswahili, the two official languages of Tanzania. All official policy documents collected and analysed from the government and the church organisations were available in both English and Kiswahili, as required in the constitution. The English versions of the policies were utilised for the policy analysis, hence all citations are referred to in English. Interview guides were translated to Swahili with the

support of a Tanzanian linguist. The vast bulk of the interviews were conducted in English, and a few in Kiswahili. In these cases, the interviews were conducted in collaboration with, and supported by, a Tanzanian sociologist in order for me to increase confidence and precision. Both English and Kiswahili were spoken during participant observations.

Ethical considerations

Development research has far-reaching ethical implications, stemming from interventions in social and cultural processes. All parts of the study have been assessed and presented in line with ethical principles of research (Longhurst 2009). I submitted the initial research design for review by the Tanzania Commission for Science and Technology. The research was conducted in line with the Code of Ethics Approved by the International Sociological Association and the Code of Conduct for Social Science Research by UNESCO and the Swedish Research Council (UNESCO 2017; ISA 2011).

Interviewees were guaranteed that the information supplied would remain confidential and that they would remain anonymous (unless they desired otherwise). Interviewees also had the right to withdraw from the study at any time without explanation. Interviewees were also promised a summary of the research results at the completion of the research project (Longhurst 2009). With regard to the use of participant observation, I followed recommendations in line with established research, as there are ethical considerations to be made regarding behaviours and wording associated with a particular culture (Longhurst 2009; Mikkelsen 2005). As a researcher, I strived to maintain a high level of integrity, even though unplanned expectations were sometimes placed on me, as if I would bring valuable funding, networks or strengthen capacity. All participants were briefed and informed on the terms of their participation.

The main ethical considerations concerned decisions about what and how to publish (DeWalt & DeWalt 2011). My role was neither to make judgments concerning the truth or desirability of particular values or beliefs, nor to urge a greater or lesser role for religious organisations in PPPs. Instead, my aim was to gain a better understanding of processes of social and religious change in Tanzania by exploring the experiences, attitudes and values of the representatives of the organisations. Since the study was centred on key individuals in their capacity as official representatives of organisations, I chose not to include truly introspective questions regarding faith-identity, instead choosing to relate the study more to the organisational context.

In order to avoid the interviews and observations becoming superficial, it was important to develop trust whilst upholding ethical principles, such as the anonymity of the interviewees and the contextual analysis of their statements. Patton has specifically developed a checklist for ethical issues occurring in development field research (Mikkelsen 2005, p. 343). These princi-

ples have all been taken into consideration in the research design, data collection and data analysis, as well as in the publication phase. I likewise strived to guarantee that the interview process did not exploit the emotional vulnerabilities of the interviewees simply to gain data and that the interviews did not provoke unnecessarily upsetting emotions. I also informed the interviewees that they were free to access the transcript and the analyses after the interviews. None of the interviewees requested to receive the transcript. I also presented preliminary findings at different seminars in Tanzania in the period of 2015-2016, both at the University of Dar es Salaam, in the districts and at the National Audit Office of Tanzania.

4. Tanzanian churches as development agents

This chapter introduces the more specific religious context of the empirical study and serves to contextualise the relationship between religion and development in Tanzania in a historical perspective. I start by reflecting on the development process at large and the position of religion in Tanzanian society, a growing and dynamic research field. Here, I highlight how religion has both contested and contributed to development policy in Tanzania, and also how the Tanzanian model of secularism has come to influence the role of religion in development. This is followed by an overview of the Christian missionary societies and their relationship to the previous colonial state and their encounter with African traditional religions. Then I discuss the church-state relationship following independence under the influence of liberalisation. Finally I look into the present church-state relationships, with a focus on three main dynamics: (1) churches as key development partners; (2) the quest of Muslims for equal treatment; and (3) churches as safeguards of democracy and human rights. Overall, the chapter serves to contextualise the relationship between religion and development in Tanzania.

Tanzania, with its population of 56 million, faces considerable challenges in terms of development, not least in areas such as poverty, shrinking space, economic distribution, religious tensions, gender inequality and HIV/AIDS. Sixty-four percent of the population is below the age of 25 and four-fifths live in rural areas. The overall development framework of Tanzania is laid out in the National Vision 2025, which, among other things, aims to achieve access to quality primary healthcare for all and access to quality reproductive health services for every one of the appropriate age by 2025.⁴ Despite a stable economic development over a number of years, 47 percent of the population is living on less than 1.90 USD a day. A majority of the poor live in rural areas (see table 4).

⁴ Tanzania Ministry of Finance (2017)

Table 4. Country profile 2016

Tanzania country profile	
Population, total (millions)	55.57 million
Population growth (annual %)	3.1%
Surface area (sq. km) (thousands)	947.3 thousand
Life expectancy at birth, total (years)	65 years
Fertility rate, total (births per woman)	5.1 births
Births attended by skilled health staff (% of total)	64%
Mortality rate, under age of5 (per 1,000 live births)	49 births
Primary completion rate, total (% of relevant age group)	74%
Prevalence of HIV, total (% of population aged 15–49)	4.7%
GDP growth (annual %)	7%
Population living on less than \$1.90 a day (2011 PPP) (% of population)	46.6%

Source: World Development Indicators database 2016

The place of religion in Tanzanian society

Religion in Tanzanian society is characterised by high visibility. Religion is deeply embedded in the lives of people (Jones & Petersen 2011). In their 2009 study, the Pew Forum on Religion and Public Life found that religion plays a central role, with some 93 percent of Tanzanians describing religion as “very important” in their lives (Pew Forum on Religion and Public Life 2010). Religion forms the basis of living, helps determine attitudes and decision-making and is the root of the Tanzanians’ search for wellbeing (Mushi & Mukandala 2006).

In pre-colonial times, there was no or little separation between politics and religion, as the welfare of the community was regarded as being in the hands of unseen forces (Green et al. 2010). Indigenous African religious ideas, values and attitudes were expressed in all aspects of life, and religion permeated all spheres of social, economic and political life (Ndaluka 2012). African traditional religions are still central in Tanzania and essentially local in character (Marsland 2007). They neither claim universality nor seek to spread their religious conceptions beyond the local context (Lawi & Masanja 2006).

Cultural and religious practises are closely interlinked (Magotti 2015; Bryceson et al. 2010). This reality is sometimes labelled “integrated religiosity”, defined as there being little or no separation between religion and other social actions (Mhina 2007a, p. 15). This is seen in religious leaders frequently being recognised for their public performance in politics, economics,

social and culture life (Green et al. 2010; Marsland 2007; Bakari & Ndumbaro 2001). At the same time, violations of human rights in the name of religion are carried out on a regular basis by means of human sacrifice to appease gods, involving the killing of deformed children and albinos (Cohan 2011; Bryceson et al. 2010; Green 2005). In 2009, the Tanzanian government introduced a new law criminalising traditional healing practices. In 2015, the law was enforced and the police arrested a few hundred traditional healers (Utrikespolitiska Institutet 2017).

Religious leaders are highly respected in society, not only by their followers but also by local public authorities (Bakari 2012). People look up to religious institutions for spiritual guidance and these institutions play a critical role in service provision (Jones & Petersen 2011; Tortora 2007). Religious beliefs to a high extent also influence individual behaviour and community actions; for example, health-related practices and health-seeking behaviour (Gary & Cochrane 2012; Cohan 2011). A 2010 Pew Forum Study found that a large majority of Tanzanians attend religious gatherings on a regular basis. Thus, an estimated 83 percent of Christians and 82 percent of Muslims regularly attend religious services on a weekly basis or even more frequently (Pew Forum on Religion & Public Life 2010, p. 27). Churches and mosques also continue to be utilised for a variety of development activities, including civic education and reproductive and child health education (Sigalla 2015; Ministry of Health 2011d; Ministry of Health 2011d).

Religion is also a crucial factor in trade and economics. For example, the National Bank of Commerce in Tanzania offers Sharia compliant Islamic banking based on the principle of Qardh (The National Bank of Commerce 2016). Tanzanians donate a lot of money to religious institutions, where politicians and business executives make particularly significant donations (Leurs et al. 2011). New religious actors and some charismatic religious movements are promoting “the gospel of prosperity”. Many religious groups are also committed to social justice issues by standing up for the poor and the underprivileged (Green et al. 2010).

At the same time, political tensions and conflicts in Tanzanian society are increasingly related to religious affairs and the mobilisation of religious identity (Bakari 2012). Religion often constitutes a divisive factor and religious tensions have grown in Tanzania since the mid-1980s (Bakari 2007; Mhina 2007a). Outbreaks of violence related to religious divisions have increased significantly since 2012 (Tanzania Development Research Group 2013). As an example, on December 31, 2012, former president Jakaya Kikwete declared that the country, for the first time in its history, faced the risk of civil strife and division along religious lines (Bureau of Democracy 2013). On May 8, 2013, the former presiding bishop of the Evangelical Lutheran Church in Tanzania (ELCT), Dr. Alex Bishop Malasusa, made this comment on peace in Tanzania: “Our community seems to have forgotten

that our predecessors nurtured peace in Tanzania and we need to be vigilant at all times to foster and groom it” (Lobulu 2013, p. 2).

Despite being religiously diverse, Tanzania’s citizens have a good record of living together side-by-side in ways that transcend their religious differences (Poncian 2015; Magesa 2007). The prevalence of mixed marriages between Muslims and Christians and the religious diversity characterising political parties are all seen as signs of religious tolerance (Heilman & Kaiser August 2002). Interfaith umbrella organisations and inter-religious dialogues are playing an increasingly important role in society (Leurs et al. 2011; Olsson 2011). They serve to foster unity, peaceful coexistence and religious tolerance (Christian Council of Tanzania 2016a; Bureau of Democracy 2013). Both the Tanzanian government and the international donor community have increased their support and funding for interfaith organisations, such as the Inter-Religious Council for Peace, Tanzania (IRCPT) (Norwegian Church Aid 2010).

A diverse religious landscape

The majority of Tanzanians are either Muslims or Christians, who practice their faith with integrated forms of African traditional religions (Bakari 2012; Richebächer 2007). African traditional religions are particularly influential, as they affect how most Tanzanians relate to one another in extended families and in the larger community (Mhina 2007a; Lawi & Masanja 2006; Mhina 2006).

The numerical balance between followers of the different religions is seen as politically sensitive (Havnevik & Isinika 2010). In particular, it is hard to estimate the number of adherents of African traditional religions, since these practices and beliefs are often combined with elements of Christianity and Islam (Lawi & Masanja 2006; Ellis & Ter Haar 2004; Green 2005). Christians and Muslims also believe in spirits and sacrifices to ancestors, and this is said to be especially common among the Catholic Masai (Richebächer 2007). However, some adherents of Christianity and Islam have renounced themselves from the practices of African traditional religions, particularly in the Pentecostal movements (Oestigaard 2014; Dilger 2014; Dilger 2007). According to the 2010 Pew Forum study, 62 percent of the Tanzanian population is directly involved in African traditional religions (Pew Forum on Religion & Public Life 2010, p. 34).

Most Tanzanians uphold these ideas and practises by, for example, consulting traditional healers when someone is sick and by keeping sacred objects like amulets at home (Ndaluka 2015). While the social impact of traditional spiritual leaders tends to be limited to certain spaces, their connection to healing provides them with considerable status in local communities (Lawi & Masanja 2006). The healing powers of Waganga (indigenous healers) are used for multiple purposes, such as explaining wellbeing, in winning

or losing a political position or when explaining sudden deaths (Jones & Petersen 2011; Lawi & Masanja 2006). In particular the Waganga of the Sukuma tribes are famous for their acclaimed knowledge of medicinal plants and healing practices, attracting patients from all over Tanzania in their search for spiritual interventions facilitating healing, wealth accumulation and success (Oestigaard 2014; Bryceson et al. 2010).

The contributions from African traditional religions to the health sector have both been officially recognised and critically examined by public authorities (Bryceson et al. 2010). In the last issue of *Notice on Assignment of Ministerial Responsibilities* on April 22, 2016, the current president, Hon. John Pombe Joseph Magufuli, mandated the Ministry of Health, Community Development, Gender, Elderly and Children to safeguard “the promotion of Traditional, and Alternative Medicine” (Bryceson et al. 2010).

During the last decades, the religious landscape in Tanzania has also been profoundly transformed (Legal and Human Rights Centre 2015). New religious actors and charismatic religious movements, in particular Muslim revivalist organisations and Pentecostal and neo-Pentecostal movements, have entered the scene and continue to expand, in particular in urban areas (Lindhardt 2015; Dilger 2007). These movements have also started to involve themselves in the provision of medical care. Through the establishment of a range of health interventions often tied to revisionist claims about religion, spirituality and politics in society, they are increasingly visible. It is worth noting, however, that these movements tend to operate outside government structures and the PPP framework. In most cases, they are self-funded through private donations and operate more from a charity approach (Dilger 2014; Tomalin 2006).

Identity politics and nation-building

Since independence, the Tanzanian state has promoted religious pluralism and a harmonious coexistence amongst African traditional believers, Muslims and Christians (Anyimadu 2016). Nyerere introduced a political culture and governance system intended to rise above ethnic, religious and cultural divisions, offering a cosmopolitan multi-ethnic, multi-religious identity. Havnevik argues that “by placing the nation as the framework for modernization, the nationalist movement and later the post-colonial state came to repress and undermine cultural, ethnic, social and religious diversity” (Havnevik & Isinika 2010). Although Nyerere’s efforts were geared towards establishing a national identity, critical groups from below (in particular Muslim groups) challenged him by questioning the hidden agenda behind his nationalistic project (Maghimbi 2015; Ludwig 1996; Repstad & Furseth 2006).

The current national debate on religious affiliation and identity is a case in point (Maghimbi 2015; Bakari & Ndumbaro 2006). Tanzania stopped col-

lecting statistics on religious affiliation in its national census survey in 1967 (Jennings 2008a). The reason behind this decision was that the demographic strength of one religion compared to that of others was a politically sensitive issue. After 1967, numerous claims and counter-claims have followed regarding which religious group is dominant in terms of membership. In most official forms, such as passports or records of vital statistics, religion and ethnic identity are still not recorded (Bureau of Democracy 2013; Mallya 2008). However, police reports must state religious affiliation if an individual has to give testimony. Public school registration forms must specify a child's religious affiliation so that administrators are able to assign students to the appropriate religion class. Applications for medical care must also specify religious affiliation so that needs related to religion can be taken into consideration by health facilities (Jennings 2008b).

The latest countrywide population statistics on religious affiliation, as reflected in the National Census of the time (1967), showed that out of 11,762,915 Tanzanians on the mainland, 32 percent were Christians, 30 percent Muslims and 37 percent belonged to African traditional religions. However, considering the political agenda of Nyerere after independence, there is a strong indication that these figures were constructed, as Nyerere needed to ensure that no religion held a majority position (Jennings 2008a; Ludwig 1996). By doing so, neither Muslims nor Christians were able to claim to represent a majority or state religion (Ndaluka 2015; Maghimbi 2015; Mukandala 2006a).

Despite the prevailing policies and the sensitivity surrounding religious identities, several supplementary surveys have been introduced in the last decades measuring religious affiliation (Pew Forum on Religion & Public Life 2010; Afrobarometer 2008; Demographic and Health Surveys 2004). One example is the 2009 Pew Forum on Religion & Public Life survey recording Christians at 60 percent, followers of Islam at 36 percent, adherents of African traditional religions at 2 percent, 1 percent belonging to other religions and 1 percent of the population being classified as "other" (Pew Forum on Religion & Public Life 2010, p. 20). Given the limited sample size and coverage of the Pew Research Forum surveys, their findings should be viewed as broad approximations (Pew Forum on Religion & Public Life 2010). At the same time, it is relevant to note that other external surveys (Afrobarometer 2008; Demographic and Health Surveys 2004) display comparable numbers regarding religious affiliation, as presented in Table 5.

Table 5. Religious affiliation in Tanzania

Statistics on religious affiliation in Tanzania from a selection of available sources					
	Pew Forum (2009)	Pew Global Attitude Project (2008)	Afrobarometer (2008)	Demographic and Health Surveys (2004)	Census (1967)
Christians	60%	64%	63%	57%	32%
Muslims	36%	35%	29%	29%	30%
African traditional believers and religious minorities	4%	---	8%	13%	37% + 1 error

Source: Pew Forum on Religion & Public Life 2010.

Religion-related statistics for Tanzania are still seen as particularly biased and unreliable. Some scholars have questioned the more recent country-wide surveys for underestimating the percentage of Muslims, often by referring back to the 1957 Population Census (Wijsen & Mfumbus 2002; Ludwig 1996; Said 1989; Lodhi & Westerlund 1997). In the pre-independence census of 1957, the ratio of Muslims to Christians was three to two (Bakari 2007). The rapid decline in the number of Muslims that followed in the 1967 Population Census has been at the heart of a heated debate between the state and some Muslim groups (Saeed 2016; Poncian 2015; Liviga & Tumbo-Masabo 2006). In these circles, some argue that the Pew Research Forum and related value surveys are not credible sources (Said 2011; Ludwig 1996).

In 2012, the National Muslim Council of Tanzania (BAKWATA) called for a reinstatement of questions concerning religious affiliation in the upcoming census study, by threatening that Muslims clerics and their followers would boycott the census if the National Bureau of Statistics did not include a clause on religious affiliation (Daily News Reporters 2012; Ludwig 1996). However, up until today, religious affiliation has not been included. It is an interesting fact, however, that alternative figures on the percentage of Muslims are presented in unverified, non-significant online sources, where Muslims are said to represent a majority of the population, around 55 percent (Africa Muslim Population 2016). At the same time, other religious groups in Tanzania are more reluctant when it comes to estimating religious demographics (Bureau of Democracy 2013).

Tanzanian state regulation of religion

Religion is a key factor in Tanzanian politics and national media (Bakari 2012; Mallya 2008). The national radio, Tanzania Broadcasting Corporation (TBC), begins and ends their programmes with Christian and Muslim prayers (Mesaki 2011). In the mass media, religious organisations, both Christian and Muslim are vocal on a range of issues, particularly in newspapers and on the radio (Leurs et al. 2011).

In a 2006 study, *Research and Education for Democracy in Tanzania*, Mhina found that at least a quarter of Tanzanian political candidates consult and visit traditional spiritual leaders before elections (Mhina 2006). At the government level, official meetings, like the opening of parliamentary sessions, include prayers by government leaders. All government executive leaders swear a religious oath (Bible or Quran) of allegiance and faithfulness to the constitution, and the national anthem calls for God's blessing (Wijzen 2015; Ndaluka 2012). Top government officials, such as the president and the prime minister, officially open religious meetings on a regular basis (Mallya 2007).

Freedom of religion

The constitution and other laws and policies protect religious freedom (Freedom House 2015; Bureau of Democracy 2013). Freedom of religion includes the right to manifest religious belief “through worship and practice or in teaching and dissemination in other forms”. Freedom of religion became part of the guaranteed human rights in Tanzania in 1984, with the incorporation of the Bill of Rights and Duties in the country's constitution (Makaramba 2006; Bakari & Ndumbaro 2006). Furthermore, Article 9g of the constitution regulates that “The Government and all its agencies accord equal opportunities to all citizens, men and women alike without regard to their colour, tribe, religion, or station in life” (Makaramba 2006, pp. 377–378) (URT; Constitution Part II: Fundamental objectives and directive principles of state policy, p. 13).

Both Christians and Muslims are governed by secular laws in both criminal and civil cases, except for family-related cases involving inheritance, marriage, divorce and the adoption of minors, where Muslims may choose Islamic law as a complement (Freedom House 2015). In 16 mainland regions, a Muslim qadi-based court system hears civil cases concerning Muslims. These courts are administered by judges trained in Islamic legal traditions (Bureau of Democracy 2013).

The Tanzanian model of secularism

Tanzania's secular state model offers some unique characteristics (Bakari 2012). Secularism is promoted as a means of ensuring that no religion gets a dominant position at the expense of another (Havnevik & Isinika 2010; St. Francis Turiani Mission Hospital 2007; Liviga 2006). A clear example is the tradition of alternating between Christian and Muslim presidential candidates (Bakari 2012). Tanzania has adopted *residual secularism*, meaning that the constitution is designed in such a way that all religions are entitled to equal freedom and protection, thus striving to uphold the neutrality of the state (Bakari 2012).

Tanzania's first president, Julius Nyerere, introduced a clear distinction between a secular state and a secular society (St. Francis Turiani Mission Hospital 2007), by declaring Tanzania a secular state, based on the assumption that the population is religious but not the state itself (Bakari 2012). Instead of separating religion from the public institutions by clear dividing lines, Nyerere declared that it was in the interest of the state to keep a neutral balance between different religions (Ndaluka 2012). Critics of Nyerere and the Tanzanian model of secularism, in particular Muslims critics, have linked the establishment of a nationalist-secularist ideology to the beginning of what they refer to as a *national Christian hegemony* (Said 2011; Lodhi & Westerlund 1997; Said 1989). Some of these scholars have proposed that the Tanzanian state is *nominally secular*, but still dominated by strong church-state relationships (Bakari 2007).

Although the Tanzanian model of secularism has developed further, it has kept some of its core principles in order to ensure that there are equal opportunities for all religions in terms of state support, representation and participation in running public affairs (Bakari & Ndumbaro 2006). However, certain restrictions on religious freedom have been put in place (Havnevik & Isinika 2010; Kapepwa et al. 2006).

The government has implemented certain restrictions on religious speech (Bakari & Ndumbaro 2006). The law prohibits preaching or distributing material that might be considered inflammatory or represent a threat to public order. As Bakari noted "the Government occasionally denies permissions to religious groups seeking to hold demonstrations if there is a perceived likelihood that the gathering could lead to confrontation or ignite religious tensions" (Bakari 2007, p. 24). In 2013, the former president, Hon. Jakaya Mrisho Kikwete, openly demanded in several public speeches that religious leaders take their responsibility seriously in ensuring that citizens continue to live peacefully regardless of religion (Bureau of Democracy 2013).

Another example is the fact that the constitution prohibits religious groups from registering as political parties and political parties from working along religious lines (Ndaluka 2012). Hence, the country's three largest political parties are all secular as stated in their statutes. However, the opposi-

tion party CUF – Civic United Front, is often associated with the coastal Muslim community on Zanzibar, whereas CHADEMA – Chama cha Demokrasia na Maendeleo is associated with the Christian majority on the mainland, in particular Protestant churches in the northern parts (Bureau of Democracy 2013).

Church-state relationships under colonial rule

Since this study reflects the developmental role of church organisations in the health sector, the remaining part of the chapter has a particular focus on the role of Christian churches in the development process.

As pioneers in the field of development intervention, as we know it today, the contribution of Christian churches to the provision of health and education services was significant during colonial rule (Loewenberg 2009; Flessa 1998; Hastings 1967). In fact, ever since the early years of Christianity in Tanzania, this contribution has remained significant, despite the changing political environment (Dilger 2010; Mukandala 2006b; Bakari & Ndumbaro 2006; Sundkler & Steed 2000).

The expansion of Christian-driven healthcare

Christianity was brought to Tanzania via European missionary societies (Sundkler & Steed 2000; Hastings 1996; Hastings 1967). The Portuguese Augustinian missionaries were the first to arrive with Vasco da Gama, travelling beyond the Cape and along the east coast of Africa to Mombasa between 1497 and 1498 (Sundkler & Steed 2000). Shortly thereafter, they arrived in Zanzibar and established the first Catholic evangelising mission documented in Tanzania (Grundmann 2005; Hastings 1996).

A second and more transformative round of evangelisation followed in the 19th century initiated by the Anglican Church Missionary Society in London (Sundkler & Steed 2000; Hastings 1996). Their contributions were seen in four areas: geographical exploration, contacts with African chiefs, translation work and the formulation of a missionary strategy (Sundkler & Steed 2000; Sahlberg 1986).

In May 1887, Karl Peters, the colonial adventurer who founded the German East Africa Company called Bismarck, declared the mainland of today's Tanzania as being "German East Africa" (Sundkler & Steed 2000). Medical missions from Germany took the opportunity of expanding their Christian missions by entering into partnerships with the German colonial rulers with regard to the establishment of health institutions (Nyanto 2015; Parsalaw 1999; Hastings 1996; Sivalon 1992; Hastings 1967).

Over time and under the motto of "prayer and work", evangelisation techniques developed into encompassing a larger portion of the entire society

(Loewenberg 2009; Grundmann 2005; Ranger 1981). In this way, Christian missions increasingly focused on saving the whole human being: body, soul and spirit (Green 2005; Sundkler & Steed 2000). During this period, several developmental achievements were documented; infant mortality was for instance significantly reduced (Widmer et al. 2011).

Christianity in general became increasingly associated with social service provision and received public recognition. In the case of Catholic missions, healthcare delivery was prioritised, together with the expansion of the church and the gospel (Green 2005; Hastings 1996). Wherever there was a mission station, there was also a dispensary or hospital (Cleall 2012) providing missionary societies with an opportunity to have direct contact with the population (Sundkler & Steed 2000). Gradually, the Christian missions moved into the centre and advanced in their capacity as development collaborators in the delivery of social services (Leurs et al. 2011; Rupper 2005; Sundkler & Steed 2000; Hastings 1996.).

Christian missions and the colonial enterprise

The bulk of the mission work, particularly the establishment of new Christian health institutions, was concentrated to the remote and rural areas of mainland Tanzania (Flessa 2005; Sivalon 1995; Ranger 1981). The early history of Tanzanian evangelisation was characterised by fierce competition between the Christian denominations over land areas (Sundkler & Steed 2000). This antagonism was sometimes so strong that the colonial government had to create exclusive areas for the different denominations in order to avoid confrontations (Green 2005; Hastings 1967). A positive spinoff from this competition was the resulting increase in efforts, such as building new schools and hospitals, following the establishment of different Christian missions (Boulanger & Criel 2012).

There were also different approaches to evangelisation and health work depending on the denomination (Bakari 2012; Mallya 2008; Green 2005; Sivalon 1995; Hastings 1996). In some cases, religion and Western medicine were used as ideological tools in paving the way for colonialism by legitimising colonial ideological and political institutions (Oliver 1952). In other cases, hospitals and dispensaries mainly offered a pathway for the conversion of people to Christianity (Cleall 2012; Westerlund 1980). Sundkler and Steed highlight the fact that medical missions implemented the values characterising their time (Sundkler & Steed 2000).

Church-state relationships in light of independence

Tanganyika gained its independence in 1961. Before it was a United Nations Trust Territory under British administration (Fouere 2015; Havnevik & Isinika 2010).

Most foreign missions handed over the ownership and part of the administration of hospitals and schools to the independent Tanzanian church organisations during the years following independence (Yates 1994). In this process, foreign missions were integrated with native church organisations (Jennings 2008a; Parsalaw 1999), even though church-based health institutions and schools were still financially dependent on foreign missions and the international donor community. In the years following independence, the Tanzanian church organisations developed into self-governing organisations (Pallant 2012; Kijanga 1978). In general, during this period church organisations continued to play a dominant role in the sectors of both education and health.

The nature of church-state relationships under TANU's leadership

Following independence, the Tanganyika African National Union (TANU) came to control the economic and political spheres (Fouere 2015; Havnevik & Isinika 2010). In 1964, Tanganyika united politically with Zanzibar and was renamed Tanzania, with Julius Kambarage Nyerere as its first president (Westerlund 1980; Kijanga 1978). Shortly after, the Tanzanian government introduced a development model based on so-called "African Socialism", or Ujamaa as it was termed in Kiswahili (Havnevik & Isinika 2010; Hunter 2008).

One of the particularities of the Ujamaa socialist model was the maintenance of religious freedom by separating church and state. However, Nyerere's speeches revealed somewhat of an ambiguous attitude, where he on the one hand proclaimed not to mix religion and politics, while, on the other hand, urging churches to play their part (Wijsen 2015; Bakari 2012; Lodhi & Westerlund 1997; Westerlund 1980).

After independency and in the following development process, the cooperation between the state and the Christian churches turned out to be very close, in particular in the case of the Catholic Church (Ludwig 1999; Sivalon & Comoro 1998; Sivalon 1995; Sivalon 1992).

The perceived preference of Nyerere's policy with regard to church organisations intensified the already tense relations between the state and the Muslims (Wijsen 2015; Sivalon 1995). Several scholars suggest that the time following independence was characterized by "an anti-Muslim stance" of the Tanzanian state. Islamic elements, often adhering to a conservative Islamic way of thinking, were silenced or at least marginalised and replaced by Mus-

lim organisations that tended to be more pro-government (Bakari 2012; Olson 2011; Leurs et al. 2011).

The response of church organisations to Ujamaa

During this time, the Christian churches started showing a growing concern with regard to the development process (Sivalon 1995; Westerlund 1980). The response of church organisations to the policy of Ujamaa was somewhere in-between full acceptance and resistance. The Protestants and the Catholics agreed to commit their resources to support the government's development objectives (TEC 2007), where the nature of an appropriate church-state relationship formed the core of their strategies (Kijanga 1978). Several of the church leaders were not particularly committed to Ujamaa and feared a Marxist and atheist drift (Westerlund 1980). Critics within the churches also questioned the nationalisation of the major means of production and the state taking over the ownership of several Christian facilities, including the Lutheran Kilimanjaro Christian Medical Centre (Leurs et al. 2011; Ngowi 2009). The resistance to Ujamaa was particularly strong amongst the Pentecostals and the Seventh Day Adventists, even though regional differences probably played a more important role than differences between various Christian denominations (Westerlund 1980).

Despite the mistrust of Ujamaa exhibited by mainstream church organisations, a majority of Catholic and Protestant bishops eventually agreed to support the policy and decided to re-orient their institutions in line with the public development policy (St. Francis Turiani Mission Hospital 2007; Mhina 2007b; Ludwig 1999). A more common view is that the church-state partnership during Ujamaa indeed remained relatively stable, while to some extent being weakened as part of the nationalisation process (Anyimadu 2016; Bakari 2012; Mallya 2006).

The return of church organisations as key players

At the end of the 1970s, Tanzania faced a severe economic crisis with accompanying political changes. The economic crisis following the Ujamaa policy culminated in the early 1980s (Otunnu 2015; Hunter 2008; Mchomvu et al. 1998). The national budget allocation in general, and for social services in particular, was drastically reduced, thus making the Tanzanian state more dependent on foreign aid (Mchomvu et al. 1998). This affected social service delivery and the maintenance of related health infrastructure (Bakari 2012). Tanzania experienced the implementation of the Economic Structural Adjustment Programmes in the mid-1980s, directly related to the privatisation of the economy and directives given by the international donor community and implemented by the International Monetary Fund (IMF) (Mallya 2007). Among other things, the terms of the IMF required Tanzania to end the

Ujamaa policy and privatise its social sector (Tripp 1997). 1985, when Ali Hassan Mwinyi replaced Nyerere as president, marked the beginning of economic and political liberalisation. The state was no longer considered the sole driver of development (Havnevik & Isinika 2010; St. Francis Turiani Mission Hospital 2007). After 1986, social policies were increasingly influenced by the Structural Adjustment Programmes (SAPs); for instance, leading to a drastic reduction in government healthcare service expenditure. These new developments in social service delivery influenced the state to further recognise private actors, including church organisations, as key players in development (Tibaijuka 1998; Wagao 1993). These developments had a major impact on the church organisations and their related facilities (Flessa 1998; Tibaijuka 1998).

The fierce competition between the Christian denominations seen in the colonial period and following independence was replaced by closer cooperation; a process where Christian denominations reunited in their common efforts in terms of development and social services (St. Francis Turiani Mission Hospital 2007). In 1992, the Tanzania Episcopal Conference (TEC) and the Christian Council of Tanzania (CCT) formed the Christian Social Services Commission (CSSC) in order to strengthen their common efforts in social service provision (Boulanger & Criel 2012). The main purpose was to create an ecumenical body that could facilitate the provision of social services by the churches and formulate common policies for education and medical services in Tanzania (Boulanger & Criel 2012; Leurs et al. 2011).

In the process of establishing CSSC, church organisations threatened to close down several health institutions if they did not receive increased public support from the state (Sigalla 2015; Tibaijuka 1998). The government felt obliged to recognise the important role played by church organisations in the social services sector and assured them that it would channel funds from foreign donors. The government also made a commitment to never again nationalise their health institutions (Green et al. 2010; Mbogoni 2004). Church organisations moved from being minor players to central players and became more explicit in their demands towards to state. The Tanzanian government more openly started promoting Christian churches as important actors for the provision of social services, even though a separation of church and state remained in place (Green et al. 2010; Jennings 2008b).

Churches started opposing and challenging the state openly (Mallya 2008). In February 1993, the Roman Catholic Church issued a statement and publicly criticised the government for worsening the economic, social and political situation in the country (Luanda 1996). Similarly, the Protestants presented their *Bagamoyo Statement* where they spoke of the deteriorating political, economic and social conditions in the country and the need for the government to take appropriate action (Evangelical Lutheran Church in Tanzania 1994). These statements symbolically marked the beginning of a

strengthened role for church organisations in their advocacy role in policy-making and in other related social policy areas (Ellis & Ter Haar 2004).

Present church-state relationships

As discussed above, the developmental role of the church organisations in Tanzania has changed through different phases (Sivalon 1995). The first phase was characterised by expansion and service delivery in the fields of education and healthcare, which took place during colonial rule up until the early 1960s (Kipacha et al. 2015; Green et al. 2010; Green 2005; Sivalon 1995). The second phase started in the late 1960s and was marked by African socialism. It meant a closer consolidation of the agendas of church organisations with that of the state, as well as the state centralising its efforts to provide services (Havnevik & Isinika 2010; St. Francis Turiani Mission Hospital 2007; Sivalon 1995). In the third phase, from 1977 up to the present, we have seen churches returning as key service providers through the promotion of contractual partnerships with public authorities (Mallya 2007; Sivalon 1995). During the third phase, church organisations, as part of the civil society, have started raising serious concerns concerning the shortcomings of government liberalisation policies and their implementation (Havnevik & Isinika 2010; Bakari & Ndumbaro 2006).

Church organisations in Tanzania are today faced with challenges similar to those experienced since the beginning of the liberation era (Maoulidi 2014; Bompani & Frahm-Arp 2010; Mallya 2008; Bakari 2007). The established Christian mainstream churches have become increasingly associated with social service delivery and “churches have turned into social centres for the solution and management of social problems” (Sigalla 2015, p. 176). In this situation, Muslim groups have also become more vocal in their accusations that the state favours church organisations (Maoulidi 2014; Ndaluka et al. 2015).

Churches as key development partners

Church organisations thus continue to play a crucial role in national development by providing important social and developmental services in Tanzania (Bakari 2007; Tumainimungu 2007). The Christian FBO landscape is a complex one, and it is hard to find a comprehensive overview of all current Christian FBOs and church-based development entities in Tanzania (Sigalla 2015; Leurs et al. 2011).

However, it is possible to conclude that the Catholic Church and its associated organisations have developed into the most widespread and all-encompassing service delivery agent, with countrywide development programmes (Tanzania Episcopal Conference 2015; Green 2014; Sivalon 1995).

It is followed by the Lutheran and Anglican Church, the second and third largest Christian denominations respectively (Tumainimungu 2007). The geographical distribution of their activities, however, is uneven, still reflecting patterns of missionary activity during the colonial period (Anyimadu 2016; Jennings 2013). The traditional Pentecostal denomination in Tanzania (FPCT), which is included in the scope of this study, similarly works in several classical developmental fields, but on a smaller scale (Nyström 1998). In addition, there are several other smaller Christian denominations operating in the development sector (Leurs et al. 2011; Noorali 2010).

As already presented above, there has been a significant expansion of new charismatic Christian movements (Deininger 2013). To mention a few, there are African independent churches, Pentecostal movements and neo-Pentecostal movements (Dilger 2014). In the Tanzanian context, charismatic churches are often perceived as mostly engaged in evangelism and outreach rather than conventional development programmes, considering the gospel of Jesus Christ to be the centre of all activity (Leurs et al. 2011). However, this view has been challenged lately, as some charismatic movements and organisations are showing increasing engagement in both health and education activities (Anagisy & Mligo 2014).

In many instances, the state and the church organisations have had an overlapping agenda with respect to development policy (Mallya 2007). The development practises of church organisations evolved from an early focus on charity, relief and service delivery to more rights-based development programmes, including an agenda for sustainable development, advocacy, good governance and human rights, as well as a think-tank (Leurs et al. 2011). Currently, there are also mechanisms and structures in place for getting involved at the district level. Current policies allow church leaders to engage in the dissemination of policies and state laws, for example through consultations on poverty reduction policies, HIV/AIDS policy and local government reforms (Maoulidi 2014; Leurs et al. 2011). Church organisations are credible in the eyes of both the state and international communities (Sigalla 2015; Green et al. 2012), and the current PPP policy gives church organisations a stronger mandate to plan and implement government programmes (Tumainimungu 2007). International funding has also changed the nature of the activities of many FBOs to reflect prevailing international development concerns and agendas (Green et al. 2012). Since the 1990s, FBOs have received increased external funding, in particular in the fields of HIV/AIDS and related work, such as working with orphaned and vulnerable children (Leurs et al. 2011; Green et al. 2010).

As church organisations have started to move beyond their traditional role as service providers with a stronger emphasis on their role as a critical voice in the public debate and watchdog of the state, church organisations have started to face new challenges in their relationship with the state (Tumainimungu 2007). At the same time, our understanding of the role of religion in

development has become more complex (Mhina 2007a). In this transition, church organisations are likely to continue to strengthen their role in development (Tumainimungu 2007).

Muslim organisations striving for recognition

During the last decade, religion and development have become increasingly politicised in Tanzania (Bakari 2012; Olsson 2011; Mesaki 2011). While both Muslim and Christian organisations contribute to the development process in Tanzania, some Muslim circles are complaining about the way the government has marginalised Muslims organisations in comparison with church organisations (Mhina 2007a; Asad 2003; Lodhi & Westerlund 1997).

Tensions were observed already back the 1990s, but they have particularly intensified since the latter half of 2012 (Maghimbi 2015; Ndaluka 2015; Lyimo 2015; Wijzen 2015; Wijzen & Mfumbus 2002). Churches have been set on fire, congregations have been bombed and clerics have been killed and injured (Ndaluka & Mapunda 2015; Masebo 2015). The global resurgence of religious activism seen in charismatic religious movements and revivalism in Islam has also contributed to intensified tensions between religions in Tanzania (Maghimbi 2015; Poncian 2015).

A discourse on *Muslim complaint* established itself in the past, during the colonial era, when conversion to Christianity was strongly correlated to the attainment of education (Ndaluka & Mapunda 2015). After independence, Nyerere already in his inauguration speech addressed religious tensions and social marginalisation (Chande 1998). Shortly after, in 1963, a Muslim society, Daawat al-Islamiyya, was established to address the underrepresentation of Muslims in the government and the uneven distribution between Christians and Muslims in terms of education (Liviga 2006; Ndaluka et al. 2015).

The discourse of the *Muslim complaint* has also been linked to an intensified global process of *politicisation of religion* and *religionisation of politics*, which “may be characterised as political manipulations of religious diversity for self-serving interests of the politicians” (Poncian 2015, p. 62). In most cases, tensions have not been religiously motivated (Wijzen 2015; Ndaluka 2015). They are rather the result of economical, historical and social claims related to perceptions of the way the state treated followers of different religions across the socio-economic and political spectrum (Poncian 2015; Maoulidi 2014; Olsson 2011).

According to Mfumo Kristo, a Muslim movement advocating against Christian dominance in Tanzania, both Christians and the state are accused of conspiring against Muslims (Ndaluka 2012; Njozi 2010). A front figure of this movement, Mohamed Said, has warned that failure to fully acknowledge and address divisive religious agendas will harm Tanzania’s national unity and political future (Saeed 2016; Maoulidi 2014; Said 1989). With reference back to the Memorandum of Understanding from 1992, which involved the

government's return of some education and healthcare facilities back to the Roman Catholic, Lutheran and Anglican churches, Muslim groups have openly accused the Tanzanian state of selling out to the churches (Ndaluka et al. 2015; Said 2011). The Muslim complaint also involves the question of religion-based discrimination in employment in relation to higher education and economic and political power (Musoke 2006). Due to the education gap between Muslims and Christians that has existed since colonial times, Muslims are said to be far behind in the development process (Mukandala 2006a). Articles published in various issues of the journal *An-Nuur* confirm this view with several stories by Muslims accusing the Tanzanian government of discriminating against them in education, employment and other political spheres (Fouere 2015; Musoke 2006; Chesworth 2004). *An-Nuur* is recognised by several scholars (Wijsen & Mfumbusa 2002) for addressing the Muslim question in the public space, while simultaneously encompassing anti-Christian and anti-government rhetoric in its promotion of an Islamic ideology (Fouere 2015; Wijsen & Mfumbusa 2002; Constantin 1993).

Part of the Muslim complaint also involves the fact that there is less support for Muslim FBOs from international donors, partly since some were banned after the 2004/5 Terrorism Act (Leurs et al. 2011). Because of BAKWATA's perceived failure to provide effective leadership for Muslims, a number of alternative Muslim organisations have emerged to provide socio-economic services for the Muslim community (Chande 1998; Ludwig 1996). The Supreme Council of Islamic Organizations (Baraza Kuu) was founded in 1992 to fight for the rights of Muslims and to ensure Muslim participation in development plans and activities. Since its establishment, this organisation has increased in legitimacy and received more followers (Leurs et al. 2011).

Despite the efforts of the government and the donor community to promote religious pluralism and harmonious coexistence, religious tensions continue to grow (Bureau of Democracy 2013). The Tanzanian state and the international donor community have increasingly shown concern and sensitivity to religious polarisation, fearing the destabilisation of local communities and national unity (Olsson 2011; Liviga & Tumbo-Masabo 2006). During the last decade, several projects have been launched aimed at promoting interreligious relations (Olsson 2011).

The role of Muslim organisations in present Tanzanian development needs to be studied further. This, however, is not the aim of this study, even though these issues are mentioned to indicate that I am aware of the different situation of Muslim organisations when compared to the Christian church organisations and the interreligious tensions mentioned above.

5. Partnerships in the health sector

This chapter gives an overview of the Public Private Partnerships (PPPs) in the health sector, and begins with a historical review of the background to the current PPP framework in the health sector in Tanzania. This is followed by a presentation of the latest developments in the health sector leading up to the current PPP policy in Tanzania. This section focuses in particular on the transition towards the private sector becoming more important in National Health Strategies (Ministry of Health 2009). Finally, I present the current PPP framework, including the various models in the health sector offered for partnerships between church organisations and public health authorities. Throughout this chapter, I have a particular focus on church organisations and their umbrella organisation, the Christian Social Services Commission in Tanzania.

Public Private Partnerships in the health sector have a long history (Itika 2009). The Tanzanian health sector has always been characterised by a mix of public and private providers and partnerships (World Bank 2013; Chiduo 2013). However, some elements have been reformed, such as in the introduction of the current PPP framework, where private for-profit actors are given an almost equal status to non-profit actors, while also being promoted more strongly (Ministry of Health 2015).

The current drive for Public Private Partnerships (PPPs) has been led by external actors, particularly by the World Bank (Ministry of Health 2015; Munishi 2004), but the advocacy from local entities, including FBOs, also took an active role in advocacy and eventually the policy development. The Tanzanian state has defined the PPP policy as “sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public” (Ministry of Health 2009, p. 33). External actors have come to argue that these partnerships play a critical role in improving the performance of health sector development (Boulanger & Criel 2012; Itika 2011). By emphasising the component of national ownership, external actors have argued that PPPs will assist in all public and privately owned healthcare facilities in the country becoming better integrated and complementing each other in the realisation of national health goals (Ministry of Health 2016; Chiduo 2013).

The current PPP framework in Tanzania has evolved from global trends in health financing (Munishi 2004). It is therefore crucial to look into the

underpinning philosophical and ideological foundation of this new framework, in particular the urge for public private actors to collaborate more closely (Mallya 2008). The PPP framework is based on a shift in policy concerning the roles of the private and public sectors; a shift that has been accelerated by the international donors becoming more willing to consider the private sector an integral part of the national health programme (Mitchell 2001; Buse & Walt 2000a; Buse & Walt 2000b). This, in turn, has led to a move away from a traditional model of public administration and state-driven development towards privatisation built on a New Public Management model (Itika 2009).

PPPs have also been recognised as an important instrument when it comes to integrating private non-profit healthcare providers in national healthcare delivery systems (Mitchell 2001; Buse & Walt 2000b). Even though the global PPP reform was initially developed for a private mix of both the private for-profit and the private non-profit sectors, it has been implemented in contexts like Tanzania where private actors in the health sector to a high extent consist of a majority of non-profit alternatives with church organisations as key implementers. As a consequence, governments have also increasingly come to acknowledge that there may be other incentives for private non-profit organisations to engage in PPPs, including motivations derived from faith and health ethics (Pallant 2012).

Tracing the roots of the partnerships

Contractual partnerships between church organisations and public health authorities have been practiced since colonial days (Sundkler & Steed 2000). Both the colonial state and the independence movement (TANU) regarded Christianity as an ally in the modernisation process, albeit for different reasons and under different conditions (Westerlund 1980). Church organisations played a key role in providing health services, with a particular focus on maternal and infant health services (Widmer et al. 2011). Church organisations continued to work in partnership with the state after independence, with certain constraints (Jennings 2013). With the liberalisation process, the Tanzanian state liberalised its health policy and, as a part of this process, church organisations were once again invited to play a more central role in health sector development (Mallya 2008; Munishi 1997; Kiondo 1995). In the health policy presented in 1990, contractual partnerships with the private sector were back on the agenda (National PPP Steering Committee 2009). However, it took another two decades until the current PPP framework was put in place and for the partnerships between the church organisations and the public authorities to become more properly structured, as well as church-based hospitals becoming more integrated into the national health system (World Bank 2013; Boulenger & Criel 2012). It is also important to note that

the health reforms were embedded in a reform package including economic, administrative and sector reforms (Structural Adjustment Programs, Poverty Reduction Programs, the Public Sector Reform, the Local Government Reform Program and the Public Financial Management Reform Program (Ewald 2013)).

Partnerships with churches during colonial rule

During colonial rule, private health service providers were divided into two categories, private non-profit and private for-profit, where the missionary efforts represented the first. There were very few private for-profit health facilities in place during this period (Green et al. 2010).

Throughout the colonial era, institutional structures linked the mission societies more closely to the colonial state. The colonial health system was officially conceived as consisting of both a public and a voluntary sector (Jennings 2013). Some scholars stress that hospitals and dispensaries were primarily a pathway for the conversion of people to Christianity (Westerlund 1980).

Christian missions became formal partners in social service delivery and, as such, established linkages with the colonial state that were to outlast colonial rule (Hastings 1996). The provision of Grant-in-Aid served as the main method for contractual partnerships under colonial rule. The Grant-in-Aid model included national level grants for patient beds, staff and training (Bandio 2012). The notion of a “mission sector” emerged, representing all church health facilities in dialogues with the colonial government (Jennings 2013). The Protestant missions drove this process through the creation of the umbrella institution known as the Medical Missionary Committee (MMC). The Medical Department of the colonial state later came to include medical missionary representatives in negotiations; as a result, health facilities of Christian missions received full recognition under colonial rule. The principle of “contracting out” became established already at this time and church-based hospitals also used patient fees (Jennings 2013).

At the end of the colonial era, Christian missions operated 42 percent of hospital beds and 81 percent of primary healthcare facilities in mainland Tanganyika (Jennings 2008b). Health institutions were still largely under the control of, and financially dependent on, European church organisations (Yates 1994).

Partnerships with churches following independence

After independence in 1961, the European missionary societies handed over the administration of most health institutions to the newly independent Tanzanian church organisations (Sundkler & Steed 2000). This meant that during the first years after independence, church health facilities were becoming

an integral part of the national health sector as a whole (Ludwig 1999). However, much of the day-to-day management remained with the medical missionaries.

In 1965, the Medical Missions Committee was renamed the Tanzania Christian Medical Association (TCMA) and acted as the main organ representing the interest of the church organisations in health sector development. Church organisations, primarily Catholic and Protestant and to a lesser extent Pentecostal, were well-represented at all levels of society, from the central government to the local village (Jennings 2008b). This was the only structure outside the state reaching most parts of the country. Their access to the global donor community also brought important external aid for health sector development (Jennings 2008a; Westerlund 1980).

The Arusha Declaration (1967) led to the implementation of a health sector reform aimed at ensuring social and health services to the marginalised populations in rural areas (Nyerere 1967). Tanzania adopted a policy of free healthcare provision through public health services, with a strong focus on achieving primary healthcare for all (Phares et al. 2014). The government also removed the principle of cost-sharing through patient fees at private non-profit facilities (Boulanger & Criel 2012). In order to gain support from church organisations, the government made a commitment to pay for some of the health costs (for some population groups – including children under five, pregnant women, the chronically ill as well as the elderly) if they were to abolish their patient fees and provide further support to the government in its effort to strengthen health sector improvements (Jennings 2013).

In response, the Tanzania Christian Medical Association entered into an agreement with the government in which five church hospitals gained the status of Designated District Hospitals (DDH) (Ludwig 1999). Under the DDH arrangement, church organisations only kept part of the ownership of their hospitals. The first DDH hospital received this status in 1965 (Ministry of Health 2011a). In some cases, church organisations were responsible for staff, building, equipment and administration. However, in most cases, the administration of these district hospitals was handed over to the government, which in turn appointed District Medical Officers to manage the facilities (Green et al. 2010; Mhina 2007a).

Under these arrangements, the state allowed the churches to continue to participate in health sector developments (Westerlund 1980; Nyerere 1967). This meant that the Catholic, the Protestant and the Pentecostal churches continued to carry out health service delivery alongside the government, based on national guidelines focusing on improving the health of the Tanzanian population (Jennings 2008a).

With time, the government attempted to centralise the health sector and impose greater controls and restrictions on church organisations working in this area. This resulted in church organisations having to partially transfer most of the ownership of some of their hospitals to the state (Mchomvu et al.

1998). In 1971, the two largest church-based hospitals, the Lutheran Kili-manjaro Christian Medical Centre in Moshi and the Catholic Bugando Hos-pital in Mwanza, were nationalised and became Designated Zonal Referral Hospitals managed by the government (Mhina 2007b). For fear of losing the ownership over more facilities to the state, some church leaders started to become more hesitant when it came to entering into contract relationships with the government (Boulanger & Criel 2012). Church-based hospitals at this time primarily received their funding through foreign support (Hazeen 2012).

As part of the national centralisation process, the government removed the local governments at the district level through an act in 1972 (Boulanger & Criel 2012). This act led to the centralisation of human resource systems for public health workers (Ewald 2013; Tibandebage & Mackintos 2012). The main argument behind this law was poor service delivery and misman-agement at the local levels. The local governments were replaced by a sys-tem referred to as “decentralisation”, which included a strong regional ad-ministration in charge of the district administration. In spite of these ambi-tions, decision-making powers still remained at the centre. In fact, what was referred to as decentralisation was in fact a reform concentrating power at the centre (Tibandebage & Mackintos 2012).

During this time, the state provided fewer incentives for private sector en-terprises, and some companies were regarded as either exploiters or enemies of the state in the public opinion (Ngowi 2009). The private for-profit sector in health was banned in 1977 (Tibandebage & Mackintos 2012). Still, in this period the state continued its struggle to provide highly subsidised health services (Ngowi 2009). In keeping with the goals of the Arusha Declaration, the government rapidly expanded its facilities to reach the rural population. In a few sources, it was stated that by 1978, the government had succeeded in establishing a health facility within 10 kilometres of 90 percent of Tanza-nia’s rural population (World Bank 2013).

However, a number of challenges remained for the government in meet-ing its commitment to universal health service access. Underfunding of health services led to drug supply shortages, deteriorating health facilities and low staff morale (Mchomvu et al. 1998). This situation was made worse by the economic crisis of the late 1970s, which forced the government to reconsider its centralisation policies (Phares et al. 2014). At the end of the nationalisation period, in 1979, there were nineteen Designated District Hos-pitals (DDH) in Tanzania operated by church organisations. Despite the at-tempts by the government to attain more control over health services provi-sion, churches and missions were still responsible for 33.9 percent of hospi-tal beds and 16 percent of dispensaries (Jennings 2008b). During the 1980s, the health sector continued to face severe challenges, and by the late 1980s, the health system was in serious decline, thus forcing the Tanzanian gov-

ernment to rethink its policy towards private sector involvement in the health sector (World Bank 2013).

Partnerships with churches in light of liberalisation

After years of crisis and efforts to return to a stable economy, the government was pushed to embrace a more capitalist model for its economy, with a market-oriented and private sector-based development vision (Ngowi 2009). Consequently, the government liberalised its health sector and re-introduced user fees in 1990 (Itika 2009). The introduction of patient fees was carried out in phases and led to the beginning of commercialised public healthcare provision (Phares et al. 2014). This policy shift led some citizens to accuse the government of abandoning its commitment to defend people's health rights to access free healthcare services (Ngowi 2009; Tibaijuka 1998).

In 1990, Tanzania received its first National Health Policy, which included the cooperation principle with the private sector (Mallya 2007). This resulted in the 1991 Private Hospitals Regulation Amendment Act, where private medical and dental services were re-established and where the private sector was once again allowed to operate (Phares et al. 2014). A rapid increase in the number of private healthcare facilities followed. The government invited more organisations to own and manage healthcare units, such as hospitals and health centres, pharmacies, diagnostic laboratories and dispensaries (Munishi 2004). The policy had two main objectives: (1) to supplement the government's efforts at a time when the economy was in decline, and (2) to improve efficiency in service provision (Mallya 2007). Some of the key principles in the current PPP framework can be traced back to the 1991 Private Hospitals Regulation Amendment Act.

In order to strengthen their social services during this time, the Catholic and the Protestant churches formed the Christian Social Services Commission (CSSC) in 1992 (Ministry of Health 2011a). The main purpose was to create an ecumenical body that could facilitate the provision of social services by the church organisations, formulate common policies concerning the medical services in the country and carry out joint health advocacy (Leurs et al. 2011). The German government supported the creation of the CSSC, as it requested better coordination and a more structured collaboration between the church organisations and the Tanzanian government (Leurs et al. 2011).

Later the same year, a Memorandum of Understanding (MoU) was signed between the CSSC and the government, where the government recognized the important role of church organisations in the health sector (Mallya 2007). One of the reasons why the MoU was signed at this particular time was to

allow for the German government to increase its level of health financing to the churches for health services (Leurs et al. 2011).

The MoU resulted in the role of church organisations in the health sector becoming more clearly defined than previously (Boulanger & Criel 2012). The government accepted to increase the share of health grants from foreign donors to be channelled to church organisations, while also granting the faith-based sector the right to retain ownership of their health facilities (Green et al. 2010; Mbogoni 2004). As a result, an increasing number of church-based hospitals acquired the status of District Designated Hospital (DDH) (Itika 2009). This to some extent enabled the Tanzanian state to compensate for the shortage of public health facilities. Contracts guaranteed public funding to the recurrent expenditures of DDHs, while the owners of the church-based hospitals (dioceses and national church organisations) were still in charge of investments and the recruitment of staff (Boulanger and Criel 2012).

The 1992 MoU was met by criticism, in particular from some Muslim groups. Their criticism contained two main points: (1) that the MoU between the CSSC and the government was not presented and discussed in public before official approval, and (2) accusations that the government was serving the interests of Christians and Western donors at the expense of Muslims groups (Ndaluka 2015; Konrad-Adenauer-Stiftung 2010).

As the funding coming in from public health authorities increased, there was a decrease in the direct core funding for church-based hospitals coming in from international donors (Pallant 2012). Several church-based institutions became indebted and a number of them were unable to deliver quality health services (Tibaijuka 1998). This resulted in church organisations making greater demands and bishops in some dioceses even threatening to close down health institutions if they did not receive increased public support (Jennings 2008b).

The government revised its vision for reforming the health sector in 1994, where the role of the government was redefined from being the dominant provider to becoming a facilitator. This meant a change in the function of the state to encompass the following duties: (1) creating an enabling environment for private enterprise, (2) regulating market failures and managing change, and (3) safeguarding institutions and promoting democracy by strengthening the civil society (Mallya 2007). At this time, there was insufficient coordination in health service delivery between the public sector, FBOs and the private for-profit sector. The health sector was severely underfunded, with public health sector spending as low as USD 3.46 per capita. The support to the health sector from development partners was also poorly coordinated (Flessa 1998).

Both development partners and the government of Tanzania found it necessary to respond to this situation. In 1999 this resulted in the first major Health Sector Strategic Plan and the Health Sector Programme of Work. An

agreement between development partners and the government was reached, stating that support to the health sector was to take place in the framework of a sector-wide approach. This change was related to changing aid modalities and the beginning of general budget support. The Health Sector Strategic Plan II (2003–2008) articulated a process of health sector reform aiming to achieve specific goals and targets in health as set out in the Millennium Development Goals and the National Strategy for Growth and Reduction of Poverty (Evaluation Department 2007). Private actors were once again invited to participate more fully in health sector development (Mhina 2007a). This led to a development model based on privatisation values in support of reduced state intervention in social service provision. In this development strategy, church organisations were given a complementary role, filling the gap resulting from the state gradually withdrawing from the provision of basic healthcare services (Mukandala 2006b).

Although these developments were seen by many as accomplishments, not least among international donors, at the same time there was also growing criticism among public civil servants towards the state for weakening its role in health service delivery (Ngowi 2009). A national conference held at the University of Dar es Salaam in 1998 addressed this issue under the slogan “The social services crisis of the 1990s”. This conference brought together many academics, public civil servants and government representatives from the health sector, who expressed their concern with regard to the new trends in health sector development (Tibaijuka 1998). Despite this growing concern, the government continued developing new policies more favourable to the role of the private sector, in particular private non-profits in the form of church organisations (Itika 2009; Ngowi 2009).

Current framework for partnerships

Since the 1990s, the Tanzanian government has provided a more structured framework for building stronger partnerships with church organisations in the health sector (Hazeen 2012; Itika 2009). The growing importance of the private sector in national health strategies and policies is evident (Ministry of Health 2015). The current PPP framework thus states that there is no need to initiate government services in locations where the private sector is already providing adequate services (National PPP Steering Committee 2009). A core principle in the current framework is that contractual relations are based on cooperation and involves the sharing of resources needed for working together, while keeping one’s autonomy and identity (Boulanger & Criel 2012). In practice, this means that the government pays church organisations to provide public services, while also subsidising the education of medical professionals trained at private universities (Ministry of Health 2011a; Ministry of Health 2011b).

Financing of the health sector

To fully understand the workings of PPPs, it is important to clarify the complex architecture of financing the health sector in Tanzania. The relevant actors here are the Tanzanian government, private actors, external donors and international NGOs and FBOs, all of which interact in a complicated and non-transparent way. The government funding is concentrated to allocations in the annual budgets decided by the government and approved by the parliament in the form of Health Block Grants. The rule is that all projects launched by the government should be budgeted for in the annual budget independent of the source of finance (internal or external). The government funds both central activities and operating costs for district and municipal council health services. Other sources for national funding are payments through the national health insurance, which only cover those employed in the formal sector, user fees and community health funds.

External donor funds are either allocated through the government budget or directly to health facilities; in both cases, however, with the approval and support of the Tanzanian government. The former allocations are aligned with the government's planning and implementation, while the latter are implemented more or less outside the national health system. Donors working within the system are part of the Development Partners Group for Health (DPG Health), which constitutes an aid framework for development assistance to health sector development in Tanzania. This is a collection of bilateral and multilateral agencies supporting the health sector in Tanzania. During the time of the study, funds were mainly provided through general budget support and through a special fund labelled the Health Basket Fund. There are presently seven core development partners contributing to the Health Basket Fund: Canada, Denmark, Ireland, Switzerland, UNFPA, UNICEF and the World Bank. The DPG Health strives to achieve a more effective and efficient use of aid resources in line with both the Paris Declaration and the aspirations of the Tanzanian government. The Development Partners Group (DPG) was created in 2003 as part of the Tanzanian Joint Assistance Strategy, recognising the crucial importance of a strong national leadership of the development programme in Tanzania (Development Partners Group Tanzania 2017).

During the time for my study, the Health Basket Fund was the key financing instrument for the Tanzanian health sector. It unites developing partners and the government in a common strategy to support health sector developments at the council level, following harmonisation and alignment procedures. The fund consists of two elements: a central fund, financing the Ministry of Health headquarters and other central organisations with central support functions, and the district fund, for operating costs for district and municipal council health services based on an action plan. The district basket fund aims at providing a stable and predictable resource base for local coun-

cils. The Health Basket Fund is developed through a partnership between the Ministry of Health, the Prime Minister's Office, the Ministry of Finance and development partners, and the basket funding is supposed to be utilised for specific implementation of the Comprehensive Council Health Plans. The Health Basket Fund secretariat is situated at the Ministry of Health. The disbursement of funding from the Health Basked Fund is based on allocation criteria for councils, taking into account population, remoteness, poverty and disease burden (Development Partners Group Tanzania 2017). The decision to channel resources through the government is based on a commitment towards a more effective and efficient use of aid resources in line with both the Paris Declaration and the aspirations of the Tanzanian government as elaborated in the Joint Assistance Strategy (Government of Denmark 2015).

The second type of external donor funding is made up of a large number of bilateral donors that have established so-called Vertical Funds that all work directly with projects, often under the management of the donor itself but in collaboration with national or local actors. This makes it an important source of funding for the Tanzanian government. This funding is for the most part not included in the annual budget, which means that it is to a large extent not under central government control and thus goes against the intentions of the Paris Declaration and the Joint Assistance Strategy. Vertical Funds are dominated by some very large donor agencies, both multilateral, such as the Global Fund for AIDS, Malaria and Tuberculosis, but also private funds, such as the Bill and Melinda Gates Fund. Most of these funds work on specific issues and they themselves take responsibility for the implementation of projects with varying degrees of control and participation from the government. The by far largest external donor to the health sector is USAID, which mainly works through two major funds: the Millennium Development Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) (Development Partners Group Tanzania 2017).

The third group of donors is made up of local and international FBOs and NGOs, which by themselves are relatively small in size, but still important for my three case studies and other faith-based hospitals in Tanzania. A popular form of organisational structure among these actors seems to be friend associations; non-profit foundations built on the principle of charity and consisting of former medical missionaries, health entrepreneurs and senior and junior volunteers. These associations are in most cases named "Friends of... and the hospital name". "Friends associations" have grown to become a popular phenomenon in health sector development in Tanzania. They represent a global network of fundraisers, supporters and medical missionaries/volunteers who choose to bypass church organisations at the central level, the state and the international missionary founders, by the mobilisation of local funding (targeting hospital management and the church leadership of the nearby congregation). It is a kind of a local-to-local development cooperation model.

Due to these different groups of donors, the Ministry of Health not only has to deal with core development partners in health, but also accommodate the needs of large, externally supported vertical programme initiatives (Development Partners Group Tanzania 2017). For local institutions, this extremely complicated and incalculable financial architecture represents a source of confusion and, frequently, conflict, and has been a major obstacle for a smooth and well-functioning cooperation with the church-based hospitals in this study. This is discussed further in Chapter 8. In table 6, I summarise all major sources of health financing discussed in this section.

Table 6. Overview of main sources of financing in the health sector

<i>Source</i>	<i>On state budget</i>	<i>Off state budget</i>
<i>Domestic</i>	Central government funds channelled through Bank of Tanzania: Health Block Grants	National Health Insurance Fund (NHIF) Community health fund TIKA Drug revolving fund Council's own sources User fees
<i>Foreign</i>	General budget support channelled through Ministry of Health: The Health Basket Fund	Vertical Health Programme Funds Development assistance outside DPG arrangements Core support from INGO and IFBOs Twin programmes/international friendship-based partnerships ("Friends of...") Private donations (e.g. bank transfers via PayPal)

Source: Development Partners Group Tanzania 2017

Growing importance of the private sector in national health policies

In 2003, the Government of Tanzania signed a Memorandum of Understanding with a number of international donors, which became the underlying basis for the drafting of the 2003 National Health Policy (Ministry of Health 2008). It was acknowledged that the private sector's contribution to health was crucial (World Bank 2013). The government declared that PPPs are complementary and not confrontational; stressing that the partnership would jointly and transparently mobilise and share resources for development and efficient delivery of well-regulated health services, while ensuring accountability to the public it serves (Ministry of Health 2003c).

A new model for PPPs was developed and launched in 2005, the Council Designated Hospitals (CDH). The main change compared to the previous model was a decentralisation to local government authorities by making them representatives of the Ministry of Health (Ministry of Health 2011b).

Once granted the CDH status, church-based hospitals operated on behalf of the government with the long-term aim of being fully compensated for their services (Government of Tanzania 2015). Council Designated Hospitals (CDHs) were in accordance with the contracts in principle supposed to be granted 25–35 *percent* out of the total district Basket Fund available for that specific council. On top of this fund for the running costs, a CDH should also receive staff grants, bed grants, training grants and medicine (Ministry of Health 2011b).

In 2007, the Tanzanian government updated its National Health Policy. The new policy retained most of the principles of the 2003 version, acknowledging “its principal goals to improve partnerships between public sector, private sector, religious institutions, civil society and community to provide health services” (World Bank 2013, p. 41). The health policy aimed at identifying and prioritising the health needs of the population (World Bank 2013). Public Private Partnerships were defined as a transparent cooperation and collaboration mechanism between public and private sectors, where equal partners work together toward a common goal with clearly defined roles (Ministry of Health 2007a).

An additional form of partnership was the Service Agreement, introduced in 2007 as a new collaborative model for church organisations (Ministry of Health 2007b). The ELCT was the first to design the draft agreement document and was also the first to sign this kind of agreement (Interview 25). These agreements were designed for both non-profit and for-profit providers as a contract between the local councils and the private owners of health facilities (Ministry of Health 2007b). The District Medical Officer (DMO) was appointed to negotiate the Service Agreement contracts while seeking official approval from the District Executive Director (DED). The idea behind the Service Agreements was for private hospitals to deliver health services to disadvantaged groups (pregnant women, children under the age of five and elderly people), without charging any patient fees. These services were to be compensated for by the councils (Bandio 2012; Ministry of Health 2011b). This form of PPP contract is explained further in Chapter 7.

The same year that the Service Agreements were launched, the government also continued to invest in public health facilities. In 2007, the Ministry of Health developed and launched its Primary Health Care Service Development Programme, with the objective of accelerating the provision of primary healthcare services for all. The programme aimed at strengthening the public health systems and had a specific focus on building new health facilities as well as improving outreach services (Government of Tanzania 2010).

In 2008, several complementary plans were added to the national health strategies and policies. The Health Sector Strategic Plan III, 2009–2015, reinforced the role of the private sector in the health sector. The PPP forums should be installed at the national, regional and district levels and Service Agreements should be used by all local governments when contracting pri-

vate providers for service delivery. A “PPP office” was established at the ministry, as well as national and district committees including both public and private representatives (Ministry of Health 2009). This resulted in an increasing number of private providers being contracted for service delivery. In the PPP forums, church organisations were to be represented by the Christian Social Services Commission together with private for-profit organisations (World Bank 2013).

New forms of public private partnerships introduced

The current institutional framework for PPP includes a PPP Policy, a PPP Act and PPP regulations. The PPP Policy was introduced by the government in 2009 and includes a comprehensive overview and description of the PPP mechanism (Phares et al. 2014). In 2010 the PPP Act was approved by the parliament and specified the purpose, role, terms and conditions for these types of partnerships. The first Strategic Public Private Partnership Health Plan (2010–2015) was launched in 2010 (World Bank 2013).

Through the 2011 PPP regulations, church organisations were offered the possibility of entering into sub-contracting and receiving funding for operating costs in a more structured way, such as basic salaries for employees, medicine and infrastructure by the local government. In return, church organisations were responsible for operating the health facilities, including the maintenance of buildings and new investments in health infrastructure (Ministry of Health 2011a).

The current PPP framework allows for different forms of collaborations between the government and church organisations. This is based on the nature of the contract, on the parties involved and on the types of service delivery (World Bank 2013). The PPPs may be classified into three main categories: (1) delegation of responsibility; (2) purchasing of services; and (3) cooperation (Boulanger & Criel 2012). The first category, *contractual relations based on delegation of responsibility*, refers to when the state delegates the task of operating healthcare facilities to another agent. The second category, *contractual relations based on an act of purchase*, is when a health actor entrusts a partner with providing services in exchange for payment. Finally, a contractual relation based *on cooperation* refers to sharing the resources needed to work together with a partner towards a common goal while respecting each other’s identity (Boulanger & Criel 2012; Ministry of Health 2011a; Ministry of Health 2011b).

In relation to the different forms of collaboration, there are three main types of collaborative contracts, as discussed above: (1) Council Designated Hospital Contracts, (2) Service Agreements, (3) Grant-in-Aid (National PPP Steering Committee 2009). Some of these contractual models may be combined, while others may only be entered into separately. It is important to note that it is not possible for every hospital to be granted the status of CDH

(Bandio 2012). However, every dispensary, health centre, hospital and any other facility can technically enter into a Service Agreement with a council (Ministry of Health 2011a). Grant-in-Aid is the oldest model and continues to be the most common arrangement for church-based hospitals. The Grant-in-Aid model is also to some extent integrated with the other collaborative partnerships (Bandio 2012). With regard to the staff grants, these are paid out directly to the church-based hospitals by the national treasury (National PPP Steering Committee 2009). However, both the Council Designated Hospital contracts and the Service Agreements are examples of collaborative forms of PPPs that increased in numbers during the years when the study was conducted (2011–2014). Table 7 shows the different forms of collaborative partnerships between public health authorities and church-based hospitals (Boulanger & Criel 2012).

Table 7. Partnerships between public authorities and church-based hospitals

Collaborative partnerships, models and funding systems for church-based health facilities	
<i>Type of collaborative partnership</i>	<i>Type of contract</i>
Delegation of responsibility	DDH/CDH/RHRL/ZRH agreements (district council level) RHRL – Referral Hospitals, such as Ilembula, Haydom and ALMC (regional level) ZRH – Zonal Referral Hospital, such as Bundando, KCMC.
Purchasing of services	Service Agreement (SA) (local level)
Cooperation <i>The national cooperation is based on a 1992 Memorandum of Understanding between the Government and the CSSC.</i>	Grant-in-Aid (GA): Bed, staff and training grants (including those who still hold a voluntary agency contract) (national level)

Source: Boulanger & Criel 2012

In spite of the contracts with the state as presented above, the majority of church-based hospitals are still financed by *user fees* set by the individual facilities and the local government systems (Hazeen 2012). Other important income sources continue to be: *Vertical Health Funds* (e.g. HIV/AIDS, malaria, tuberculosis, etc.), *external direct support*, *Income Generating Projects* (IGPs) and *National Health Insurance Funding* (NHIF) (World Bank 2013; Tibandebage & Mackintos 2012). Grants concerning medicines are also channelled to church-based hospitals through a lump sum given to local hospital pharmacies (World Bank 2013).

Table 8 summarises major health reforms and policies that have had an impact on the healthcare provision and financing of church organisations' health services since 1990 (Ministry of Health 2016; Ministry of Health

2015). The fields marked in grey represent the collaborative arrangements, models and funding systems for church-based health facilities.

Table 8. Overview of major health sector reforms⁵

Major health developments affecting church organisation healthcare facilities	
<i>Year</i>	<i>Reform/policy</i>
1990	The first National Health Policy (cost-sharing)
1991	The liberalisation of private healthcare provision
1993	Government/Development Partner Appraisal Mission on the Health Sector
1994	Proposal for Health Sector Reform Agreement to Enter a SWAP Programme in Health
1998	Agreement to enter a SWAP Programme in Health
1999	Poverty Reduction Strategy (PRS) identifies health as a priority
1999	Health Sector Strategic Plan I (HSSPI) (1999–2002) (including PoW and SWAP)
1999	Comprehensive Council Health Plans (CCHP) introduced
2000	Health Basket Fund introduced
2002	National Health Insurance Fund (NHIF) established
2003	Health Sector Strategic Plan II (HSSP2) (2003–2008)
2005	Revision of the DDH contract model – CDH introduced
2006	Joint Assistance Strategy for Tanzania
2006	The Grant-in-Aid Regulations to Voluntary Agencies (VA)
2007	The National Health Policy (2007 – approved draft from 2003)
2007	Health Services Agreement (SA) template released by the government. Service Agreements introduced. Funding starting to be channelled through CHMTs
2008	The Primary Health Care Service Development Programme (2007–2017)
2009	Health Sector Strategic Plan III (HSSP III) (2009–2015)
2009	The Public Private Partnership (PPP) Policy
2010	PPP Act – A structured framework for the implementation of PPP
2010	The Strategic PPP for Health Plan (H/PPP) (2010–2015)
2011	PPP regulation
2011	Comprehensive Council Health Planning Guidelines (CCHPGs)
2012	Tanzania National eHealth Strategy 2012–2018
2013	Health Sector and Social Welfare Public Private Partnerships Policy Guidelines
2015	Health Sector Strategic Plan (HSSP IV) 2015–2020

⁵ In addition, the following national frameworks have also had an impact on health sector developments: (1) Vision 2025; (2) MKUKUTA I-II; and (3) Big Results Now (2011). All these development plans and frameworks have important objectives related to health sector developments at large.

The state as guardian of public health

Despite an emphasis on the private sector in the last two decades, the government still delivers the bulk of all health services (Ministry of Health 2016). Mainland Tanzania is currently divided into 25 regions. These regions are then divided into districts, some are divided into councils. These councils are local government units providing both public services and contracted-out services through PPPs. Church organisations tend to be major actors at the district level, whereas at the lower levels of the health system, the local government tends to dominate when it comes to operating dispensaries and rural health centres.⁶ Approximately 87 percent of all health services in Tanzania are delivered at dispensaries (Boulenger & Criel 2012). Where the government does not have a district hospital of its own, the church organisations in question integrates its own facility through a Council Designated Hospital contract (CDH). Primary healthcare services constitute the base of the pyramidal structure of the health system. Community-based health activities, often in the form of disease control programmes promoting good health practices and preventive measures, are supposed to reach families in villages and neighbourhoods. Public and private providers operate dispensaries and health centres. Dispensaries provide preventive and curative services, while health centres may also admit patients and sometimes provide surgical services. Council hospitals provide healthcare, medical and basic surgical services to referred patients. Regional referral hospitals provide specialist medical care, whereas zonal and national hospitals offer advanced medical care (Ministry of Health 2016.).

⁶ There are a few exceptions, for example along the Muslim dominated coastal area.

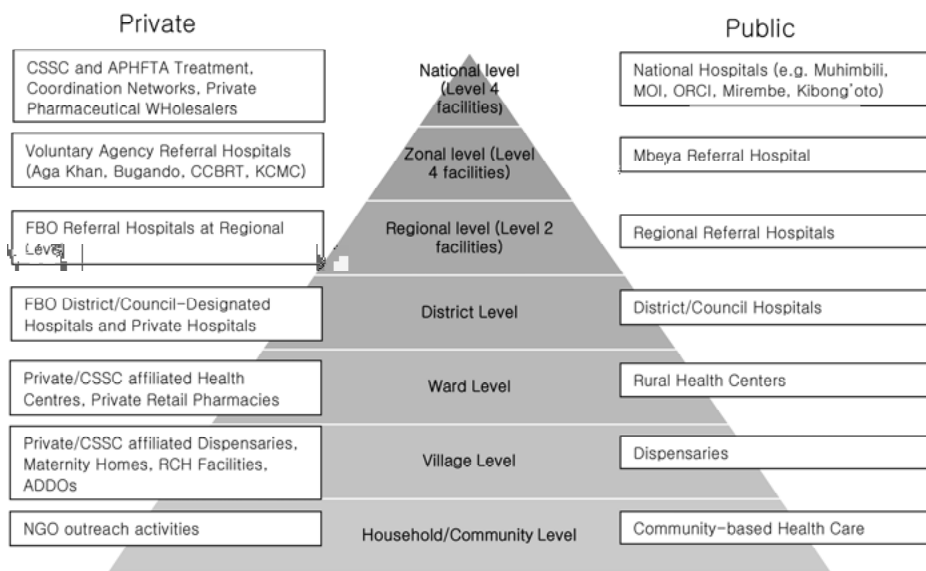


Figure 2. The healthcare pyramid

Source: Tanzania Service Assessment Survey 2015–2015 (2016)

Church organisations enter into PPP contracts directly with the local governments at the council level. Districts are granted funds to run district community services. The Local Government Reform Programme introduced in 1998 has had a profound impact on health sector development, as the decentralisation process has been seen as one of the main strategies of the health sector reform (Fjeldstad et al. 2005).

As a consequence, setting priorities and resource allocation planning has gradually been delegated from the Ministry of Health to the district councils, where local government staff in the health sector fall under the authority of the district councils. The Prime Minister's Office – Regional Administration and Local Government has been given the authority to oversee the district system of district hospitals, primary healthcare centres and dispensaries. However, the health systems are still administrated by the Ministry of Health, providing overall policy direction and quality control. The Ministry of Health is also in charge of the regional and national referral hospitals (Ministry of Health 2016; Hazeen 2012). The decentralisation reform has aimed at strengthening cooperation with faith-based health facilities at the council level and the private sector at large (Itika 2009). During the time of the study, international donors supported the Local Government Reform Programme with significant external support (Ewald 2013).

The Local Government Reform Programme

The centrepiece of the Local Government Reform Programme has been to transfer duties and financial resources from the central to the local government levels (Hazeen 2012; Itika 2009). For an overview of the regional and local governance structure in Tanzania, see Figure 3. This has been done with the intention of strengthening local authorities and transforming them into becoming effective instruments for social and economic development at the local level. The core idea has been *decentralisation by devolution*, aiming at fiscal, administrative and political decentralisation of service delivery, in addition to altered centre-local relations (Ewald 2013). Even though the policy of decentralisation by devolution has emphasised local autonomy and community participation in theory, in practice, however, local governments have not been granted complete autonomous authority, but have rather been assigned to take on functions from the central government (Fjeldstad et al. 2006). In fact, the autonomy of the local governments is considered rather weak (Ewald 2013).

Decentralisation started already in 1982, but it was not until 1996 that the current Local Government Reform Programme was effectively implemented and later formulated into a policy to be launched in 1998 (Ewald 2013; Itika 2009). The decentralisation process developed further in the mid-1990s when the full implementation of the Local Government Reform Programme was put in place (Boulanger & Criel 2012; Fjeldstad et al. 2006). However, due to difficulties in mobilising the local tax base in most local government authorities, the local governments are still dependent on funds from the central government (Ewald 2013).

The majority of health resources allocated to district health services thus still come from the central government and international donors (Fjeldstad et al. 2006). Given this situation, the government faces a difficult task in convincing district authorities to accept decentralisation as a means of providing better and more efficient health services (Mushi & Katunzi 2004).

Council Health Management Teams

The district level is the main site for local government administration, including local government authorities referred to as district councils (Figure 3). Council Health Management Teams operate at district level and manage health facilities at the district, town and municipal level, implement health policies and strategies, allocate funding and resources, and report health and service data back to the Ministry of Health. The District Executive Directors (DEDs) authorise budgets and PPP contractual agreements. The Council Health Services consist of primary referral hospitals and primary healthcare facilities, health centres and dispensaries. The level of funding to the coun-

cils is defined by an allocation formula applied to the Health Basket Fund (Development Partner Group for Health 2016; World Bank 2013).

The Council Health Management Teams produce annual Comprehensive Council Health Plans, which in theory outline all the district health activities and budgets for services (Ministry of Health 2007a). The Ministry of Health provides the councils with tools for developing these plans based on district planning guidelines, guidelines on the utilisation of Health Basket Funds and health block grants, as well as various guidelines and protocols in service delivery. Within the local districts, most of the decision-making power regarding health issues is concentrated in the hands of the District Medical Officer, the Council Health Management Team and the District Executive Directors. The teams perform a range of activities, such as preparing comprehensive council health plans, ensuring the provision of transportation, drugs and medical supplies to health facilities, carrying out supportive supervision to lower level facilities and ensuring the provision of quality health services in the district, while also drafting PPP contracts and financial agreements (Prime Minister's Office 2012).

6. The three selected cases in the study

Church organisations are the largest civil society organisations in Tanzania. Combined, the three selected church organisations have almost 20 million members. In this chapter I present the three church organisations and the three hospitals I focus on in the empirical study. For each church organisation, I give an overview of its involvement in the health sector, its national church health department, national health policy and specifically the partnership related to the selected hospital.

The descriptive overview presented in this chapter is an outcome of the empirical study. Most of the information was collected through an explorative mapping exercise using qualitative policy text analysis, semi-structured interviews and participant observation. Part of the information presented was collected based on secondary sources (literature, reports and websites).

I start the chapter with a presentation of the first case study: (1) Tanzania Episcopal Conference (TEC) and its related church-based hospital, St. Francis Turiani Mission Hospital Tanzania. I then present the second case study: (2) Evangelical Lutheran Church in Tanzania (ELCT) and its related church-based hospital, Selian Lutheran Hospital, followed by a presentation of the third case study: (3) Free Pentecostal Church of Tanzania (FPCT) and its related church-based hospital, Mchukwi Mission Hospital.

Case I – Tanzania Episcopal Conference

Tanzania Episcopal Conference (TEC) is the national Catholic episcopal organisation in Tanzania. The Roman Catholic Church in Tanzania is part of the worldwide Roman Catholic Church, under the spiritual leadership of the Pope and the curia in Rome. The Roman Catholic Church in Tanzania consists of about 10–12 million members (Tanzania Episcopal Conference 2016). The Pew Forum's report states that 51 percent of Christians living in Tanzania are Roman Catholics (Mukandala 2006b, p. 12). TEC is considered the most influential religious organisation in terms of levels of social service provision, such as health and education, and also in terms of impact on national policy and public affairs (Ludwig 1999; Sivalon 1992). The Catholic Church in Tanzania is built up from semi-autonomous Catholic religious orders, grassroots lay movements and religious communities, in some cases headed by women.

The formal episcopal organisation for the Catholic Church (TEC) was founded in 1956 under the name of the Tanganyika Catholic Welfare Conference. The main mission of the TEC secretariat is to coordinate, promote and support all Catholic dioceses to ensure integral human development. Its vision is: “A righteous society with integral and sustainable development” (Tanzania Episcopal Conference 2008, p. 4). TEC is the apex body for six archdioceses and thirty-four dioceses with parishes and sub-parishes comprised of small Christian communities. TEC is headed by a president, a vice president and a secretary-general in charge of the secretariat with nine departments. In addition, TEC has twelve commissions and heads three units (Tanzania Episcopal Conference 2016). Apart from being the largest private provider of healthcare services, TEC is also a leading provider of educational services and civic education (Tanzania Election Monitoring Committee 2016). TEC coordinates the pastoral and health activities of the dioceses, and grassroots lay movements bring representation from the local communities up to the national level. The independent Catholic Relief Systems Organisation (CARITAS) is also connected to TEC.

TEC’s developmental activities, including health, reach the beneficiaries regardless of faith (Tanzania Episcopal Conference 2008). In its vision statement, TEC wants to see “a society which is just and free from social and spiritual constraints, a transformed society with holistic sustainable integral human development that frees people from poverty, diseases and social injustice” (Tanzania Episcopal Conference 2008, p. 4). The Catholic faith is central in all policies and operations, including its position on family planning. This means that TEC does not officially participate in activities contrary to its policies; for example, programmes promoting contraceptives (Leurs et al. 2011). This position is even motivated in the TEC Health Policy: “The Catholic Church shall continue providing healthcare in collaboration with government and other providers of good will, without compromising Catholic Church values and identity” (Tanzania Episcopal Conference 2008, p. 43). In all other areas, the central leadership of TEC reports a positive relationship with the government by emphasising a culture of understanding and mutual dialogue.

Health sector engagement

All Catholic health institutions in Tanzania are coordinated and supported by TEC’s national Health Department. The vision of the Health Department is to contribute to: “A mentally and physically healthy society with integral and sustainable human development which is evident of a fulfilled mission.” Its mission is “to continue with the healing ministry of Jesus Christ by providing a holistic, qualitative and sustainable healthcare, in line with Roman Catholic Church moral and ethical values” (Tanzania Episcopal Conference 2008, p. 4). The main task of the Health Department is to assist Catholic

dioceses in Tanzania in improving the management and quality of their health services, and the general tasks of the Health Department are further specified in the national Catholic Health Policy (Tanzania Episcopal Conference 2008).

TEC has a long tradition in health service provision in Tanzania (Grundmann 2005), where healthcare ministry has been carried out as an integral part of missionary work, evangelisation and pastoral care (Tanzania Episcopal Conference 2008). In 2014, when the study was conducted, TEC was operating 46 hospitals (20 Designated District Hospitals/Council Designated Hospitals and 26 Voluntary Agency Hospitals), 52 health centres and 328 dispensaries and maternity waiting homes. There were seven officially recognised referral hospitals at the regional level (Tanzania Episcopal Conference 2008, p. 4). TEC officially claims that the health services provided by the Catholic Church in Tanzania constitute about one third of all healthcare services in the country (Roman Catholic Church in Tanzania 2016). Figures from the Ministry of Health and the Christian Social Services Commission instead point towards a somewhat lower figure, around 20 percent (Christian Social Services Commission 2015).

The work of TEC is grounded in the calling of the Catholic Healing Ministry with an emphasis on Catholic social teaching and a holistic view of salvation, by incorporating a great concern for health and wellbeing. This has been true since the missions started. As an example of this, pastoral counselling and spiritual services are offered to all patients in Catholic health facilities, with a particular focus on the marginalised (Interview 15). At the same time, health services are open to people regardless of religious background. The TEC Health Policy stresses that “services by other religious denominations shall be recognised and respected and patients shall be assisted to access the required spiritual care” (Tanzania Episcopal Conference 2008, p. 14). This includes aspects of African traditional religions, as the Catholic Church has a selective collaboration with traditional healers. The TEC Health Policy also emphasises collaboration with public health authorities in order to avoid duplication and to work in common areas of interest. Through the Christian Social Services Commission (CSSC), TEC works at the national level with health advocacy for the common promotion of solidarity and collaboration with the government. TEC is considered the leading agent within the CSSC and wishes to continue strengthening this organisation, without compromising its Catholic identity (Tanzania Episcopal Conference 2008). However, the natural family planning policy and restrictions on modern contraceptives are negotiated outside the CSSC, directly between TEC and the government (Interview 16).

St. Francis Turiani Mission Hospital

St. Francis Turiani Mission Hospital, hereafter referred to as Turiani Hospital is situated in Bwagala, three kilometres from the village of Turiani and about 120 kilometres from the town of Morogoro in Tanzania. (Salahuddin 2016; Ministry of Health 2011c).

Hospital profile

The Catholic Diocese of Morogoro currently operates Turiani Hospital. The hospital is integrated into the public health system in the Mvomero District through a Council Designated Hospital contract (Interview 32).⁷ Since its establishment, the Turiani hospital has grown to become the largest hospital in the district with a capacity of 180 beds. The Turiani Hospital offers services typically associated with a rural hospital and is divided into seven wards with an estimated number of 12,000 inpatients/year and around 58,000 outpatients. The hospital is surrounded by a few other hospitals: Mtibwa Sugar Cane Estate Hospital, Kilosa District Hospital, Handeni District Hospital, St Kizito Hospital, Morogoro Regional Referral Hospital and Berega Hospital in Gairo District (Ministry of Health 2011c). As of 2014 Turiani hospital had approximately 150 employees serving around 370,000 people, mainly from the Mvomero District, but also from neighbouring districts. The hospital covers an estimated population of 400,000 people. Due to the remoteness of the villages, a number of mothers arrive at the hospital at a late stage, which means that the prolonged labour necessitates obstetrical emergency services. The maternity and female wards are often so overcrowded that expecting mothers and female patients have to sleep on the floor. I observed this during participant observation. The hospital also runs health outreach activities in the surrounding villages to provide vaccination and basic treatment of malaria, malnutrition and eye infections, as well as distributing information on the prevention and control of tuberculosis and HIV/AIDS. Maternal and primary care is prioritised.

The vision of the hospital is “to aspire for quality health services to all” with the mission “to provide holistic, high quality, affordable and sustainable healthcare to the community in accordance with Catholic medical ethics” (St. Francis Turiani Mission Hospital 2012.). This mission is reflected in the daily devotions that take place at the hospital (Memo 1a). The hospital is furthermore built on nine core values (Salahuddin 2016). The hospital management highlights that the hospital is operated in accordance with Catholic ethics, while also emphasising that they follow the medical ethics of the

⁷ The hospital was originally registered as a Voluntary Agency Hospital and changed its status to a CDH in 2011.

Ministry of Health, except with regards to natural family planning (Interview 32).

Hospital ownership and PPP contract

The Turiani Hospital was initially built and operated by the German Missionary Sisters of the Precious Blood. It opened in 1962⁸ and was registered as a Voluntary Agency Hospital in 1967. The German missionaries owned the property until 1978, when it was handed over to the Catholic Diocese of Morogoro and the management was taken over by the Immaculate Heart of Mary Sisters or, as they are commonly known, the Mgolole Sisters. The Mgolole Sisters is a Tanzanian order of Catholic nuns with no affiliation to any Western order of nuns. (St. Francis Turiani Mission Hospital 2016).

This transition took place as a result of the withdrawal of financial support from the Sisters of the Precious Blood in Germany (Interview 31). During the transition period, a board of governors was installed to advise and assist the diocese and the hospital management. The board consisted of representatives from the Mgolole Sisters, the Catholic Diocese of Morogoro, the Ministry of Health, the hospital staff and the district council (St. Francis Turiani Mission Hospital 2007). Despite changes in management, the hospital was still centred on faith.⁹ During the period of 1982–1989, a closer and more structured collaboration with the local government was initiated by an expatriate Dutch medical doctor (Memo 1e).

However, it took two more decades until the hospital management started to negotiate a formal contract with the Ministry of Health and the Mvomero Council. In April 2010, the Ministry of Health agreed to support the signing of a CDH contract, soon leading to the transition to a Council Designated Hospital. This meant that the Council Health Management Team (CHMT) of the district of Mvomero engaged in a formalised contractual relationship with the Turiani Hospital (Interview 36), which became official when the Mvomero District Council and the Catholic Diocese of Morogoro signed the contract on May 28, 2011 (Chiduo 2013). In 2012, the hospital formally gained its status as a CDH and started operating through a contractual partnership with the district council. Turiani Hospital thus became responsible for implementing the National Health Policy, focusing on improving the healthcare services for the district communities at large (Ministry of Health 2011c). As part of this agreement, and in order to reach national health objectives, the Turiani hospital management team committed to each year par-

⁸ According to other complementary sources, the hospital was established three years later, in 1965.

⁹ The initial mission of the hospital was: “To bear witness to the compassionate love of Jesus Christ through continuing his healing ministry by providing holistic, quality, sustainable and affordable healthcare to the community in line with Catholic Medical Ethics” (St. Francis Turiani Mission Hospital 2007).

ticipate as members of a Comprehensive Council Health Planning Team. Turiani Hospital also continued receiving staff grants from the district council to cover 39 staff members (Chiduo 2013, p. 7–8).

Hospital partnerships with external partners

The Turiani Hospital has been engaged in several global partnerships and collaborations outside the partnership with the district council. These partnerships have had a significant influence on the development of the hospital, which is obvious when comparing this hospital to nearby public health facilities (Memo 1c). As explained initially, the hospital received core external funding from the Misereor through the German Missionary Sisters of the Precious Blood. However, this support ended at the turn of the millennium. The hospital then entered into a new partnership with a support group based in the Dutch city of Groningen. This partnership has subsequently developed further and constitutes the current core external support of the hospital. The support group is built on two Groningen-based foundations, namely the Foundation Friends of Turiani and the Burns Turiani Foundation (Foundation Friends of Turiani 2015). Both of the foundations consist of friends and experts who support the further development of the hospital. Both are officially not religiously affiliated (Memo 1b).

The Burns Turiani Foundation was established in 1999 with the main purpose of strengthening the educational capacity of the hospital by acting as a key strategic partner in new areas of development. The link with Groningen goes back to as early as 1977, when a group of medical students from Groningen under the name of Medical Aid by Student Help started supporting Turiani Hospital by regularly sending medical material from Groningen hospitals. An agreement was later signed between the Burns Turiani Foundation and the Martini Hospital in Groningen, making the expertise of that hospital available and contributing to the strengthening of skills and knowledge at Turiani Hospital. According to representatives of the BTF, the links are still strong and the manner in which they work together is very inspiring for all parties (Burns Turiani Foundation 2012).

The Foundation Friends of Turiani was founded in Groningen in 2008 with the goal to support the hospital management in the strategic development of the hospital district (Foundation Friends of Turiani 2012). The collaboration started when they acknowledged changes in the development of the hospital related to both financial and organisational challenges, as the hospital was about to sign a Council Designated Hospital contract (Burns Turiani Foundation 2012).

It is important to highlight that the friends associations are the driving force behind the latest development projects at the hospital. In 2007, a master plan for the hospital was developed with support from the associations and CORAT Africa (CORAT 2016). The project “New Maternity and La-

bour Wards” has been the largest infrastructure project executed with the support of these foundations, realised through support from donors and experts in Holland. The new ward was built exclusively with funding from the Dutch friends associations (Interview 32). Since 2012, the foundations have also supported the development of a nursing school as a first step in launching a healthcare training centre at Turiani Hospital. This initiative is carried out together with St. Kizito Hospital in Mikumi (Foundation Friends of Turiani 2012).

Case II – Evangelical Lutheran Church in Tanzania

The second case study included in this study is the Evangelical Lutheran Church in Tanzania (ELCT). The ELCT is the dominant Protestant denomination in Tanzania with the vision statement to be: “A communion of people rejoicing in love and peace; blessed spiritually and physically, hoping to inherit eternal life through Jesus Christ” (Evangelical Lutheran Church in Tanzania 2016). The ELCT consists of 25 dioceses and has seen a remarkable growth in membership with around 6.5 million members (Lobulu 2015).

At the beginning of the 20th century, there were seven Lutheran churches in Tanganyika. In 1938, these churches founded a federation known as the Federation of Lutheran Churches in Tanganyika (FLCT), which brought together all seven Lutheran churches spread out in different parts of the country. At the time, their total membership was approximately 500,000 members (Evangelical Lutheran Church in Tanzania 2015). Each Lutheran church had its own connections with a particular foreign mission society (Bendera 2014). Following independence, on June 19, 1963, the seven churches merged to become dioceses of a single church, known as the Evangelical Lutheran Church in Tanganyika. The following year, when the union with Zanzibar was created, the church was renamed the Evangelical Lutheran Church in Tanzania (ELCT), or *Kanisa la Kiinjili la Kilutheri-Tanzania* (KKKT) in Kiswahili, and became a member of the Lutheran World Federation (LWF) that same year (Evangelical Lutheran Church in Tanzania 2015).

Its current mission is “to make people know Jesus Christ and have life in fullness by bringing them the Good News through words and deeds based on the Word of God as it is in the Bible and the Lutheran teachings guided by the ELCT constitution” (Evangelical Lutheran Church in Tanzania 2016). The ELCT head office is located in Arusha. They also run a radio service called Voice of Gospel, as well as the magazine *Uhuru na Amani* and the weekly paper *Tega Sikio* (Noorali 2010). The leadership of ELCT is represented by the presiding bishop, elected for a four-year term amongst the bishops of the dioceses. The organisation’s decision-making bodies are the General Assembly of the ELCT and an Executive Council consisting of diocese bishops, diocese secretary-generals and directors of ELCT institutions.

The ELCT focuses on propagating the “holistic Gospel” serving man through spiritual, social, economic and environmental programmes in order “to have a God loving community hence fulfilling God’s mission in Tanzania” (Evangelical Lutheran Church in Tanzania 2015).

The structure of the national secretariat is built on the secretary-general and four departments, including a Desk for Advocacy, Democracy and Communication. In addition, the ELCT also has several institutions serving the entire church and its units, as well as a Lutheran Investment Company Ltd. (LUICO Ltd) (World Council of Churches 2016). Relations with external actors and donors are mainly facilitated through the Lutheran Mission Cooperation (LMC), which is a joint instrument of the Evangelical Lutheran Church in Tanzania (ELCT), and international partners from the global north with the objective of fulfilling the national vision, mission, goals and thematic priorities. The ELCT is also an active and integrated member of the Christian Social Services Commission (CSSC), Christian Council in Tanzania (CCT), the Lutheran World Federation (LWF), the ACT Alliance and the World Council of Churches (WCC) (Evangelical Lutheran Church in Tanzania 2016).

Health sector engagement

The ELCT Health Department coordinates and supports all of the organisation’s health activities. The ELCT Service Charter is the organisation’s health policy. It describes the vision and mission of ELCT health services, principles of service delivery and core values to be applied in all ELCT health institutions. Referred to as the healing arm of the church, the vision of the ELCT health work is “to have a healthy society with healthy individuals and communities whereby physical, emotional, mental and spiritual needs are met and balanced, resulting in a peaceful and joyful life”. In its health services delivery, the department uses a “wholeness approach” with regard to the individual, taking care of the body, soul and mind. It operates under the Social Services and Women Work Directorate of the ELCT (ELCT Health Department 2016). A Health Department representative stresses that “the mission of the church is to serve human beings; holistically, physically, mentally and spiritually and to serve without any discrimination” (Interview 24).

Since its establishment, the Health Department has been funded by the national Managed Health Care Programme (MHCP) with core funding from the Danish Mission Development Department. The MHCP has been implemented in dioceses, at ELCT hospitals and in surrounding communities, which has resulted in several projects and programmes (ELCT Health Department 2016). Other international partners have simultaneously supported the development of the ELCT’s own healthcare provision and advocacy work, such as the Evangelical Lutheran Church in America (ELCA), the

Church of Sweden and the Finnish Evangelical Lutheran Mission (Finish Evangelical Lutheran Mission 2016). At the time of the study, the department was operating about 15 percent of Tanzania's health services: 24 hospitals and up to 148 health centres and dispensaries (ELCT Health Department 2016).¹⁰ A representative of the ELCT Health Department claimed that: "A big segment of the Tanzanian national health services are provided by the ELCT; 15–20% as part of the national health policies" (Interview 24).

The Lutheran health services are provided at the grassroots level and organised all the way up to the central level with a health secretary in each diocese and with local health representatives in each parish (Interview 24). The respective ELCT diocese appoints a pastor to support the hospitals with spiritual services (prayer and spiritual counselling) under the concept of pastoral and spiritual care (Evangelical Lutheran Church in Tanzania 2010). Through support from the Church of Sweden, ELCT has developed a national programme training ELCT pastors to become chaplains at ELCT hospitals. The Clinical Pastoral Education takes place at KCMC in Moshi (Memo 2e). As stated in the ELCT Health Charter: "Patients should feel free to express his/her spiritual needs to the healthcare provider" (Evangelical Lutheran Church in Tanzania 2010, p. 19). Spiritual services at the health facilities are regulated in the ELCT's Pastoral Care Policy, in the form of a routine that each day, and in every ELCT hospital and health facility, the staff gathers to start the day by praying for God's blessings on the clients, staff and the work, and all staff "shall pray together with patients, as appropriate, before delivery of services" (Evangelical Lutheran Church in Tanzania 2010, p. 6–7).

The ELCT Health Charter emphasises that the Lutheran health institutions are part of the National Health Services network (Evangelical Lutheran Church in Tanzania 2010). The ELCT also works together with the Catholic Church on advocacy through the Christian Social Services Commission. As part of this partnership, it collaborates with the Tanzania Public Health Association in order to identify ways of improving quality in healthcare in ELCT hospitals. Since 2002, the organisation has also conducted negotiations with the Ministry of Health to revisit reform policy and ensure more access to funds from the basket funding (Ministry of Health 2003b). At the regional level, the ELCT is also affiliated with the All Africa Conference of Churches (Noorali 2010).

¹⁰ Three out of those were District Designated Hospitals (DDHs)/Council Designated Hospitals (CDHs), three zonal referral hospitals and a wide range of community-based health services, including programmes for HIV/AIDS control, primary healthcare, palliative and home-based care. (ELCT Health Department 2016). Päivänsalo confirms same figures (Päivänsalo 2013).

Selian Lutheran Hospital

The second church-based hospital included in the study is the Selian Lutheran Hospital (SLH), hereafter referred to as SLH. It is located near the village of Ngaramtoni within the Arumeru District of the Arusha Region (Selian Lutheran Hospital 2015).

Hospital profile

SLH is a semi-rural medium-sized hospital of the Evangelical Lutheran Church in Tanzania – North-Central Diocese. As of November 2012, SLH is one of three district hospitals in Arusha, and the hospital is integrated into the public health system through a CDH contract. SLH currently assists nearly 200,000 people in the wider catchment area of urban Arusha and the broader area of two regions, namely Arusha and Manyara, technically extending its activities to nearly 3 million people (Selian Lutheran Hospital 2015). SLH is also affiliated with the Kilimanjaro Christian Medical Center and Tumaini University Makumira (Drain 2009).

The mission of SLH is to “serve, treat, and minister to the whole person; in body, mind, and spirit”. SLH strives to fulfil this mission by providing competent and compassionate medical care, promoting health development community projects and proclaiming the Gospel of Jesus Christ from a holistic approach (Selian Lutheran Hospital 2015). Since its start, SLH has served the physical, emotional and spiritual needs of its patients, and this policy is reflected in the daily morning prayer taking place at the hospital chapel every weekday at 8.00 am. A chaplain is regularly attached to SLH, conducting spiritual services at the hospital, including counselling for patients and staff, devotions and praying for patients (Memo 2d). A management representative refers to the motto as: “We call prayer our first medicine” (Religions & Ethics 2007).

At the time of the study, SLH had 254 permanent employees on its payroll (Selian Lutheran Council Designed Hospital 2012, p. 5) and approximately 125 hospital beds offering outpatient and inpatient services, including medicine, paediatrics, general surgery, obstetrics and gynaecology. Most patients come to the hospital with infectious and tropical diseases or with surgical emergencies (Selian Lutheran Council Designed Hospital 2012). SLH also provides regular orthopaedic care to those in need.

In addition to its mainstream activities, the hospital is also engaged in many thematic projects focused on supporting and providing assistance to HIV/AIDS treatment. These programmes are based on a community-based approach. The AIDS Control Programme provides a full range of comprehensive, high-quality care activities and preventative education (Memo 2e). The programme aims to introduce Christian values and life skills to young people through the training of pastors, evangelists and other church leaders

in AIDS counselling. The programme is funded through a five-year USAID PEPFAR grant (Selian Lutheran Council Designed Hospital 2012). The hospital also hosts a support group known as ALPHA+ (Arusha Living Positively with HIV/AIDS). This is the largest such support group in Arusha, and it meets regularly at the Selian's Uzima (Wholeness) Centre in Arusha (USAID 2014; Vähäkangas 2006). SLH also conducts AIDS education and awareness-raising activities, which aim to expand into new areas concentrating on the training of local church leaders, school educators, peer groups, traditional leaders and high-risk groups within the community (Selian Lutheran Council Designed Hospital 2012).

SLH also runs health development programmes, such as the Selian Hospice and Palliative Care Programme. The hospice team provides inpatient care in hospitals and as community and home-based care, in addition to hospice and palliative care activities throughout the four districts of Arusha. The team working on this programme consists of medical, social and spiritual personnel. This programme uses trained volunteers who make regular home visits and help provide day care services (Arusha Lutheran Medical Centre 2014). The Palliative Care Programme has received a great deal of international recognition for its inter-religious character. The services in this programme are available to patients regardless of religious background, a point stressed in the volunteer training. In fact, as many as ten percent of the Selian volunteers are Muslims serving in the Lutheran programme (Vähäkangas 2014). The Selian palliative care programme has become a model for similar programmes throughout the country (Foundation for Cancer Care in Tanzania 2015). SLH also runs community projects to identify disabled children and offer them surgery, physical therapy and rehabilitation. This programme also enables children to be restored and obtain acceptance in their communities, while also creating opportunities for some of the beneficiaries to return to school (Arusha Lutheran Medical Centre 2016).

Hospital ownership and PPP contract

SLH was started as a Lutheran dispensary in the 1950s by a female missionary from the Evangelical Lutheran Church of America (ELCA) (Selian Lutheran Hospital 2014). In 1985, a medical missionary worker from the Evangelical Lutheran Church of America (ELCA) arrived at the small clinic and started transforming it into a full hospital together with a team of Lutheran Tanzanian health workers. Ever since then, SLH has continued to expand (Erikson 2004). In 1991, SLH was registered as a private hospital. It is now governed by a board of directors and is an integrated part of the ELCT North-Central Diocese (NCD) (Selian Lutheran Council Designed Hospital 2012).

In December 2008, SLH entered into an agreement with the government of Tanzania through the local government – the Arusha District Council in

Arumeru District. Shortly after, SLH started operating in accordance with a Council Designated Hospital contract (Selian Lutheran Council Designated Hospital 2012). In order to get the CDH contract, the North-Central Diocese (ELCT-NCD) entered into an agreement with the Ministry of Health to transfer SLH to the government system. This process led to a further integration of SLH into the national health system, and SLH formally became one of three district hospitals in Arusha in November 2012 (Selian Lutheran Council Designated Hospital 2012).

As elaborated by a management representative of SLH: “The best thing was to get into a partnership with the government through the local authority so that we could at least get some subsidies to fund the hospital. Otherwise we would have had to close down. If everything depends on patient fees, it is not sustainable” (Interview 43). According to the agreement between SLH and the Council Health Management Team (CHMT), the government is obligated to pay for staff salaries, hospital supplies and other recurring expenditures. SLH, on its part, is supposed to remove patient fees for vulnerable groups. A management representative confirmed that “there are three groups of patients we are supposed to treat free of charge: children under the age of five, pregnant mothers and elderly people 60+” (Interview 44). As a CDH, the hospital should receive no less than 25–35 percent out the total district basket fund for the running costs of the hospital.

Whilst SLH is accountable to the public authorities, the hospital also reports to the Health Department of the ELCT North Central diocese and to international donors, such as the Evangelical Lutheran Church in America (ELCA) and several global health funds, and is under the guidance of the doctor in charge of the hospital and the Hospital Management Committee. The hospital management consists of a hospital board with ultimate responsibility for the direction of the hospital. The medical doctors and surgeons meet daily for prayer, administrative issues and discussions concerning the medical upgrading of the hospital. This meeting serves as the link between management and the medical care being provided in the hospital (Selian Lutheran Council Designated Hospital 2012).

Hospital partnerships with external partners

SLH is very dependent on external support (Interview 43–44). Since its establishment, the Evangelical Lutheran Church in America (ELCA) has been the core global supporter of, and partner to, the hospital. ELCA’s medical missionaries base their work on the motto: “God’s work. Our hands”. There are particularly strong ties between the ELCA Northern Illinois Synod, which is a companion synod of the ELCT North-Central Diocese (NCD) (Arusha Times 2009). Most of the medical missionaries are actively engaged in the local Lutheran congregation, the Arusha Community Church (ACC), which serves as a network arena for several international and national hospi-

tal staff members, visiting health personnel and medical and nurse students. Funding for different health activities is also raised through the ACC, even though the majority of funding is raised in congregations in the United States. This was observed during the time of the study. The ELCA partnership has also opened up the hospital for collaborations with other international partners and funds, primarily based in the United States (Memo 2a). Numerous external organisations in the area are involved in different collaborative projects with SLH.

The palliative care service of SLH has been linked to the Hospice of Metro Denver since 1999, thereby creating a long-term relationship that goes beyond fundraising (Selian Lutheran Hospital 2006). Since 2005, SLH has collaborated with hospitals in the Denver area associated with the Sisters of Charity of Leavenworth Health. This organisation has sent clinical teams to Arusha each year to care for patients, to help build human and medical infrastructure at SLH and to strengthen ongoing relationships between these hospitals. This partnership involves a two-way exchange of ideas, staff and approaches to hospice, as well as a commitment by the American hospice to give moral, educational and financial support (Denver Hospice 2016).

SLH also responded to a government request to consider developing an internship for Tanzanian and other international medical school graduates. One staff member developed an internship program that has been in place since 2006 (Selian Lutheran Hospital 2006). Another example is that SLH also collaborates with, and receives support from, the Pan-African Academy of Christian Surgeons in which they train medical doctors to the specialist level of surgeon in a fellowship form of doctors training (Pan-African Academy of Christian Surgeons 2014). Since 2011, Maternity Africa has also worked in close partnership with SLH. Maternity Africa has increased the level of fistula services available at SLH's 16-bed gynaecology ward, and in 2013, the organisation supported a volunteer midwifery tutor to build the capacity of the local health professionals, giving them support to conduct safer deliveries for Tanzanian women. Through this collaboration, several health experts (foreign doctors and midwives) from South Africa, Australia and the US have been based full-time or part-time at SLH. The hospital also receives support, both expertise and funding, through the Lutheran Mission Cooperation Tanzania (LMC) and the ELCT Health Department (Evangelical Lutheran Church in Tanzania 2008). Foreign donations have enabled the hospitals and healthcare institutions to keep and uphold affordable fees for patients and to avoid deficits. As an example, there is an annual Greenwood Village event, the Selian Lutheran Hospital 5K Run/Walk, held in collaboration with the Saint Peter Lutheran Church in Greenwood Village (St Peter Lutheran Church 2016). There are also several individual Lutheran churches in the US supporting the hospital, such as the Mount Calvary Lutheran Church (Mount Calvary Foundation 2017). Many global partners are cur-

rently addressing sustainability issues and wish that ELCT was in a position to generate more of its own funding (Interview 43). The present approach for overcoming this challenge facing the delivery of medical services is to negotiate the CDH contract further and to develop community health funds.

Case III – Free Pentecostal Church of Tanzania

The Free Pentecostal Church of Tanzania (FPCT) is the third case study. The FPCT has around 400,000 members in 192 local congregations and 850 local congregations all over Tanzania. Most of the congregations are situated in rural areas. The vision of the FPCT is: “A Matured and Self-Sustained Church bearing witness in target communities with the holistic Gospel of Christ”. Its mission stresses evangelisation and outreach as: “To preach the Gospel of Christ in every nation, making disciples and supporting the needy”, by reaching out with the gospel and starting new churches in neglected areas (Free Pentecostal Church of Tanzania 2013, p. 36–37). The FPCT Master Plan 2014–2024 was launched in 2014 including twelve objectives. It aims to cover programmes and activities as planned and implemented by the FPCT institutions and constituents. All departments, regions and institutions implement activities in thematic areas (Free Pentecostal Church of Tanzania 2013). The FPCT is one of the leading Pentecostal denominations in Tanzania; in fact, it was the first Pentecostal denomination to be registered in Tanzania.¹¹ The FPCT collaborates closely with the other predominant Pentecostal denominations through its membership in the Pentecostal Council of Tanzania (PCT). As of 2014, the presiding bishop of the FPCT, Bishop David Batenzi, was also the national chairman of the PCT. Furthermore, the FPCT is also a member of the Tanzania Evangelical Fellowship (TEF), an umbrella institution bringing together 53 member congregations and denominations. The mission of TEF is to mobilise and empower evangelical churches, as well as to empower the community and civil society by building capacities (Tanzania Evangelical Fellowship 2016).

The FPCT has its roots in the early 1930s when the Swedish Pentecostal churches in 1932 ordained and sent missionaries to Tanganyika under the name of the Swedish Free Mission (SFM) (Free Pentecostal Church of Tanzania 2016). Those joining the movement called themselves saved or born-again (Niwagila 1991). The notions of the confession of sins, redemption, consciousness of forgiveness and the commencement of a new and different life have together formed the basis of this movement (Ludwig 1999). The

¹¹ The first Pentecostal mission to arrive was the Holy Mission in 1927 in Mbeya Region. However, this mission did not establish itself until 1939, as it was connected to the Tanzania Assemblies of God (TAG). At this time, missionary Paul Deer handed the church over to the general council of AG in the United States (Tanzania Assemblies of God 2016).

SFM missionaries started their work in Nzega District in Tabora Region and in Kigoma Region (Nyanto 2015; Nyström 1998). However, it was not until 1955 that the SFM was incorporated as a mission society under the laws of Tanganyika (Ludwig 1999). After independence in 1961, the SFM volunteered to hand over its portfolio by establishing a trust and transferring all the mission properties and those of individual missionaries to the trustees of the Pentecostal Churches Association in Tanzania (PCSAT). PCSAT was formally registered as a trust in 1964, whereby the local churches were independent while simultaneously operating under a common constitution for the association. However, the social influence of the Pentecostals was marginal until the end of the 1960s (Free Pentecostal Church of Tanzania 2016). In the 1970s, however, Pentecostal movements started expanding more rapidly through national and local evangelisation campaigns. At this time, Pentecostal movements became the fastest growing grassroots movements in Tanzania. In the 1980s, a conflict broke out in the PCAT. A group discontented with the new directives founded a new movement, the Pentecostal Association of Tanzania (Ludwig 1999). The concept of “membership” as defined by the association was critically examined and later replaced by the doctrinal concept of membership within the spiritual body of Christ. This change brought about increased centralisation, both in terms of theological doctrine and organisational structure. And, as part of this transition, the PCAT changed its name once again in 2000, this time into its current name Free Pentecostal Church of Tanzania (FPCT) (Free Pentecostal Church of Tanzania 2016).

The FPCT is represented by an archbishop, a vice bishop, a secretary-general, a deputy secretary-general and an administration officer. The full authority of the FPCT is entrusted to the Annual General Meeting. The organisation is divided into three units, a Central Board, a Regional Board and a Board of Trustees, where the latter heads the Department Secretariat and manages seven departments (Free Pentecostal Church of Tanzania 2016). Education includes seven educational institutions, in addition to schools for disabled children (Anagisye & Mligo 2014). Health includes hospitals, health centres, dispensaries, training collages and children’s homes. The Youth & Children Department includes training and youth centres, while Theological Education includes Bible collages and schools. Press and publishing includes bookshops and publishers, but also eye clinics. There are also additional institutions that are part of the organisations, such as the Women Department and the Media Department. Funding is sought from within FPCT churches and from local and international partners. An important institution of the FPCT is the Tazengwa Pentecostal Bible College founded in 2002 (Free Pentecostal Church of Tanzania 2016).

FPCT provides a variety of social services to the community, as stated by the central leadership, to be given regardless of religious affiliation, gender, ethnicity, economic status, linguistic differences, race or disability (Inter-

view 27). The organisation also runs around 150 social projects (pre-schools, primary and secondary schools, hospitals, community health education projects, youth centres, disability programmes, etc.) with the overall aim of providing special social welfare and community activities (Free Pentecostal Church of Tanzania 2016). A particular focus has been on children and people with disabilities; for an example, the FPCT HQ runs a project named Empowering Children with Disabilities in Tanzania. In collaboration with international partners, the FPCT also runs projects aiming at poverty eradication, sustainable development, HIV/AIDS projects, human rights and democracy initiatives (PMU InterLife 2016).

The FPCT has also established a company in association with the church organisation, called the Diakonia Company LTD. The vision of the company is “to be a growing company proving quality educational, healthcare, tourism and real estate services in a competitive manner for nationals and internationals” (Diakonia Company LTD 2016).

Despite its national organisational structure, the FPCT holds a deep belief in self-governing local congregations. This is also reflected in the FPCT constitution, where it is stated that: “We believe that each local Church under the FPCT shall be self-governing under the official and spiritual guidance of an elders’ Committee according to Biblical Principles” (Free Pentecostal Church of Tanzania 2008, p. 6). Since the FPCT is not a formal member of the Christian Council of Tanzania (CCT), nor the Christian Social Services Commission (CSSC), and since the denomination was established much later than its Catholic and the Protestant counterparts, its relationships with the state and the ruling political elite are less developed (Ludwig 1999). The FPCT has traditionally stressed its independence in relation to the state, and its relation to the state is partly reflected and regulated in its constitution. The constitution states that: “The Church and its organs shall take deliberate measures to avoid direct involvement in national politics, but shall cooperate in a positive way with the Government and international public organs in endeavouring to promote the objective of human and societal welfare, peace, unity and social security for the purpose of human deliverance from an oppressive environment and from spiritual bondage” (Free Pentecostal Church of Tanzania 2008, p. 8). Another article (Article 6.16) states: “We believe that the Government is ordained of God and the powers that be are ordained as ministers of God to us for good” (Free Pentecostal Church of Tanzania 2008, p. 7).

Health sector engagement

The FPCT operates several health centres and dispensaries, including two hospitals: (1) Mchukwi Mission Hospital in Kibiti and (2) Nkinga Refer-

ral Hospital in Nzega (Free Pentecostal Church of Tanzania 2016). In the FPCT, the health work is coordinated through a national Health Department consisting of a National Health Coordinator in charge. The Health Department coordinates all hospitals, health centres and dispensaries. The National Health Coordinator is not based at the FPCT HQ in Dar es Salaam, but at the Nkinga Referral Hospital in Nzega. The Health Department has been developed through close collaboration with the Swedish Pentecostal Movement. Since the 1980s, a medical missionary from Sweden has been appointed to give direct strategic support in the capacity as the focal point of the Tanzania Health Care Committee.¹² She has been the chairperson of the Hospital Committee within the Swedish Pentecostal Movement (Östersund-Posten 2016; Boork 2013).

The FPCT has no central health policy; however, the FPCT constitution brings up the healing mission, mainly expressed in spiritual terms. In Article 6.13, it says: “We believe in the healing of the body by Divine power or divine healing in its varied aspects as practiced in the early Church” (Free Pentecostal Church of Tanzania 2008, p. 6).¹³ According to Article 7.2 of the FPCT constitution, one of the main objectives of the church is to provide special social welfare, including healthcare services (Free Pentecostal Church of Tanzania 2008, p. 7), and health activities have been central for the FPCT ever since its establishment. During the first two decades, its healthcare services were primarily developed by Swedish medical missionaries (nurses and midwives), who trained and worked in local partnership with Tanzanians. 1949 saw the establishment of a more formalised collaboration with district authorities, where the Swedish Pentecostal Mission was promised financial support and compensation for its dispensary in Nkinga on an annual basis. The Swedish Free Mission was promised a similar agreement with regard to its dispensary in Igunga. The first medical doctors from the Swedish Free Mission (SFM) arrived in 1959. At the same time, the colonial state established a midwifery school in Tabora, which facilitated the promotion of local midwives into the health work carried out by the SFM (Nyström 1998).

Within health sector development, the FCPT prioritises women and children as key target groups, and in particular children with disabilities. The FPCT has developed a national disability policy aiming to inform members concerning the biblical perspective on disabilities and to ensure that services to people with disabilities are provided appropriately without discrimination. Furthermore, the FPCT also works to protect people with disabilities from intentional and unintentional discrimination and segregation in a long-term

¹² In Swedish: Tanzaniska Sjukvårdskommittén.

¹³ When the healing mission is expressed, the FPCT refers to the following Biblical texts: Acts 4:30; Rom 8:11; 1 Corinthians 12:9 and James 5:14 (Free Pentecostal Church of Tanzania 2008, p. 6).

partnership with Fida International in the Youth with Disabilities Community Programme (Fida International 2014).

Prayer, counselling and devotion are included as central activities at all FPCT health institutions. All FPCT staff members (including Muslim employees) participate in the morning devotion at the two hospitals. A representative of the Mchukwi hospital management confirmed: “We are still here to save people” (Interview 55). The spiritual services are not regulated by any health or spiritual policy, but are guided by the constitution and follow a pattern similar to that observed during participant observation: (1) morning devotion with Christian hymns, scripture readings and prayer before the beginning of the daily activities at the health institutions; (2) individual prayer before all surgery and when severe conditions occur; (3) preaching and outreach activities at the entrance of the hospitals; (4) spiritual counselling for patients or staff members with special needs (5) prayers and testimonies from hospitals in nearby congregations during Sunday services and prayer meetings (Memo 3d).

Mchukwi Mission Hospital

Mchukwi Mission Hospital (MMH) is a non-profit hospital, owned and operated by the Free Pentecostal Churches of Tanzania (FPCT). It constitutes the third church-based hospital in the study. The hospital is situated in the ward of Mchukwi, a remote rural area in Kibiti (former Rufiji District) in the coastal region 150 kilometres south of Dar es Salaam. Mchukwi ward has around 20,000 inhabitants, spread in small villages within a radius of about 20 kilometres of the hospital (Mchukwi Mission Hospital 2016).

Hospital profile

MMH targets people’s health problems from a holistic perspective based on taking care of their physical, mental and spiritual health problems (Interview 55). The hospital director confirms that MMH is faith-driven and maintains that the hospital vision is focused on achieving the physical, mental, spiritual and social wellbeing of the people in the area where the church is involved in providing healthcare services (Mchukwi Mission Hospital Management 2012). Although the hospital target group is the general population, there is special emphasis on caring for pregnant mothers and children with the aim of reducing maternal and child mortality. Most deaths at the hospitals are the consequence of the poor health and nutrition status of mothers, coupled with inadequate care before, during and after delivery. In this regard, there is a special clinic at the hospital and mobile units delivering antenatal care to pregnant mothers and providing services, such as growth monitoring and vaccination services, which are available at almost no cost to the patients

(Mchukwi Hospital Tanzania 2016; Rufiji District Council 2011). MMH also provides mental health services focusing on psychological wellbeing, as well as mental health services that include outreach clinics in the divisions of Kibiti, Ikwiriri and Kikale in Rufiji District. Their work in the area of HIV/AIDS exhibits a special emphasis on the prevention of re-infection and transmission of HIV, reducing stigma and discrimination, restoring immunity of people living with HIV/AIDS (PLWHA) and increasing access to anti-retroviral (ARVs) treatment regimens (Mchukwi Mission Hospital Management 2012).

The hospital currently has 100 hospital beds. Out of these, 55 are funded through a Grant-in-Aid contract: bed grants by the Ministry of Health. The hospital employs about 80 people and 21 of these are funded through the Grant-in-Aid contract: staff grants (Interview 55).¹⁴ The Hospital Board is the highest managing organ. The MMH Board Chairperson is selected from outside the FPCT Health Department, whilst the secretary is the doctor-in-charge of the hospital. The Hospital Board normally meets quarterly, with a minimum of three annual meetings (Mchukwi Mission Hospital 2016).

Hospital ownership and PPP contract

As of 2016, MMH collaborates with the government through a Grant-in-Aid contract (bed grants and staff grants). However, during the time of the study (2011–2014), the hospital also negotiated and implemented another key PPP component, a Service Agreement, which was signed in 2012 and started to be implemented in 2013 (Malmberg 2015).¹⁵ According to the Service Agreement (SA) with the government, MMH was supposed to receive Basket Fund Grants to cover services provided to pregnant women for free (Interview 54).

Mchukwi Mission Hospital (MMH) was established in the late 1960s in response to a catastrophic situation following the heavy floods of the Rufiji River. Although Muslims dominated the area, the civil servant in charge of social affairs worked in favour of the Swedish Free Mission to take on this task. Due to a shortage of both financial and human resources, the local authorities sent a request to the FPCT in Dar es Salaam, where the organisation was asked to establish a dispensary north of Rufiji River. On February 23,

¹⁴ Some sources claim 75 employees.

¹⁵ However, the transition from the Rufiji District to the Kibiti District in 2015 meant that the Service Agreement (SA) from 2012 with the CHMT in Utete was no longer valid. Currently, as of 2017, the hospital management is discussing and negotiating a new CDH contract with the new Council Health Management Team (CHMT) of the new district of Kibiti. In accordance with the Service Agreement that was valid until the beginning of 2015, MMH was supposed to provide services based on an agreement between the FPCT and the local government through the Council Health Management Team (CHMT) (Free Pentecostal Church of Tanzania 2010).

1970, a dispensary was officially in full operation. At that time, there were two missionary families working at the dispensary. The dispensary expanded and MMH received its official hospital status in 1973, managing around 40 hospital beds. The hospital continued to expand and several extensions were made during the period of 1984–1990 (Nyström 1998). The last Swedish medical missionaries to be doctor-in-charge and administrator-in-charge at MMH stayed at Mchukwi during 1991–1993. Shortly after this, the hospital was handed over to a local management.

During the period of Swedish expatriate management (1973–1993), foreign assistance to the hospital was higher in comparison to the assistance received after the hospital was handed over to the local management (Interview 55). The clearest example of this is seen in the supply of drugs and other medical supplies. In addition, under Swedish medical missionary management, the resources for paying medical staff salaries were not dependent on the income derived from patient fees (Nyström 1998).

In 2010, MMH developed its first strategic plan for the period of 2010–2015. The plan aimed to improve the quality of the health services through qualified and motivated staff with the necessary knowledge and skills. It also expressed the goal to renovate the hospital buildings and provide modern equipment and machines. Other elements included the creation of sufficient space with modern private rooms and other necessary buildings, as well as improving the availability of drugs and supplies (Free Pentecostal Church of Tanzania 2010). Over the years, MMH has gone through several challenges, mainly related to sustainable funding and human resource shortages, but the hospital has managed to survive (Mchukwi Mission Hospital Management 2012). Since the Service Agreement was not implemented as planned and the core funding from Sweden ended, MMH is currently facing a number of challenges related to how to sustain the funding for the hospital while simultaneously renovating the hospital and staff buildings and the water drainage systems (Interview 53). It should also be noted that a radical increase in salaries and the price of drugs and medical supplies has meant that the hospital has failed in retaining skilled staff and procuring the required supplies (Interview 54–57).

Hospital partnerships with external partners

The key partner for MMH is still the Pentecostal Movement in Sweden (Interview 53–55). This collaboration originates from when the hospital started. The hospital administrator emphasised that: “We have been receiving funds primarily from Sweden. About 13 percent of the hospital budget was until

recently given in core support” (Interview 55).¹⁶ The PMU InterLife has traditionally been the key financial supporter for all FPCT health facilities. However, it started fading out its core support for the Mchukwi hospital in 2011. The support that is currently channelled is targeted for specific projects or new developments at the hospital and mainly comes directly from individual Pentecostal congregations in Sweden and goes directly to the hospital. Currently, the local Pentecostal congregations¹⁷ continue to develop their support to MMH. In this support, several key individuals from the Swedish Pentecostal Movement play a key role for MMH. Worth noticing is that most of the support bypasses both the central leadership in the Swedish Pentecostal Movement and the central leadership of the FPCT (Interview 53).¹⁸

With regard to external funding directed towards human resources, the largest external funder is Läkarmissionen (Läkarmissionen 2016) and the ERIKS Development Partner (in Swedish Erikshjälpen). Both are linked to the Swedish Pentecostal Movement (Erikshjälpen 2016). Their funding includes funds for medical short-term personnel, scholarships for hospital workers, procurement of drugs and medical supplies, as well as health-related projects (Mchukwi Mission Hospital 2016). MMH also collaborates with academic institutions in Sweden and the United States. MMH has signed a core agreement with Linnaeus University in Kalmar, Sweden and regularly receives Swedish nursing students. As part of an agreement with Columbia University (CU) and the Centers for Disease Control and Prevention (CDC), MMH receives technical assistance and support for its HIV/AIDS programming. In the field of education, MMH has also built and developed a nursing school with support from Sweden. MMH also collaborates with the Red Cross Tanzania, which extends support to the students from the nursing school concerning emergency care (Interview 57).

MMH also receives support from vertical health funds for its HIV/AIDS care and treatment services, prevention of mother-to-child-transmission, early infant diagnosis, HIV testing, counselling and TB/HIV integrated services (Mchukwi Mission Hospital 2010). The hospital is supported by the Norbert and Friends Missions free surgery programme in Rufiji District, as MMH has been selected to be one of the intervention hospitals for a new HIV/AIDS programme sponsored by ICAP (Global Health Action 2016). AMREF sends specialist doctors from Nairobi, and during the years of the

¹⁶ In comparison, the government contributed with about 23 percent of the hospital budget, including salary, for 21 staff members. The rest is funded through patient fees (about 40%), health insurances, donations and vertical health funds (Mchukwi Mission Hospital 2013).

¹⁷ The congregations are: Östersund, Jönköping, Helsingborg, Vennäs, Norrtälje, Dorotea, Stockholm and Edsbyn.

¹⁸ For example, in 2013–2014, the local Pentecostal congregations of Jönköping, Vimmerby and Helsingborg supported the development of the electricity network of the hospital, and in 2015–2016 they supported the building of a new maternity ward (Memo 3d).

study, MMH collaborated with the Finnish Christian Medical Society in implementing a project focusing on Psychiatry in Primary Health Care. The main objective of this project, which ran in 2010–2012, was the improvement of medical services available to patients suffering from psychiatric illness and epilepsy (Shedafa 2013). The hospital also receives ad hoc funding and private donations. Rotary clubs from the south of Sweden have played an active role in fundraising for MMH and there is a support group for Mchukwi called “Help Mchukwi”. It takes the form as a Facebook group on social media and the members are mostly representatives of local Pentecostal congregations supporting Mchukwi.

7. Public private partnerships in practice

In this chapter, I present results from the empirical study concerning the first research question 1: *How are the contractual partnerships (PPPs) with church organisations in the health sector constructed?* The results are based on a content analysis of the collected data generated from three main data sources: policy documents, interview transcripts and field notes.

Central themes

Four central themes have been generated from the data analysis. These four themes are: 1) type of PPP contracts with church organisations; 2) function of each actor in the PPP collaborations; 3) critical components in the PPP collaborations; and 4) implementation of contracts needs to be improved. The analysis of data at the national level shows results with regard to the specific roles of the Ministry of Health vis-à-vis the Christian Social Services Commission and the three national church health departments. I also consider the role of external partners and to what extent key foreign individuals influence the partnership contracts and the implementation phase following the signing of the agreements. At the local level, I present an overview on how the PPPs are constructed between the Council Health Management Team (CHMT) and the church-based hospitals. The findings are summarised in a table at the end of the chapter.

Type of PPP contracts with church organisations

So, how are the PPPs constructed? As I have presented before, there are three main kinds of partnership contracts and collaborations agreed upon and signed by church organisations and public health authorities: (A) DDH/CDH agreements; (B) Service Agreements (SA); and (C) Grant-in-Aid. In Table 9 below, I include the three case studies and their current PPP contracts.

Table 9. Partnerships between public authorities and church-based hospitals

Collaborative arrangements and type of partnership contract for church-based health facilities	
<i>Type of collaborative arrangement</i>	<i>Type of partnership contract</i>
Delegation of responsibility <i>Local level</i>	DDH/CDH agreements funded by District Basket Fund: Case study I and II
Purchasing of services <i>Local level</i>	Service Agreement funded by District Basket Fund: Case study III
Cooperation <i>National level</i>	Grant-in-Aid funded by National Basket Fund (i.e. bed and staff grants): Case study I, II and III

Source: Model designed by Josephine Sundqvist based on PPP contracts and the collaborative typology model as developed by Boulenger & Criel 2012.

Model A: Delegation of responsibility

As discussed in chapter 5, Council Designated Hospital (CDH) is a contract between church organisations and public health authorities according to which the running costs of the hospital are to be covered by the district health budget. On top of that, a CDH should receive staff, bed and training grants as well as medicine. The CDH arrangement is intended for a council being able to utilise a voluntary agency hospital as a district hospital in locations where there is no government district hospital. When it comes to capital and infrastructure developments, a CDH must in theory seek alternative funding or mobilise within the local community and council (Ministry of Health 2011b).

The CDH contract follows a national template composed of around 30 articles. The church organisation retains ownership of the hospital and is responsible for management, building, equipment and administration (Ministry of Health 2011b). The CDH contract is currently negotiated and signed by the council at the local level and by the diocese or local church-based hospital. The Ministry of Health and the Christian Social Services Commission act as witnesses when the contracts are signed. In accordance with the contract, the council, the diocese representative and the church-based hospital participate in the governing board of the Council Designated Hospitals.¹⁹ Equipment and supplies for the hospital are tax exempt, just like for public hospitals, and certain patient groups are supposed to receive services for free

¹⁹ The governing board recommended having ten members, six of which are appointed by the church and four by the government, and where the chair is appointed by the church. The church shall nominate the director of the hospital, who is then appointed by the governing board (Bandio 2012).

or at a low administrative fee. Even though ownership of the hospital remains with the church organisation, the council must approve any expansion of the church-based hospital. In theory, under the CDH contract the running costs should be covered by the local government. A budget should be negotiated and approved annually between the church-based hospital and the CHMT. But as I discuss later in relation to my findings in this study, there is a great discrepancy between theory and practise (Council Health Management Team 2005).

Two of the three church-based hospitals in the study (case study I and II) have entered into CDH agreements. In 2012, both of these church-based hospitals had formally gained their full CDH status and had started operating in a contractual partnership with the Council Health Management Teams (CHMTs).²⁰

The CDH collaborations between the CHMTs and the two church-based hospitals in the study were in both cases implemented before the CDH contracts were legally approved and signed. When the contracts were implemented, none of the two hospitals was compensated in accordance with the contracts. This is discussed in more depth in Chapter 8 under the heading *Dissatisfaction in the short-term implementation of the partnerships*.

Model B: Purchasing of services

During the time of the study, the third case study signed a Service Agreement (SA). This Service Agreement for Mchukwi Mission Hospital was negotiated during 2012 and started to be implemented in 2013 (Interview 53). Service Agreements are a PPP collaborative form, where the hospital is supposed to receive a small grant per patient treated.²¹ In case study III, the Basket Fund Grants have been used for this purpose. One principle in Service Agreements is that church-based hospitals are supposed to be compensated for the services they deliver for free to disadvantaged groups in accordance with a scheme where each service is accounted for. The Service Agreement (SA) summarises the responsibilities of the parties of the agreement, including the details of the services to be provided, their expected costs and details about financing to the hospital by the state, as well as from other sources. The key objectives of Service Agreements continue to be: (1) to involve more of the private sector in the delivery of health services, thus strengthening the PPP, and (2) to have a tool for measuring health services and use of money provided by the government to the private sector. However, in case study III, instead of being compensated for the services delivered,

²⁰ In the third case study, the hospital management team has recently initiated discussions on the possibilities of entering into a CDH contract in 2017. However, during the time of the case study, the third church-based hospital had so far only entered into a SA contract.

²¹ Between 2008 and 2010, 28 Service Agreements were signed (13 of which between FBOs and councils) (Tanzanian German Development Cooperation 2011).

the hospital management was only given a lump sum from the district council, which even turned out to be less than 10–15 percent of the total Health Basket Fund allocated for the district.

Several representatives of the national church health departments and CSSC officers mention that the Christian Social Services Commission has advocated for Service Agreements. It has been promoted as a kind of “pay for performance” contract. To give some examples, the CSSC has informed public authorities and councils, offered training of health personnel at various levels, developed a grant management scheme to address the existing crisis concerning human resources in health and shared information before policy review sessions in support of increased funding for Service Agreements (Interview 6–8, 16 and 24).

In fact, several challenges met in Service Agreement contracts are discussed by interviewees from the third case study (Interview 53–56). The CSSC officers (Interview 6–9) also raised similar critique and experiences. A critical component of Service Agreements is that church-based hospitals are not supposed to charge for maternal, new-born and child health services (Ministry of Health and Prime Minister’s Office 2011). The official allocation of Basket Funds from the council to all Voluntary Agency Hospitals (VAH) is between ten and fifteen percent of the Basket Fund budget (Ministry of Health and Prime Minister’s Office 2011). However, in the third case study, the hospital management team stresses that the Council Health Management Team had not fulfilled its obligations in the SA. They also indicate that the SA was never legally approved nor properly signed. An interesting observation was also that the former model, Grant-in-Aid for staff and bed grants, was said to work better compared to Service Agreements (Interview 55).

Model C: Cooperation – Grant-in-Aid (GA) contract

All three case hospitals also receive support directly from the Ministry of Health by signing Grant-in-Aid contracts. These arrangements are seen as traditional complements to newer forms of local PPP contracts (CDH and SA agreements). Grant-in-Aid arrangements remain the oldest of all available PPP arrangements, reviewed from time to time, where the latest review was carried out in 2006. The key component concerns two types of centralised support from the Ministry of Health, bed grants and staff grants, and are intended to assist church-based hospitals (located in rural areas) in offering services to the community at affordable rates. Training grants are also part of this support. The aim of training grants is to give staff the opportunity to develop their skills and knowledge through further studies, such as specialisation degrees (Ministry of Health 2015). Even though the bed and staff grant (as part of the Grant-in-Aid) is not the main PPP contract, a great majority of interviewees from the church-based hospitals consider it the type of

collaborative agreement with public health authorities that works the best. In fact, hospital management representatives from all three church-based hospitals consider centrally funded staff grants and bed grants the most efficient form of public private collaboration. One possible way of interpreting the findings is to say that the Grant-in-Aid model works more effectively because the funding is channelled directly from the Ministry of Health and not through the local governments.

As an example, a Hospital Management Representative from the second case study stated:

Of course the church and the CHMT are co-partners since we signed the CDH agreement, but as far as money is concerned, they are the ones responsible and they do not send the money. Therefore, you sometimes find our hospital experiencing a shortage of funds. The only money that comes straight from the government comes from the treasurer for staff salaries (Interview 43).

Despite this, the Grant-in-Aid model with the Ministry of Health is likely to be phased-out, as all public support is eventually supposed to be channelled to the church-based hospitals through the President's Office for Regional Administration and Local Government.

Function of each actor in the PPP collaborations

Who takes the lead in the local PPP negotiations in the Tanzanian health sector? The public or the private side, or both jointly? The case studies indicate that the process of initiating partnerships is often externally driven from outside Tanzania and that the growing focus on collaborative partnerships between church organisations and public authorities with regards to healthcare has to a high degree been the result of an externally driven global reform agenda.²² In fact, it appears as if in each of the three case studies, external medical missionaries took the very first informal initiative to begin the PPP negotiations with Council Health Management Teams (Participant observations 1a, 2c and 3a).

This was confirmed by several hospital management representatives in the interviews (Interview 42 and 55). However, church organisations and their church-based hospital management teams have been quick to follow-up initiated contacts with public health authorities and continued to advocate for

²² As an example, Natan Associates Ltd states on its official website that the PPP process was externally driven as the World Bank took the lead and engaged Nathan Associates to develop a national PPP policy for Tanzania with operational guidelines, review gaps in existing laws and regulations, provide training on relevant issues and assess potential PPP projects (Nathan Associates Inc 2016).

PPP contracts to be signed. The case studies show that these partnerships have built on pre-existing public collaborations and on health infrastructure in some cases in place already before independence (Interview 7). Each case study also points to the fact that the Tanzanian church organisations have continued to advocate for PPP collaborations with support from the Christian Social Services Commission and the respective church health department at the national level until the contracts have been signed (Interview 43). This is frequently done by appealing to the national PPP framework and its legal approval of the contractual models available to private actors.

On the contrary, the support for PPPs in the local district authorities is not as strong (Interview 25 and 55). The interviewees from the Tanzania Council for Social Development and the Council Health Management Teams directly criticised the central government for not involving local actors in the full process of initiating partnerships. They suggest that the partnership dynamics are still mainly limited to the central level and with insufficient support and funding at the local level. As an example, an officer from the Tanzania Council for Social Development (TACOSODE) stated:

We always try to say that we agree, but we are not supposed to just imitate and to copy things that we are not yet ready for. This is our problem. We do not have our own vision as to in which direction we want to move. Instead, there are these forces coming from the outside, pressuring us to adopt things. Also as regards the PPP policy, who is the actual initiator? It is coming from the outside and not from our people (Interview 13).

The role of international external partners

Several of the medical missionaries in the study argue that despite a sharp reduction in financial aid from Western donor agencies to church-based hospitals since the 1990s, they are still taking the lead in the strategic long-term planning concerning the sustainability of the church-based hospitals.

In two out of the three case studies, former missionaries have created non-religiously affiliated friends associations in order to continue supporting the hospitals. These are established as independent foundations in the global north. The main reason for this, according to several foreign interviewees, is to be able to help the church-based hospitals in identifying alternative funding for operating healthcare services. In this struggle, PPP contracts appear to offer a good solution, since church-based hospitals can access core funding for their health service provision. Even though church-based hospitals are in most cases situated in remote areas, through medical missionaries and global friends associations they are far more connected globally than what is generally recognised in PPP policies and related research studies (Participant observation 2e).

From this study, it is possible to conclude that missionary societies and global friends associations still play an important role in developing and maintaining church-based health facilities in Tanzania (Interview 32, 42 and 53). Interviewees from both the public and private sector strongly emphasise that even though the founders of the church-based hospitals (foreign missionary societies, medical missionaries, international FBOs) handed over these facilities several decades ago, they still are deeply engaged in the development and funding of the church-based health services (Interview 48 and 61). One of the reasons may be that PPP funds cannot be used for long-term and costly training for staff, construction of new hospital buildings, purchasing cars or other technical equipment.²³ So the PPP policy itself encourages church-based hospitals to seek diversified funding for any new developments within the hospitals (Ministry of Health 2009).

All of the three church-based hospitals strive to promote local ownership and bottom-up development. Still, they work in global partnerships with medical missionaries and global friends associations, due to a shortage of human resources, financial resources, drugs and specialist competence. A challenge, however, is that in several of the cases, there is no Memorandum of Understanding or Terms of Reference regarding the collaboration with external international partners. The majority of all external international partners I met within the scope of the study argue that as long as they are continuously invited by the church organisations to provide support, they will continue to be engaged regardless of whether they have an established collaboration or more of an informal cooperation. Some also refer to their calling from God. Still, reducing maternity mortality and saving lives seems to be one of the strongest motivational factors for the external medical missionaries, in particular for midwives and obstetricians, which are the two most common types of medical missionaries appearing on site at the three case hospitals (Participant observation 3d).

Even if the medical missionaries are often the ones suggesting or informally starting to lobby for PPP contracts, the official negotiation process is always carried out by the medical missionaries in close partnership with the church-based hospital management teams. In all three cases, the hospital directors are the ones formally representing the church-based hospitals in these negotiations. In each of the three cases, they have conducted advocacy work in relation to local councils (CHMTs) before signing the agreements by appealing to the right to enter into contractual partnerships. Since the church organisation must have the basic infrastructure and staff according to the standard set by the Ministry of Health in order to start negotiating an agreement, PPP contracts are usually based on existing health infrastructure going all the way back to the mission stations. In none of the three case studies did

²³ Technical equipment is allowed if the price does not exceed USD 2,000.

the CHMT conduct a needs assessment before agreeing on the contract (Interview 3).

Several interviewees from the three hospital management teams refer to a situation where the church-based hospitals are influenced strategically and torn between two sides: external demands of external partners at the global level and directives from CHMTs at the local level. These strategies are in most cases complementary, but there are also some examples where they contradict each other, in particular concerning the emphasis on Vertical Health Funds. These funds are in most cases favoured more strongly by external partners than CHMTs as an important complementary funding mechanism for church-based hospitals. The discussions and negotiations on the future development and sustainability of the church-based health services thus involve stakeholders ranging from the local village to the international level, thus making the local church-based hospitals highly globalised in nature (Participant observation 1a-c).

Some interviewees from public authorities (Ministry of Health and the CHMTs) confirm that the PPP agenda is partly donor-driven and to a high extent promoted externally. Some of the DMOs also share this view (Interview 58). The Catholic central leadership even states in one of the interviews that this policy came into existence due to an external shift in development policy (Interview 16). To date, it looks as if the donor community and external partners continue promoting PPPs in health. As an example from the first case hospital, found in a secondary source, one of the external Dutch donors reflected on the signing of the CDH contract as an improvement for the hospital:

Overall we found Turiani Hospital developing from a Missionary Hospital into a [CDH], a process which in the end will result in an even better organisation. For now we are impressed by the energy required from the Hospital Management Team and from [the Hospital Secretary] in particular to meet all new regulations (Burns Turiani Foundation 2012, p. 1).

All of the three case studies point to the conclusion that PPP contracts are viewed as a way for church-based hospitals in Tanzania to decrease their financial dependency on foreign donors and the missionary founding organisations, thus becoming more sustainable (Participant observation 1a).²⁴ However, an alternative interpretation of the same transition is that church-based hospitals are moving their dependency on foreign partners towards a stronger dependency on the state and on Vertical Health Funds, which are partly generated through external donor funding (i.e. moving from one kind of external dependency to another).

²⁴ This discourse was well-represented in the donor community already in the 1990s; for instance, it was discussed in Dahlgren's "1991 Sida study" on the health sector in Tanzania (Dahlgren 1991).

It is evident that church-based hospitals perceive external funding from Vertical Health Funds as a crucial complement to the PPP contracts, as the public funding within these partnerships is both limited in volume and not transferred to the church-based hospitals prior to service delivery. Hospital directors and secretaries/administrators from all three church-based hospitals also perceive their direct links with medical missionaries and global friends associations as crucial for the sustainability and development of their facilities, even though most of this support is received outside the national health system structure and the PPP contracts (Interview 29 and 32). These donations are said to enable the church-based hospitals to uphold affordable patient fees, to overcome deficits and to invest in new maternity wards. Most of the global partners participating in this study address sustainability issues and wish for the church-based hospitals to generate their own funding in terms of accessing funding from several partners, as well as developing community health funds and increasing income from private and public health insurance companies.

The role of the CSSC and national church health departments

The Christian Social Services Commission (CSSC) seeks to promote partnerships between Christian organisations and the state. In all three cases, the process of entering into contractual partnerships with CHMTs has been supported by the CSSC and/or the respective health departments within the church organisations (Interview 5–8). In its statute, the CSSC defines its duties to support the social assistance sector through partnership, advocacy and protection of interests in a way that will ensure transparency, quality, equality and availability based on Christian values. This is confirmed by interviewees from both the private and the public sector. The CSSC is very active in the health sector by monitoring national financial resources allocated to the health sector, supporting social care and representing the interests of the church organisations in PPP negotiations with both the central government and foreign partners (Christian Social Services Commission 2016).

Among the central national church health departments, the ELCT Health Department from the second case study is considered the strongest advocate of PPPs. To give an example, an ELCT Health Department officer stated that the ELCT was in fact the first organisation to be on board. He explained that the ELCT was part of the Tanzania PPP delegation that went to Zambia to learn about how to implement PPP in the Tanzanian health sector. This was before the current PPP framework came into place in 2009:

We concluded that there was a need to scale-up good practices and one of our programmes was also among those good practices chosen. We had to show the government that we were implementing good quality assurances, and when they developed quality assurance guidelines, they in fact referred back

to the ELCT. In that sense, I would say that we acted as catalysts for change and also as forums for them to come and learn best practices (Interview 24).

The long-term strategic plan (2015–2025) of the ELCT also confirms this, by stating that the organisation should lobby for an expansion of the current PPP framework. Service Agreements are specifically emphasised under Priority Area 5 in the ELCT's long-term strategic plan (Evangelical Lutheran Church in Tanzania 2015). However, there also seems to be strong support for these agreements even among the central church leadership of the FPCT. A health department officer emphasised that they looked favourably at Service Agreements, while simultaneously acknowledging the related challenges:

I remember when the Service Agreements (SA) came. I thought it was one of the best interventions I can recall for the central government to boost and reinforce the PPPs. However, when it was implemented, it was left to the CHMTs and district authorities to decide and to choose, so it was not optional, as it is up to the council to decide which hospital will be offered a Service Agreement (Interview 30).

The respective health department often works with advocacy and policy dialogues through the Christian Social Services Commission (CSSC) before the PPP contracts are negotiated and signed. The church-based hospitals are also in direct contact with the Ministry of Health before signing the contract in order to complement the support given by the CSSC (Interview 55). Several interviewees say that the CSSC facilitates a closer, more cooperative health sector development. It is also evident that the CSSC represents all three church organisations in the formal national, regional as well as some local negotiations and policy dialogues with the government in areas related to these partnerships, even though the FPCT was not a formal member of the CSSC during the time of the study (Interview 27). Several interviewees of the FPCT, national and local, confirm that they have participated in CSSC training sessions and seminars (Interview 53 and 55). The Ministry of Health also recognises the CSSC as a key player in health service delivery and health policy formulation, planning, coordination and monitoring (Interview 1–3 and 5).

The fact that the CSSC is so influential means that the central ELCT leadership mostly argues in favour of the CSSC. However, representatives of the ELCT also acknowledge that the CSSC risks creating a distance between the ELCT and the central government in health sector dialogues, since the Catholic Church tends to be more influential than the ELCT in the CSSC organisational set-up (Interview 25). A representative of the TEC Health Department also stressed that in all issues relating back to the Catholic doctrine, such as Catholic views on natural family planning, the Catholic Church is in direct dialogue with the national government, outside the CSSC framework

(Interview 16). As part of the participant observation, I also observed the opinion of a few that the CSSC has drifted from its core role of working as an umbrella organisation to support all the “National member Church Health Departments” in advocacy at the national level and are instead down to “project implementation” at a diocesan and even hospital and community level (Participant observations 2c and 3c).

The role of the Ministry of Health

It is evident from the qualitative policy text analysis that the PPPs between church organisations and the central government have been legally regulated and promoted in several National Health Policies and PPP frameworks (Ministry of Health 2007a; Ministry of Health 2003a). To give some examples from the policy analysis as described in detail in Chapter 5, the Third Health Sector Strategic Plan entitled *Partnership for Delivering the MDGs* from 2009 in particular promotes partnerships with church organisations further (Ministry of Health 2009). The National Public Private Partnership (PPP) Policy stresses that these partnerships may be initiated by non-governmental actors themselves, and the policy itself has strengthened the legitimacy of church organisations in PPPs at the central level (Prime Minister’s Office 2009). The National Poverty Reduction Strategy (MKUKUTA) from 2005 repeated the political commitment to PPP. It called for partnerships with all stakeholders, including CSOs, the private sector and FBOs, in the provision of quality social services. As a follow-up to this commitment, the Ministry of Health and the private health sector mutually agreed to strengthen partnerships in health by forming a National Steering Committee with members representing the government (Ministry of Health and Prime Minister’s Office), FBOs, the for-profit private sector and other CSOs (Private Health Sector Alliance 2009). In the Third Health Sector Strategic Plan, the government includes FBOs in the private sector concept, where the CSSC is said to represent most of these as an umbrella organisation. It is stated that:

Partnership with the private sector is necessary, to increase accessibility and quality of health services. The Service Agreements between Government and Private Service Providers offer opportunities for a regulated collaboration. We believe that, to join hands, with all who can provide services to improve the health of the people, is beneficial for the Development of the Country (Ministry of Health 2009).

Moreover, the government has continued to partially provide tax exemptions for private non-profits (including church organisations) with respect to their

contribution to the national development in various sectors, and the health sector in particular (Ministry of Health 2009).²⁵

Besides what has been found and presented from the qualitative policy text analysis, representatives in the interview study express strong support from the national public authorities. Several interviewees argue that church organisations and the Ministry of Health are closely linked at the central level through the umbrella organisation CSSC and through the intersection between religious and political elites. In fact, all three hospital directors find that their central PPP collaboration with the Ministry of Health works better than their collaboration with the corresponding council (Interview 32 and 53).

It is also evident from the interviews at the Ministry of Health that the church organisations, in their capacity as a “private non-profit” alternative, are favoured by the ministry in relation to the “private for-profit” providers. One reason is that they are mainly serving the rural poor population. Some interviewees also consider “private for-profit” actors less trustworthy (Interview 3). Several interviewees at the Ministry of Health portrayed church organisations positively, as assisting in the shaping of social values, promoting responsible health behaviour, increasing public knowledge, supporting healthy attitudes and promoting action from the grassroots level up to the national level. Beyond the efficiency argument, church organisations are also said to be useful in creating legitimacy for public health policies due to religious authority. As an example, the Ministry of Health has created the Sermons Guide, which is guiding material for church leaders on how to conduct sermons based on the Bible and central public health messages. The Sermon Guide is an initiative whereby the Ministry of Health has collaborated with the church organisations and designed twelve sermons to be delivered throughout the church year (Ministry of Health 2011d).

Despite the fact that interviewees from the Ministry of Health generally tend to view the performance of church-based hospitals as high or relatively high, there are two exceptions: (1) the hospital pharmacies frequently run out of stock, which leads to utilization of expired medicines; (2) shortage of human resources, since public facilities offer better salary packages, such as social benefits and pension savings (Interview 3). The interviewees from the Ministry of Health are generally more positive towards church organisations in comparison to the views of the Council Health Management Teams locally. Several representatives of the church organisations also express a more positive attitude towards the Ministry of Health. A public health officer at the Ministry of Health confirms the existing good relationship by pointing out that the CSSC is very receptive and willing to cooperate:

²⁵ After the 2015 election, some new restrictions were put in place regarding the taxation of the import of medicines, etc. These regulations are not discussed within the framework of this study.

The CSSC members are much better off because the CSSC is more pro-government and they are involved and they know what is happening. The CSSC has even facilitated the design of the PPP reforms and the CCHP guidelines (Interview 3).

From another public health officer's point of view, the Ministry of Health tries to be supportive towards the church organisations (Interview 1).

It is up to the central level to come up with solutions, since the contracts governing the hospitals were originally signed with the Ministry of Health and not with the district. For us, for the government of Tanzania, we are having decentralisation by devolution, which means that the councils are the government and then again at the regional level. So they have the power to decide on their issues concerning health but we are the advisors. We are just advising them and we are developing the guidelines, we are giving them guidelines for health programmes; what they should look like and what a dispensary should look like, setting guidelines. Nevertheless, in terms of decision-making, at the end of the day, the decision is up to the council (Interview 1).

However, it is clear that the formal decision to enter into an agreement lies with the council and not the ministry. Nevertheless, several representatives from the Ministry of Health also acknowledged that councils lack knowledge concerning this reform. As an example, a public health officer stated:

We need more awareness and to create capacity, as there are still those lacking knowledge concerning the PPPs, and people are struggling with the contracts. What is needed is first of all to create awareness where people should understand what PPPs are and how to follow them (Interview 3).

There are a few variations of perspectives within the ministry, where one public officer in the study in fact criticised the PPP framework and the private actors:

Actually, with the PPPs, that area is a little bit tricky for me. I can't say I am convinced about PPPs because I know private institutions also get insurance compensation for their service provision. So why do they also need public funding? That is a bit controversial to me (Interview 4).

The role of the dioceses and church-based hospitals

Interviewees from the hospital management teams generally display a positive attitude towards the PPP policy and are in most cases the ones promoting the contracts (Interview 32), where church-based hospitals consider themselves having the personnel, financial resources, equipment and local knowledge needed for entering into PPP contracts. In the local contract negotiations, both the diocese bishop and the hospital director and hospital

secretary/administrator are represented. Usually, the health professionals from the church hospital management teams, in collaboration with external medical missionaries/friends associations, are the ones formally initiating negotiations, whereas the church leadership often enters at a later stage when the negotiations have reached a more formalised stage and when the outcome is more predictable. Several interviewees emphasise that the local congregation next to the church-based hospital plays a key role in the promotion and marketing of the church-based hospitals and are used as entry points to the hospitals (Interview 53). This was also evident during the participant observation. A health department officer explained how this is worked out in practice:

We are showing the government that we can deliver. We have a network of evangelists and a church structure, so we can very easily reach communities. That is also why we have so many innovative programmes, such as the malaria programme where we use pastors to educate people (Interview 24).

From the second case study, a hospital management representative clearly argued that the church-based hospital took the lead and initiated the CDH contract:

I initiated the transition for Selian from being a purely church-run hospital to becoming a CDH hospital, since it is impossible to survive as a church-run hospital only on patient fees. It is not feasible (Interview 43).

The role of the Council Health Management Teams (CHMTs)

The local governments are more critical towards the integration of church-based health services into the public system than other actors in PPPs in health (Participant observations 2c and 3d). CHMTs have not been the ones advocating or pushing for PPPs in any of the three cases, but have rather acted as implementers (Interview 37–41, 49–52 and 59–62).

In particular, interviewees from the CHMT in the third case study were more reluctant concerning the PPP policy itself, instead wishing to spend available public funding on public health facilities run by themselves (Interview 60). Members of the CHMTs from the first and the second case studies also support the idea of promoting the expansion of the public health services in the councils instead of contracting the services to church-based hospitals. Some CHMT members defended their opinions by referring to the National Health Policy and the vision clause of establishing “one health unit per village and district”. A public health officer from the Ministry of Health also experienced this when visiting the councils:

In many places where we have our faith-based facilities, the council constructs new hospitals. You know our politicians; especially before election,

they want to show that they help the community, and then they build a public hospital although the councils already lack resources. Still, you will find that the CHMT has budgeted for constructing a new hospital or a new health centre. You might wonder – why constructing another hospital when this faith-based hospital is already there? (Interview 3)

Representatives from the church organisations also confirm that they have met these attitudes and actions. In all three case studies, they observed some kind of informal local resistance towards PPPs within the CHMTs. This could be interpreted as a lack of consistency between the national and the local public authorities (Interview 55). It could also partly be explained by a lack of public health funding allocated for the district councils (Interview 44). The attitudes of the CHMT members could also reflect the very fact that the PPP policy was developed by the Ministry of Health, but that the implementation takes place at the level of PMORALG and Ministry of Finance.

Despite this, most representatives of the church-based hospitals consider the partnership with local governments important for the long-term security and stability in operating their hospitals. As an example, an officer from the church health department in the second case study stated:

The reason why things did not work out well before was because the government saw us as competitors in health services. They saw us as a negative force and they never considered us equal stakeholders in health provision. But later on, at the ministry level, they understood that these are potential stakeholders. However, down at the regional and district level, their assistance remains when the districts authorities approach us, both policing and inspecting (Interview 25).

According to the CHMTs, the PPP policy is considered externally driven (Interview 59–62). Several CHMT members from all three cases expressed how they felt obliged to respond to requests, agreeing and signing the PPP agreement with church organisations due to pressure from the Ministry of Health and from the international donor community (Interview 50). This leads to scepticism among some CHMT members and makes them even more critical of the PPP policy and health sector reforms at large. Within the Council Health Management Teams in each of the three case studies, the District Medical Officers (appointed by higher authorities) are more in favour of the partnerships and more willing to support the church-based hospitals in comparison with the rest of the CHMT members. As an example, some CHMT members indicated that they were unaware of the financial difficulties of church-based hospitals, even though the DMOs in all three cases acknowledged this factor as critical (Interview 36, 48 and 58).

Furthermore, it is also clear that several CHMT members lack knowledge of the PPP Policy, the PPP Act and the PPP framework, and they state that new directives and different funding models confuse and complicate their

work (Interview 50). Some CHMT members also express that they lack confidence in the church-based hospitals; partly as they are unable to get an overview of all existing partnerships or comprehensive audits from the church-based hospitals. Some CHMT members requested to receive a comprehensive overview of all the flows of funding to the church-based hospitals (including individual donations, support from global friends associations, medical missionaries, international FBOs and Vertical Health Funds). During the time of the study, such data were not accessible at any of the three church-based hospitals. The CHMT members argued that in order to build trust in the Vertical Health Funds and to improve transparency and subcontracting at the local level, they wished to be further integrated into the planning and programming systems (Interview 50). The District Medical Officer of the Arusha District Council confirmed this:

If we are open as regards to the funds we are giving and then you don't want to show how much you receive, don't you think that relationship is unequal and why we sometimes feel sceptical. Why should we give all this money when they do not want to show what they are getting? This is a big challenge (Interview 48).

A public health officer from the Ministry of Health has also experienced something similar and asked himself during one of the interviews:

Are the FBOs really ready to become transparent and explain what resources they are spending, including their actual external support? If FBOs reveal all their different partnerships and all their resources, will the CHMTs still be ready to re-reimburse them for conducted services? Do the CHMTs even have sufficient funds to reimburse? Sometimes the CHMTs are avoiding this question because they know they do not have sufficient funds to reimburse. This is the challenge, but if FBOs gradually become more involved in the whole process of budget and health planning, they will get the opportunity to understand more exactly how much has been allocated by the donor agencies to the basket funding and the respective CMHT so the discussion can be based on the actual available resources. The challenge now is that FBOs are thinking that the CHMTs are getting much more funding than they do, and the CHMTs are thinking that FBOs are getting considerable external parallel funding that they are not revealing (Interview 5).

Another finding was the religious profiling of the church-based hospital that constituted an obstacle for the local partnership negotiations with the CHMT in the third case study, as it is located in a predominantly Muslim area (Interview 55). An interviewee from the CSSC at the national level also experienced this in the field and confirmed that religion sometimes poses an obstacle for PPPs:

In some of the places, there are challenges because the districts may know that the church-based hospital is there. But if the local leader is a Muslim, he

will not support that hospital to be the district hospital, but will instead construct a new district hospital in order for the funding to be channelled to a government hospital. This has been a very big challenge. They cannot recognize this, so instead they say that this is for the public and not for the church, but how can you build a new hospital instead of strengthening the existing one when the hospital board says: "Please support us and make this the district hospital as we are ready to collaborate." The CHMT will then respond: "No, this is for the church." So it is a very big challenge that they construct new facilities instead of recognizing the FBOs, though we have been discussing this issue with the Ministry of Health and then they say: "We told them, but you know they are politicians and we can't interfere with politics" (Interview 9)

Both a lack of health funding and a lack of knowledge among the CHMT members might explain their unwillingness to promote PPPs, since they simply do not seem to understand the PPP framework and how it is supposed to be implemented:

Maybe we will experience some problems, since there is need to educate the district council about the PPP policy and how it works (Interview 43).

In the third case study, a hospital management representative stresses the importance of the religious, tribal and political background of the respective District Medical Officer and the Council Health Management Team members in the negotiations. Some other interviewees refer to this as a form of dependency on interpersonal relations and social capital (Interview 55). In most of the interviews with representatives of church-based hospitals, the DMOs are portrayed as the most understanding and supportive individuals. The DMOs are formally also members of the church hospital boards in their capacity as DMOs. Still, during the interviews, the management of the church-based hospitals gave the impression that the executive power of the DMO is limited compared to the District Executive Directors who will authorise the funding. The DMOs also represent different views in comparison to other CHMT members (Participant observation 3a). A result from the study is that personal relations and the quality of these relations remain as a key to success for PPP collaboration experiences at the local level. This is also a weakness in the PPP policy seen in all three cases; in particular the relationship between the hospital directors from the private health facilities and the District Medical Officers from the public authority.

Critical components in the PPP collaborations

The analysis of the data from the study indicates that through the PPP negotiations, the health work of the three cases has been further incorporated into the national public health system (Interview 8). Despite that the government

is lacking funding for effective implementation, it still looks as if the current PPP policy has enabled church organisations to further enter into subcontracting with CHMTs with the aim of receiving funding to cover some of their operating costs, such as basic salaries of employees, medicine, facilities and compensation for specific services. In return, some church-based hospitals have removed part of the patient fees. By agreeing to participate in comprehensive health planning at the district level, church organisations have also agreed to strengthen their role in national health planning (Ministry of Health 2009).

Integration of church-based hospitals into the national health infrastructure

The Ministry of Health is very clear in its commitment to further integrate church-based hospitals into the national health infrastructure. It is considered the only possible solution to a national health crisis caused by population growth and a shortage of health funds. The local governments, on the other hand, are more critical in their approach and to some extent perceive the private hospitals as a competitor for local health funds.

The church-based hospitals wish to integrate their facilities further into the national health system although they stress the importance of safeguarding their ownership of the facilities (Interview 32). The interviewees from the Ministry of Health also share this view. To give an example, a public health officer stated:

The government has realised that the need for healthcare services is high and that the government alone cannot meet all demands, so it has encouraged the PPPs. It has also encouraged FBOs to specifically step in to enter these agreements (Interview 4).

The local government in the case study districts have a tendency to primarily look upon the PPPs in financial terms while the national public authorities (i.e. the Ministry of Health) clearly put more emphasis on the importance of integrating church-based hospitals into the national health infrastructure in terms of comprehensive health planning. It sounds as if church organisations are called upon to help the state in the development process. A CSSC officer argued that PPPs ultimately serve the further integration of church-based hospitals into the national health infrastructure:

Whether we like it or not, we as FBOs are part of the national health system, so there must be some coordination of all the activities within the district. The CHMTs are supposed to oversee different facilities, the funding, the services provided and check so that all the guidelines are followed. If funds are being sent to the district so that it can distribute them to both public and private health facilities, then we have some challenges. This is because the dis-

tribution of funding will depend on who is there and how these people interpret the partnership (Interview 7).

In cases where the relationships have been based on trust, increased formalisation has not disrupted, but rather facilitated, the process. However, some interviewees argue that one of the factors impeding the further development of PPPs is a general lack of understanding of what is meant by PPPs, or rather, the intended role of PPPs in the Tanzanian health sector. This was apparent in many of the interviews carried out during the participant observation (Participant observation 3d).

Several interviewees from the national level also argued in favour of a further integration of church-based hospitals into the national health infrastructure and considered it an important step towards a more sustainable healthcare system. A good illustration of this comes from an interview with a health department officer:

Before, for example the Church of Sweden would support some of our hospitals and the Finnish Evangelical Mission would support one or two other hospitals. To me, that was a good approach and it worked really well. However, we can now conclude that this model promoted and encouraged dependency on foreign donors and that this is the kind of dependency that is now killing some of our health facilities (Interview 25).

In the first case study, representatives of the Health Department argue that there is an increasing need for coordinating healthcare facilities at the diocese level, especially considering the decentralisation process that has moved critical delegated powers from the central level to the local governments:

It depends on the government's plans, because we are not fighting the government, we are trying to work together to see what we can do. They won't force us, but we have to complement each other (Interview 16).

A key challenge with the integration of church-based hospitals into the national health infrastructure appears to be lacking financial compensation. In none of the three cases are church-based hospitals fully compensated financially in accordance with the PPP contracts. Nor have any of the contracts been fully implemented in accordance with the PPP principles. As an example, the public health authorities have in none of the cases refunded the services; neither with regard to funding nor on time. It is also clear that the church-based hospitals continue to practise cost-sharing between the patient and the hospital through the use of patient fees. Despite the fact that these are supposed to be removed for vulnerable groups once the PPP contracts have been implemented. According to several interviewees from the CHMTs, the approval of disbursements to councils have been delayed (In-

interview 48). Although development partners and the central Tanzanian government have used a wide range of funding mechanisms for supporting and strengthening church organisations and health sector development, this study also finds several weaknesses and conflicting issues in relation to the implementation of the PPP policy. This dilemma is discussed further in Chapter 8.

Inclusion of church organisations in national comprehensive health planning

An important component when integrating church-based hospitals into the national health infrastructure is acknowledging the Comprehensive Council Health Plan (CCHP). The Prime Minister's Office considers the CCHP a principal requirement for well-functioning district health systems. Every CHMT is under the current framework asked to produce an annual CCHP, which is supposed to cover three aspects: technical, financial and structural, in addition to all sources of funding at the council level (public funds, locally generated funds, local donor funds, etc.). It seems as if the private actors are not sufficiently involved in this work, and thus several interviewees from the church organisations criticise the fact that CHMTs do not involve private actors, like church-based facilities, the way they should in the full process of health policy-making, from planning to implementation (Interview 6–9, 16, 30, 32, 43, 54 and 55).

The CCHPs include objectives, strategies, activities and indicators for measuring health progress and the district level budget. In accordance with the policy, the CCHPs are supposed to be assessed and approved by the Regional Health Management Teams and later forwarded to the central level. Access to the Health Basket Fund has been an incentive for the CHMTs to involve private stakeholders (such as church organisations) in the comprehensive health planning processes (Ministry of Health and Prime Minister's Office 2009).

Another aspect worth pointing out is that church organisations (addressed in the CCHP guidelines as FBOs) are also formally included in these guidelines:

CCHP is an Annual Health and Social Welfare Plan for a Council which collates the Health and Social Welfare Plans at all levels and involves all stakeholders. FBOs, between other Health and Social Welfare Providers, have to be considered when preparing the CCHPs (Ministry of Health and Prime Minister's Office 2011).

In the Comprehensive Council Health Planning Guidelines Act. 1.11, it is stated that the local government authorities are responsible for managing service delivery, including developing, negotiating and signing service agreements with FBOs and private facilities. FBO representatives are also

invited to participate in the CHPT responsible for the respective CCHP (Ministry of Health and Prime Minister's Office 2011).

After reviewing the CCHPs in the respective three districts of the three case studies, in addition to the lists of members in the Council Health Planning Team (CHPT), it is possible to conclude that all church-based hospitals participated at least to some extent. In most cases, the hospital directors together with the hospital secretaries or medical officers represented the church-based hospitals in the CCHP preparations. Nevertheless, based on my interviews, it is also clear that the participation in the preparation of CCHPs was not large enough, both in terms of time and influence. Simply having a member on the planning team is no guarantee of participation or influence. While some participants from the church-based hospitals indicated that they to some extent participated in the CCHP process, others noted that their participation was minimal. Several interviewees from the church-based hospitals argued that they generally lacked full involvement in comprehensive health planning in their respective local district. CHMT members also argued that church-based health facilities lacked the capacity to show full interest in health planning at the local level (Interview 49–50 and 59–60).

A key challenge discussed during participant observations was related to a lack of consistency in reporting systems for health data and a lack of participation in comprehensive health planning (Participant observation 2f). Several interviewees explained that they lacked the information required for participating in a more meaningful way (Interview 32). After the planning sessions and budget negotiations, several hospital directors and administrators lacked updates on the progress and follow-up on the cuts in funding and explanations as to why the district health basket funding had been delayed. In the policy dialogue with district authorities, some church-based representatives felt like they were not in control of the dialogue in health policy-making. Several interviewees also stressed that the CHMTs do not involve private actors, like church-based facilities, the way they should in the full process of health policy-making (Interview 25). According to one interviewee, representatives of church health facilities are often not perceived as agents, but rather as executors on behalf of the CHMTs (Interview 4).

CHMTs, on the other hand, argued that church-based hospitals did not show full interest in health planning at the district level. Some of the interviewees in fact accuse church-based health facilities of being more loyal to foreign partners than to the CHMTs (Interview 36). This is partly confirmed by interviewees from the church-based hospitals, although expressed differently, where they rather complain that they are not integrated into the health planning process at the district level. It was also made clear that a sense of mutual suspicion persisted in the partnership between the district councils and the private service providers. A CSSC officer discussed this challenge:

We are experiencing some councils that don't involve the FBOs. People still think that the money coming through the government system is for government facilities only. The funds that come through the Basket Fund are for the whole district, so the FBOs have the right to be compensated from these funds. This is why they have to come together and plan together with the CHMTs. In some councils, they try to exclude the FBOs and other private stakeholders in the CCHPs. However, at the same time, other councils really involve the FBOs and other private stakeholders. For example, in the districts where I have been and where I worked before, the involvement of FBOs in CCHP was high. However, it also depends on who is representing the FBOs in the CCHPs. It must be someone who has the voice, who has a good understanding and who can stand up for him/herself. Otherwise, if you don't, sometimes we joke that if you fall asleep in the meeting, the agenda is passed (Interview 8).

Several hospital management representatives in the study also raised this issue:

Because the CCHP is supposed to compass all the income sources and expenditures for the council, but as far as these things are concerned we are not participating. They make up their own budget for income and expenditures and then they invite us to discuss how we are going to spend the 30 percent²⁶ of the basket funding we are supposed to get. So we couldn't go into how the council could inject some resources, taking into consideration that our hospital is a designated hospital, but the discussion has only been about us telling them how we are going to use the 30 percent they sometimes reduce to 25 percent. But 30 percent of the district budget is supposed to be allocated to the district hospital, so we are supposed to account for how we are going to spend that. That is all (Interview 43).

If the partnerships between church-based hospitals and CHMTs are to be more effective, considerable work will need to be carried out to develop accountability, transparency and the mutual trust necessary for partnerships to succeed and for church organisations to be further and more actively involved in comprehensive health planning.

Implementation of the contracts needs to be improved

A template for CDH and SA contracts has been designed nationally and the contract is partly adjusted for each facility. In general, standardised contracts are used. There are several aspects of the contractual agreements that need to be improved in the implementation of the PPP policy. These are presented below.

²⁶ In accordance with the guidelines, it supposed to be between 25–35 percent of the total district basket fund.

Lack of signatures before implementation of the contracts

Not all PPP agreements were signed before implementation started. It is also evident that in none of the three cases was there an electronic signed copy of the agreement available at the church-based hospital nor with the Council Health Management Teams (CHMTs). It looks as if the contracts were implemented after an oral agreement and a drafted unapproved printed copy was made available. Formally, the District Executive Director is supposed to sign the agreement on behalf of the CHMT, and the bishop of the diocese is supposed to sign it on behalf of the church-based hospital.

Lack of funding for compliance of the contracts

Several interviewees indicate that even if the PPP contracts (CDH and SA) may exist on paper, in practice many challenges remain, including the shortage of financial resources, human resources and medicine (Interview 31 and 36). The PPP contracts are also time-limited, which some interviewees claim have a negative effect on the sustainability of the church-based hospitals. Legal implications of the contracts were in particular discussed by the national church health departments and among some CSSC officers, and less at the lower level:

If you sign an agreement that is respected, then you are on the safe side, because then it is only about fulfilling your obligations based on the agreement. However, in most cases you find that the government does not implement the PPP contracts accordingly. Consequently, you find that the church is struggling to raise money from other sources. This is the challenge we are facing and that is why I cannot say whether or not the PPP is good, because sometimes you have to struggle to look for other sources to offset whatever the deficit may be (Interview 17).

Local critical voices were also heard:

The CDH contract is only there in theory, in practice it is not yet functioning. This is not what we expected, so therefore we still depend on funds from the central level, the Ministry of Health (Interview 32).

Another problematic factor is that the church-based hospitals are governed by a complex structure, with the church leadership at the top and the health professionals lower down in the hierarchy. It means that those who have the decision-making power over health sector developments are not the same church representatives as those who work directly with the implementation of the PPP contracts in health. Wrong decisions might be taken due to lack of understanding of the complexity of health sector developments.

There are some occasions where church-based hospitals feel limited by the PPP contracts. As an example of this, a representative of the church-based hospital management team said the following:

Since we are a faith-based institution, we have our own principles and we are running the hospital as a Lutheran hospital. Even if it is a Council Designated Hospital, we are not running it as a government hospital. However, it appears as if this is not fully understood by the council. They think that after signing a CDH contract, we are a government hospital and that they can treat us like any other government institution. Therefore, we try to resist. We want to stress that we are a church-based hospital and we conduct our services and affairs according to our Lutheran faith. However, the other side of the coin is what the district council says: “Since you are now a CDH hospital, you are going to follow the council regulations.” We say yes, but we still emphasise that the government and the district council do not own our facility. As an example, the council wanted to introduce its own logo for our hospital, and then I said: “NO, we are going to use our own logo. We are in a partnership with you but this is still our hospital. We provide services for everybody without any discrimination, but we are Lutherans so you have to respect that and that we run our services according to our Lutheran faith” (Interview 43).

This quote illustrates a key finding in the study as it not only concerns the very identity of the church organisations, but also how public health authorities interpret the PPP policy differently from the church organisations. This finding also relates back to some central debates in sociology of religion regarding appropriate forms of church-state relationships.

Lack of legal component for monitoring of the contracts

In all three case studies, there is a lack of monitoring and evaluation on compliance of the respective PPP agreements. All hospital management teams are requesting a structured compliance audit of the PPP contracts (both CDH and SA). As it currently works, there is no proper monitoring tool for compliance audit of the PPP contracts. It is therefore difficult for private health facilities to rely on the contracts in terms of securing long-term health financing. However, an inherent challenge in the PPP contracts is that there is no legal option for the church organisations to take the Tanzanian state to court for non-compliance with regard to the articles in the agreements. Theoretically, the PPP would function accurately if the funding level would amount to a certain number of health services recipients. But without any monitoring, most of the contracted CDHs are providing services to large numbers of patients far above what the district councils compensate financially.

Key results

Table 10 gives an overview of the empirical findings described in this chapter. The types of PPP contracts are in practice found to be CHDs and Service Agreements in combination with Grant-in-Aid. The contractual partnerships between the three church organisations and public authorities in the health sector are found to be constructed based on a division of roles under the current PPP policy. The international external partners are found to act as informal initiators of the PPPs, the CSSC and the church health departments as advocates, the Ministry of Health as facilitator, the dioceses and church-based hospitals as formal initiators and finally the CHMTs as the core implementers. If the partnerships between church-based hospitals and CHMTs are to be more effective, considerable work will need to be carried out to develop accountability, transparency and the mutual trust necessary for partnerships to succeed. Local governments need to be sensitised on the PPP reform itself in order to increase both knowledge and legitimacy. The PPPs are currently not properly legally approved and both the public and the private side are requesting that the contracts receive better follow-up with a component of monitoring. Even though the PPP contracts are not fully legally recognised, the contractual partnerships with local governments are still more formalised than those with external partners, which are almost completely based on trust and oral agreements.

Table 10. Overview of empirical findings related to research question 1

How are the contractual partnerships (PPPs) with church organisations constructed?	
<i>1. Types of PPP contracts with church organisations</i>	
Case study I	CHD contract in combination with Grant-in-Aid
Case study II	CHD contract in combination with Grant-in-Aid
Case study III	Service Agreement in combination with Grant-in-Aid
<i>2. Function of each actor in the PPP collaborations</i>	
International external partners	Informal initiators of the PPPs
The CSSC and the church health departments	Advocators of the PPPs
The Ministry of Health	Facilitators of the PPPs
Dioceses and church-based hospitals	Formal initiators of the PPPs
The Council Health Management Teams	Implementers of the PPPs
<i>3. Critical components in the PPP collaborations</i>	
Integration of church-based hospitals into the national health infrastructure	
Inclusion of church organisations in national comprehensive health planning	
<i>4. Implementation of the contracts needs to be improved</i>	
Lack of signatures before implementation of the contracts	
Lack of funding for compliance of the contracts	
Lack of legal component for monitoring of the contracts	

8. Financial and organisational dimensions of the partnerships

This chapter includes a presentation of the main research findings from the three case studies related to the second research question: *How do church organisations and public authorities perceive contractual partnerships in health from a financial and organisational perspective?* The question is analysed from a rational/instrumental perspective. Church organisations appear to be sensitive to new trends in health financing, but the question remains whether adherence to these new trends in general makes the health system more resilient.

From a *rational and instrumental perspective* in terms of religion and development, church organisations are often said to be efficient actors. By looking upon religion instrumentally, the focus is on the role of church organisations as service providers and implementers of development health programmes. The notion behind an increased involvement of faith-based organisations (FBOs) is first and foremost to achieve deliverable results (Beckford 2017).

When analysing the collected data on how the public and private sectors view the PPPs, *resource dependency* is found to be a useful concept in order to describe current partnerships and the financial and organisational dynamics in these partnerships. Resource dependency as a concept sheds light on the fact that church organisations are vulnerable and depend on partnerships for the survival of their service provision role. By focusing on the dependency of church organisations towards their external environment, issues related to financial and human resources become central (Pfeffer & Salancik 2003).

Central themes

Six central themes can be deduced from the themes found in the qualitative analysis of the three main data sources: policy documents, interview transcripts and field notes. These six themes are: 1) increased state dependency; 2) PPPs accompanied by complementary financing mechanisms; 3) partnerships constructed to secure long-term funding; 4) removal of patient fees – challenging condition for PPP entry; 5) misappropriation of funds – a hidden

and sensitive factor and 6; human resources for health crisis. The themes are summarised in a table at the end of the chapter.

Increased state dependency

Since the sustainability and national ownership paradigm became the dominant discourse in development, there have been some core changes in health sector financing, including decentralisation and integration of private actors into national health systems (World Bank 2013). Global development partners have moved away from funding individual church-based hospitals towards funding community-based health programmes, strengthening health systems at large and developing capacity for health more structurally. This move forms a background for the formulation of the new strategy adopted by church organisations and international FBOs in development cooperation (Interview 55). However, it is important to emphasise that foreign development assistance still remains the largest source of financing for the Tanzanian health sector at large, even though a large part of the contributions during the period of this study were provided through general budget support, a health sector basket fund and direct programme financing (World Bank 2013).

As shown in Chapter 5 on how the health sector is financed, the financial architecture of this sector is very complex and not particularly transparent. For church organisations, funding is available from many sources, which often leads to tensions with the local district councils. From having received funding almost exclusively from external sources, today more and more of the funding comes from the state, lately through PPPs. Several interviewees in this study have therefore emphasised their wish to find effective strategies for church organisations to decrease their dependency, both regarding single foreign partners and the state. They have tried to increase their own room for manoeuvre by creating a situation where the state and international donors are dependent on them for the implementation of their health policies. To lessen their dependency on the state, church organisations also work on broadening their financial base. One example of this strategy is when church-based hospitals collaborate with external partners and Vertical Health Programme Funds, generating direct finance outside the partnership contracts (Interview 11).

Despite church organisations' search for diversified funding, I have still found that the three church organisations included in the study are foremost seeking to develop stable and long-term relationships with public health authorities. This is partially achieved through exchange of information and mutual understanding between the two partners – the church-based hospitals and the Council Health Management Teams. An example of this, seen in all three cases, is that in accordance with the PPP contracts, a government rep-

representative in the form of a District Medical Officer (DMO) attends the church-based hospital board meetings. In these meetings, the DMOs on the one hand appear to be supportive of the church organisation with the possibility that he/she will be more concerned with the hospital's challenges and try to take action to address the problems. On the other hand, inviting an external person into the hospital board could also mean that this person could influence the organisation's hospital agenda and that the church organisation could risk losing some of its autonomy.

Core global partners in health have promoted PPPs as a funding solution to the global health crisis. The most important argument behind these developments is that these partnerships offer the best available solution to achieve the realisation of health rights in light of a national shortage of financial and human resources for health sector development. The current development assistance allocated for health sector development follows two different avenues, as described in Chapter 5. Primarily, the funding is channelled through the PPP framework and the related Basket Fund Grants, which are supported by the Development Partner Group. This has been confirmed in a series of World Bank studies, stating that FBOs through PPP contracts have been critical in extending the reach of government health service provision into rural or hard-to-reach areas. Similar World Bank reports have also emphasised that partnerships constitute a necessary tool for avoiding duplication and fragmentation of efforts by channelling all resources through one common mechanism in support of the government's strategic health plans (World Bank 2013). The second avenue is built on Vertical Health Programme Funds and direct support channelled thematically in relation to HIV/AIDS funding, tuberculosis, malaria funds, etc. All three local cases receive external funding through both structures. In the second avenue, the state is not involved to the same extent; it is more of a global-private local partnership.

The three church organisations are faced with the dilemma of, on the one hand, seeking financial stability by entering into partnerships and, on the other hand, avoiding being controlled by the state or external global development partners. Different strategies for decreasing dependency on one single actor are discussed by several interviewees, in particular by the heads of church health departments, hospital directors and hospitals administrators (Interview 16 and 55).

It looks as if church organisations are to a large extent seeking to collaborate with the government because they lack finances. The relationship between the church-based hospitals and the Council Health Management Teams (CHMTs) could in this sense be considered a resource exchange partnership. The national interviewees claim that it would be tremendously hard for the local hospitals to survive without the partnership contribution from the government. Besides, the interviewees also claim that the government is

dependent on them in fulfilling its health services delivery (Interview 16 and 28). As an example, an FPCT church representative says that:

The struggle we face in our health services is to secure salaries for the staff, so what we need more of is that the government should support the staff in our health centres, to ease the burden of payment of the staff, because the government is still responsible for the healthcare of the people of Tanzania (Interview 27).

The responses at the local level are similar in nature. Several representatives of church-based hospitals confirm that they consider the partnership with local governments important for long-term security and financial stability. Some of the interviewees even express a wish for the local government (CHMTs) to fully support the hospitals in financial terms beyond the existing levels of basket funding, Service Agreements and Council Designated Hospital contracts (Interview 44).

If the church organisations included in the study are to survive in the health sector, they need to manage both cooperation and compromises with the government and external partners in order to get the necessary resources. What I observed, though, is that sometimes the three church organisations act in contradictory ways, trying to be independent at the same time as they seek certainty and stability. This might lead to the creation of less flexible partnerships. Actors in the partnerships or external collaborations controlling power are the ones holding the resources that might lead to dependency.

Shifting dependency from international partners to the state

The dependency of the churches has shifted from dependency on international partners to a dependency on the state. This is closely related to the ownership approach that is implemented in health sector development after the launch of the 2005 Paris Declaration for Aid Effectiveness. The declaration more clearly promoted the involvement of partner countries and local actors in defining their own development priorities. The country ownership paradigm represented a departure away from the largely externally donor-driven approaches in development towards state control of financial resources (Organisation for Economic Co-operation and Development 2008).

The Tanzanian 2009 PPP Policy, 2010 PPP Act and 2011 PPP regulation have all required a multi-sectoral machinery and collaboration for health system development (Kisanga & Msoffe 2014). In these processes, the church organisations have been identified as key stakeholders and crucial partners of the government. The PPP Policy has emphasised that church-based hospitals need to change their financing models away from being based on patient fees and that they also need to integrate with the national health system in order to access Basket Fund Grants (Interview 8).

A TEC church representative describes this shift from private to public funding:

Before, our traditional donors were giving us funding through the faith forums in Germany, but then the situation changed. The funding was still there, but the way to access it changed. The German government, in collaboration with the German Lutheran Church and the Catholic Church organisations, told us that we would get the funding in a new way. “From now on, the funding will be given to you through the Tanzanian government. So if the funding goes through, it is available to you from them, but we cannot force your government to give you the money. You have to ask your government.” Shortly after that, we signed a MoU and started the CSSC (Interview 15).

After this shift, there has been a decline in the support for FBOs from their sister organisations overseas. A public health officer from the Ministry of Health confirms this:

Most of these FBOs used to get a lot of money from the mother donor organisations, but in recent years they are getting much less than what they are used to getting (Interview 3).

But even if the PPP framework has been in place for some years now, missionary societies continue to be influential when it comes to new developments. According to most interviewees, they are still important for the hospital system (Interview 55). The church-based hospitals still receive strong support from Western church-related development agencies, constituting at least 10–15 percent of the total hospital budget. Medical missionaries still come to work in church-based hospitals on a regular basis. An example of this is found in the third case study, in the long-term master plan of FPCT, where its foreign partners (PMU InterLife together with Fida International, Interact Sweden and International Aid Sweden) are described as having a high level of influence on the organisation of the hospital (Free Pentecostal Church of Tanzania 2013). Similar tendencies were also identified in the two other case studies, even though it was expressed more clearly in the FPCT case compared to the two other cases. I have reached the conclusion that the Tanzanian church organisations are involved in dual resource exchange partnerships, where PPPs constitute only one part of the funding they receive for health provision.

The interviewees argue that the remaining external funding has enabled the church-based hospitals to overcome deficits (Interview 31). Several external partners in all three case studies emphasise how they work to address sustainability issues and wish that the Tanzanian church organisations would generate more funding on their own. One example comes from the ELCT case study, a hospital management representative who addresses ownership and sustainability:

If donations dry up, we will lose the opportunity to deliver health services to needy people. The big difficulty, though, is that the local government does not meet its commitment. Therefore, instead of providing Selian Hospital with 80 percent of the hospital's budget (which equals 25–35 percent of the district basket fund), which is in the agreement, they only provide about 55 or 60 percent of our budget, so there is a shortfall (Interview 42).

Another hospital management representative from the same case study reflects further on the shift from external donor dependency to state dependency:

Before we started the partnership with the government, we were very dependent on the cost-sharing from the patients/patient fees. But at the same time, we had funding from the USAID and this was coordinated by our external medical missionary. After our foreign hospital director left, we entered into the PPP, so now we are just operating depending on the government funds and the patient fees (Interview 45).

Despite the challenges in the PPPs, some of the interviewees are overall relatively optimistic and see the transition as both necessary and rewarding:

So, since the mid-90s, there has been a great recognition that the long-term survival of the church hospitals is going to require partnership with the government. To serve the poor, somebody has to pay for it. Western churches are no longer able to support healthcare. We either have a choice of closing this part of our ministry or to collaborate more closely with the state. Our long-term question concerns how we can sustain our work into the future, as sustainability really requires a sophisticated planning process and financial planning (Interview 42).

A third hospital management representative from the ELCT case study confirms this view by arguing that the partnership with the government was a necessity:

The wisest thing was to get into a partnership with the government through the local authority so that we could at least get some subsidies to fund the hospital. Otherwise, we would have to close down (Interview 43).

However, in the FPCT case study, it is evident that the transition was marked by hardship. In one of their management reports, the hospital management describes how the transition away from receiving core funding from the donor partner in Sweden was “a hard transition”. The report states:

The letter from Sweden about ending their core support shocked us and we took it seriously and informed the Public authorities. The matter was then reported further to the Ministry of Health: “We are still waiting for an answer from the Government about what is going to happen [...] Apart from a promised donation from external medical missionaries, we hope that partner West-

ern churches will continue to support us with free bed funds etc.” (Mchukwi Mission Hospital 2010).

While acknowledging that core funding from Sweden is no longer an option, an FPCT church representative reflects on this change:

The challenge is that even the government itself does not have enough funds for their health services, so you can see that even within the government, they are struggling. So the challenge for us is access to funding. They can do their part, but it is not enough because the government is not able to sufficiently provide assistance at the same level that we used to get from our foreign partners (Interview 27).

There are representatives from the TEC case study also confirming that their transition has been marked by difficulties:

Nowadays there is no external core funding from the outside. Therefore, we normally want to make the people living around our hospital feel that they are supposed to depend on themselves and pay for all their needs. However, what we are also doing is to go to the district office and try to convince them to sign, to implement the PPP contract, and normally they come here and have meetings with us (Interview 33).

Completely in line with the notion behind the PPP reform, some interviewees have reflected on the transition from foreign partners to the state as a shift from religion-based health funding to secular-based health funding. In relation to this transition, many interviewees are also referring to a new form of state dependency and a potential risk of institutional isomorphism. While securing long-term funding, they might create new dependency, either in relation to the state or the Vertical Health Programme Funds. Church organisations are faced with crucial choices, as current funding for healthcare engagement of church organisations is becoming more secular-based.

Interviewees from the TEC case study indicate that this causes local tensions, since the church-based hospitals are owned by the church diocese (and represented by the bishop) but nowadays funded through secular mechanisms. Still the bishops tend to look upon the hospitals the way it used to be, as an income generator for the diocese and the church at large (Participant observation 1c). The problem is also that the church leadership seems unwilling to mobilise funding for church-based hospitals at the same level as the former medical missionaries. As a hospital management representative of the first case study reports:

This hospital is now under the bishop from the diocese of Morogoro. The bishop, as the owner of the hospital, is supposed to do something when we are in a crisis, but still we do not get much from the bishop as the top manager of the hospital. When we have a big crisis, we have to tell him that we

have this, but we still do not get any support from him as an owner of the hospital (Interview 32).

An important finding is that it seems as if the special position of the church largely comes from its access to external resources (Interview 31). With resources comes power for the clergy in distributing these resources. Similar reflections are made in the second ELCT case study, as a hospital management representative argues that:

When the churches became independent or self-governing, they did not for a very long time have the external resources to continue paying for a holistic ministry. I think that this has been an underlying challenge in the way that the church leadership perceives healthcare as part of their ministry (Interview 42).

Sustainability and affordability – contradictory goals

Sustainability as a concept is not unique to health financing. It was introduced in the development debate already in the 1990s (Goldberg & Bryant 2012), at a time when church-based health institutions faced severe challenges (Dahlgren 1991). The ELCT, for instance, lacked adequate financing for its services, had poor health infrastructure, inadequate and poorly trained personnel, low staff motivation and, subsequently, high staff turnover. Consequently, the quality of services and thus the sustainability of the institutions were compromised. Service levels and the quality of the services were not proportionate to needs and available resources. During that time, available resources primarily came from external partners, aid organisations and medical missionaries, and the church organisations were therefore looking for ways to access alternative support (Bengtsson 2013).

Swedish International Development Agency (Sida) conducted a sustainability and phase-out study on church-based health facilities in Tanzania in the 1990s, which included two out of my three case studies, ELCT and FPCT. The Sida study used sustainability as a point of departure for the assessment and concluded that its external support to the health programmes of church organisations, in the form of capital investments, had perhaps been too generous:

In this way, hampering sustainability. Further, it was concluded that given the actual situation within healthcare, the church-based facilities would function better if they were dependent on, and more integrated into, the government healthcare structure (Dahlgren 1991, p. 9–10).

The evaluator of the Sida phase-out study stated:

The relationship between church-based health facilities and their foreign partners is perceived as a deep, reciprocal relationship between sisters, and

the Swedish denomination supports the Tanzanian sister church as long as, and whenever, she needs assistance. Such a relationship has no time limit, even though the Swedish churches try to reduce the dependency (Dahlgren 1991, p. 15).

The Sida phase-out study concluded that even though the health facilities were owned by Tanzanian church organisations and registered as Tanzanian voluntary agencies, they were still associated with the missionaries and were even called mission dispensaries, mission health centres and mission hospitals; not only by public representatives, but also by patients and the health staff. The study recommended that the church-based health institutions should invite representatives from the local governments, both on local and district level, for advice and exchange of ideas about the health facilities and discuss and elaborate on alternative sources of income (Dahlgren 1991).

Based on my case studies, it is possible to conclude that the sustainability and dependency problems discussed in the 1990s still today remain key dilemmas for the church leadership, local management and external partners. A Health Department officer from the third case highlights the following in one of the interviews in my study:

The support we are receiving from Sweden is charity. It is not structural. The government is not even aware of it or does not understand it. It is just in the heart of Swedish people in the Swedish Pentecostal Movement (Interview 30).

This question is also discussed in other publications. One of the three case study hospitals is addressed in a 2010 study from Uppsala University. Here, the external mission organisations are referred to as the formal owners of the church-based health facility. This comes as a surprise, as all hospital documents state that they handed over the facility to national church organisations several decades ago. The study did not, for example, mention that the FPCT was the owner and manager of the church-based hospital (Pembe 2010).

In 1998, almost a decade after the Sida sustainability study, a German health development economist, Steffen Flessa, followed-up with a sustainability study on the ELCT and its church-based health infrastructure in Tanzania. He concluded that church-based hospitals were in need of receiving patient fees in order to cover the costs of health services. At the same time, he argued that with full cost recovery through patient fees, poor people would be excluded from accessing the hospitals. For that reason, sustainability and affordability were found to be contradictory goals (Flessa 1998).

In my interviews I have come across similar contradictions between sustainability and affordability. For example, after entering into PPPs, the church organisations are pushed to change their policy of cost-sharing by not

charging patient fees for disadvantaged groups. By removing patient fees, they on the one hand support the accessibility for poor people to health services in a positive way, but, on the other hand, the church-based hospitals lose independently generated income. Local governments, through the CHMTs, have agreed to provide financial grants from the state in accordance with the agreed contracts to compensate for the services delivered. However, the interviewees in my study indicate that in several instances, the CHMTs have not disbursed the funding in time or in some cases not in sufficient amounts, which means that the church hospitals have not received compensation for some of the services (Interview 3, 30 and 32). All three hospital directors in the study acknowledge that it is no longer possible to only depend on foreign donations and still keep user fees at affordable rates. Core funding from the government is also needed in order to compensate for the fact that many of the patients are not willing or able to pay for their services (Interview 31, 42 and 53).

A common challenge facing church-based hospitals engaged in PPPs is access to medicine. In order for church-based hospitals to operate successfully, they need consistent access to high-quality pharmaceutical products. The Ministry of Health has emphasised that Tanzania's medical supply chain and drug access is critical in order for the country to address key national health challenges (Ministry of Health 2009). Church hospitals are faced with many constraints in their procurement and management of equipment, medical and pharmaceutical supplies. The government's Medical Stores Department, which is supposed to address this, has not been able to meet the needs of the church health facilities (Tanzania Episcopal Conference 2008). This department is meant to operate as an independent para-governmental organisation, ensuring consistent access to high quality and affordable pharmaceutical products. However, a recent study from the World Bank observed that drug prices were higher than average market prices. The World Bank study also found that the Medical Stores Department was frequently running out of stock, leading to a disrupted supply chain also for church-based hospitals (World Bank 2013). This challenge was brought up in all three case studies within respective health department of each church organisation.

In order to address the poor availability of essential drugs to church-based hospitals, and in response to the increase in the price of drugs and their questionable quality, the ELCT launched the Mission for Essential Medical Supplies in 2004. Through the MEMS, church-based hospitals are able to provide pharmaceutical services (Government of Tanzania 2015). As a positive outcome, these FBO hospitals are currently in a better position to access drugs than government hospitals, a result of more flexible and less complicated procurement procedures. The pharmacies at FBO health facilities are currently also better organised (Ministry of Health 2015; EPOS Health Consultants 2007).

Complementary financing mechanisms

As previously discussed, church-based hospitals are located in remote areas, but are nevertheless far more globally connected than what is commonly known. In all three local cases, external agents strongly influence the financing strategies of the hospitals. External funding is often earmarked for specific projects and primarily comes in the form of technical assistance (medical expatriate staff) and infrastructure support (Participant observations 1a and 2c).

An interesting finding is that all three church organisations operate commercial activities and have established for-profit companies that are linked to the organisations. For example, the FPCT has started a company that has incorporated part of the FPCT health work as an asset for the company. The company aims to reduce the patients-to-doctor ratio and the bed-patient ratio, to improve working conditions in the proposed hospitals, to create jobs and to construct medical institutes at new sites (Free Pentecostal Church of Tanzania 2008).

The ELCT is known to be actively engaged in income-generating activities. For instance and as discussed above, the ELCT launched the Mission for Essential Medical Supply, which was the first market- and faith-based private supplier of medicine. The ELCT is also said to utilise income from these sources to fund some of its development activities (Leurs et al. 2011). The ELCT for instance owns the Lutheran Investment Company Ltd. (LUI-CO Ltd). The first business enterprise to be managed by LUI-CO was the New Safari Hotel Ltd (New Safari Hotel 2016; World Council of Churches 2016). TEC and the FPCT are also to some extent engaged in income-generating business activities. At the local level, interviewees brought up several income-generating projects based at the church-based hospitals, such as small-scale farms, shops, restaurants, hotels and guesthouses. The surplus of these projects was used to subsidise the health services, but it was unclear to what level or extent.

As discussed in Chapter 5, external health financing is channelled to private actors in Tanzania through a complex structure. The first includes the bilateral donors that signed the Paris Declaration. Funds are mainly provided through general budget support and through a special fund labelled the Health Basket Fund. The second category includes thematic global health funds that concentrate their efforts on project aid to combat major diseases such as HIV/AIDS, tuberculosis and malaria (EPOS Health Consultants 2007). A third group includes local and international FBOs and NGOs, which by themselves are relatively small in size, but still important for my three case studies and other faith-based hospitals in Tanzania.

I found that even though global health funds and disease-specific programmes have provided significant financial resources for the three church-based hospitals, they have nevertheless largely remained outside the plan-

ning and priority-setting structures in place at the national and local level in the Comprehensive Council Health Plans (Interview 36 and 58). It is evident that the Vertical Health Programme Funds have adopted an alternative approach in comparison with the development partners group in the PPPs, as their funds are channelled directly to the church-based hospitals, thus bypassing the local governments. Several evaluations and other reports suggest that these programmes need to be more integrated into government health planning in order to avoid distorting local priorities and long-term sustainability in the health sector. A common suggestion in several evaluations is that Vertical Health Programme Funds should proactively seek to incorporate their funding with the Development Partners Group Health Basket Funds. This would require making some compromises regarding reporting and management, which would potentially increase transaction costs in terms of managing the basket. However, such compromises could potentially reduce overall transaction costs for the health sector (Ministry of Health 2009). The interview study with CHMT members confirms that there is a need and a request to integrate Vertical Health Programme Funds into Comprehensive Council Health Plans (CCHPs) in order to improve transparency and subcontracting at the local level (Interview 49–52 and 59–62).

All three church-based hospitals, however, have benefitted from the Vertical Health Programme Funds, including the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Emergency Plan for AIDS Relief (World Bank 2013). In fact, the church organisations have been the most common recipients of HIV/AIDS funding (Gifford 2016). Since the beginning of the epidemic, church organisations have typically been engaged in HIV/AIDS interventions; however, often in ways not related to the national coordination plans. The Christian Social Services Commission has now developed an HIV/AIDS strategic plan for a more comprehensive response by church institutions in terms of combatting the disease (EPOS Health Consultants 2007). The Vertical Health Programme Funds often consider church-based hospitals suitable partners, since they have access to existing structures able to coordinate a scalable response and also because they have an understanding of, and acceptance in, communities due to a long-standing presence (USAID 2014).

Church-based hospitals perceive external funding from the Vertical Health Programme Funds to be an important supplement to the public funding within PPPs. Interviewees from all three church-based hospitals perceive these direct links between local church-based hospitals and global actors as crucial for operating their services, even though they operate outside the government structures and the PPPs. As an example, the overall hospital director of Selian states:

Particularly the poor and marginalised continue to be funded through the Vertical Health Programme Funds. For example, the HIV/AIDS funding is a

big one and there are some donations from the US government, for example for fistulas. All our fistula operations are funded with external support (Interview 42).

However, a few of the interviewees from the church-based hospitals also stress that these funds can be complicated. As an example, a hospital management representative from the TEC case study says that:

The global health fund is complicated since it is not related to other funds (Interview 31).

New forms of secular-based friends associations

A new form of funding found in the study is that in two out of the three cases, former missionaries and traditional partners have formed more secular-based foundations, often called “friends associations”, in order to continue supporting the church-based hospitals. Although foreign partners still influence the development of church-based hospitals, these relations lack regulations and written agreements. Some of the interviewees indicate that these long-lasting relational global partnerships could have helped the church-based hospitals in extending the long-term development and sustainability of the cooperation (Interview 43). While contractual partnerships with local governments and agreements with Vertical Health Programme Funds are more formalised, the collaborations with other external partners instead tend to be based on trust and traditional partners. In most cases, there is no Memorandum of Understanding or Terms of Reference in the collaborations.

A hospital management representative from the first case study states the following:

The ones who worked here in the past days, after going back, the expatriates started to organise and asked if some foreign people could help the Tanzanian people (Interview 33).

In the FPCT case study, the hospital administrator confirms that foreign partners funded the development of a maternity ward (Interview 55). A representative of the TEC Health Department also confirms that the partnerships with medical missionaries and friends associations are seldom formalised:

What we have been talking about is partnership; we are not their servants. If we fail, we fail together, and we have to work together (Interview 16).

It is clear that the church-based hospitals are depending on foreign visiting doctors. A hospital management representative from the first case states:

The specialist doctors are coming from AMREF, through the flying doctors service. There are also some other medical students who come here from Holland for internships. We also have specialist doctors coming from the friends associations (once or twice a year in supporting specific services in the hospital) (Interview 32).

In the ELCT case study, a hospital management representative confirms that they receive foreign doctors on a regular basis:

A lot of doctors and international students come and do their fieldwork here. In fact, we for example have a physician who comes here and does most of the clinical work. We have an internship programme for medical students, and they are based here during their internship. Since we are lacking expatriates in surgery, we instead have consultants coming to do their work (surgery/operations) like twice a week, so that link is still there. Then we got the supply chain from a global health fund. So we still have that link too (Interview 43).

The IMA World Health Country Director also highlighted the issue of foreign support to the church-based hospitals:

I think there is an important relationship between the FBOs and their relationships with the Lutheran churches in Europe. The health sector is a main fundraiser for them. That's why it is so important for them to have that link back to their sister churches; because that's how people mobilise and send money (Interview 11).

Some foreign medical missionaries interviewed in the study argue that for as long as the health rights of Tanzanians are not realised and they are invited to provide support, they will continue to be engaged in church-based health services. There is, however, a grassroots challenge when the involvement of external partners is not openly accounted for and fully integrated into the health planning of the local councils.

Key individuals as gatekeepers to external funding

The notion of a stable relationship is crucial in order to access and sustain resources in a partnership. This can be achieved through friendship, exchange of information and mutual understanding (Pfeffer & Salancik 2003). All three case studies indicate that there is a small number of key individuals acting as gatekeepers with regard to foreign organisations and Vertical Health Programme Funds. Such key individuals are in most cases foreign medical missionaries who used to work full-time at the church-based hospitals. The gatekeepers support the church-based hospitals and are often concerned with the problems they face, while offering support with fundraising activities. They mostly do this work on a voluntary basis, even though some

of the medical missionaries obtain a small honorarium (Participant observations 1b and 2a).

To give an example, in the ELCT case, a hospital management representative says:

The Americans are generous if you find a key individual to act as promoter. But without the key individual, you're not quite sure whether you will get the funding. But I can say that when the former American director was here, we had plenty of external funding and even supply of equipment. As an example, the global health fund gave us equipment from the US (Interview 43).

The current hospital director confirmed that the former American hospital director was considered a key individual, as they received a lot of external assistance from the United States through him (Interview 44). Another hospital management representative admits that he is considered a key individual, while at the same time working to make the hospital sustainable:

We work very hard not to become dependent on our expat staff. That is probably the one thing I am the most proud of regarding my work here – if I die tomorrow, this hospital will go on for a long time. Some of the external funding would probably drop off, but our core services would continue just fine without the expats. Now, we are big enough that we can invite other expatriates to assist us. However, in their assisting us, they are assisting the Tanzanians, rather than the Tanzanians being dependent on them to bring in extra services, new techniques and new ideas. But it is clear that the ownership is with the Tanzanians (Interview 42).

Donor funds and donor priorities are dominant factors in the process, whereby there is usually a lack or loss of ownership with regard to the intended beneficiaries. Several interviewees see direct funding from external partners as crucial for the sustainability of the facilities. I also identified some examples when external partners had not considered the local ownership component; such as in the TEC case study, where one of their contracts between Turiani Hospital and a partner hospital in the Netherlands was written in Dutch. A hospital management representative notes:

We have [a contract with a university in Holland] but although I do not know the contents, I know that we have the contract to help each other (Interview 33).

It is evident in all three case studies that key individuals are appreciated in their capacity as gatekeepers in order to access funding for specific purposes, such as training, development, expansion, etc. However, all hospital directors express that when it comes to core funding, they prefer to rely on public funding as part of the PPP contracts. To give an example, an ELCT Health Department officer states:

To have friends or supporters of a health facility is a very good idea, but it should not be the responsibility of these donors to run those hospitals, so this model can never be sustainable. It is only when it comes to small support for specific improvements in specific areas that we still agree on the old model and think it is a good system. Even here at the ELCT head office, we have these healthcare programmes. These programmes are funded by Denmark, Finland, Germany and the Church of Sweden, so all together these programmes are funded through external support (Interview 25).

Partnerships to secure long-term funding

PPPs have been pushed by the World Bank and other global donors from the partnership group as a strategy for promoting local ownership by decentralising the collaborations (World Bank 2013). The intention was that by allocating donor funding directly to the government, redistribution to the end users of the funds would now be the responsibility of the Tanzanian government and its institutions. Several interviewees confirm that following a sharp reduction in financial aid by donors for missionary organisations, these partnerships were the only available option in order to sustain their health sector services (Interview 32 and 55). It is evident from the three case studies that church organisations mainly seek to engage in these partnerships in order to access and secure long-term funding. Very few interviewees, however, address local ownership, participation in comprehensive health planning, better coordination or realisation of health justice as their main reason for entering into PPPs.

Partnerships perceived as necessary for long-term stability

A few interviewees acknowledged that the partnerships had generated increased levels of public funding. As an example, the medical officer in charge at Turiani Hospital confirms that the hospital has gained resources through its partnership with the CHMT in Mvomero:

In this process, we saw some benefits as the District Medical Officer and the District Executive Director had both agreed to direct money from the basket funds to our hospital as a district hospital; around 30–35 percent of the district health budget (Interview 31).

A hospital management representative supports this view:

Currently, there is no external core donor support, so we only depend on the Ministry of Health for funding. However, this is uncommon, as it is only about 45 hospital beds getting funds from the Ministry of Health. Moreover, apart from this, we also get Basket Fund Grants (BFGs) from the district council (Interview 32).

Through the local partnerships, pressure was placed on the CHMTs to release more funding for the church-based hospitals (Interview 36). For that reason, several representatives of the church organisations consider the partnership with local governments important for the long-term security and stability of operating their hospitals (Interview 27).

What is interesting in terms of linking supervision to the notion of resource dependency is that the Council Health Management Teams are both the implementers of the PPPs as well as the monitors of these partnerships (Itika 2009). It is therefore important to consider the power balance, both between the District Medical Officers and hospital directors, as well as between the district and the central government, since the study indicates that the CHMTs have insufficient trust in the central government (Interview 36).

One challenge that is often brought up is that despite health sector development, the population still faces a high burden of disease, especially related to malaria, tuberculosis and HIV/AIDS. Another challenge is the very high population growth. The Local Government Reform Programme and the PPPs have to some extent been implemented, but have only had limited financial resources available for implementing the actual PPP contracts. Lack of health financing at the national level has clearly had a negative effect on the priority-setting and planning processes of the CHMTs (Interview 49–52). In several PPP reviews (including my three case studies), allocated health funds do not match planned needs in accordance with the corresponding Comprehensive Council Health Plans and the signed PPP contracts with church-based hospitals (Interview 59–62). An ELCT Health Department officer stresses:

The Service Agreements (SA) are supposed to be funded directly from the local district authorities. But since these authorities do not have enough funds for that particular code, they are not able to meet these obligations (Interview 25).

It looks as if the communication channels from the district to the central level are indirect, passing through the Regional Medical Officer to the Ministry of Health via the Prime Minister's Office for Regional Administration and Local Government. One of the interviewees stated that this represents a major challenge as the PPP policy is developed by the Ministry of Health, but implementation happens at the level of PMORALG and the Ministry of Finance, yet none of them has any authority over the other (Interview 25). This is an obstacle for effective financing when combined with unclear perceptions of power and accountability mechanisms.

In theory, PPPs may build effective institutions and systems to achieve health capabilities at the local level. However, both sides, the public and the private, lack the full capacity required. To give an example of this, a national ELCT Health Department officer says that:

We have a very good framework for PPP, but now we need more investments in the implementation at the district level (Interview 24).

The implementation of PPPs largely depends on how particular public officials understand and interpret the government's intentions. PPP negotiations are often informal and largely dependent on personalities and social capital. Officially, the PPP negotiations result in an annual contract between the CHMT and the church-based hospital; however, the three case studies show that the final sum of financial input from the council district remains uncertain.

Personal relations and the quality of these relationships remains the key to success for collaboration experiences and financial compensation. From a perspective of sustainability, such a high reliance on personal ties risks creating new dependencies and power relations, and directly counteracts sustainability (Pfeffer & Salancik 2003). As an example, the cooperation with DMOs might be limited at times when there are conflicts of interest. When discussing strategies for sustainability and local ownership, several interviewees from the three church-based hospitals rely on the legal aspect by referring back to the national Comprehensive Council Health Planning Guidelines (Act. 3.5) stating:

Independently of if the church-based hospital has signed a Service Agreement; the hospital will receive the Basket Funds grants in the range of 10%-15% out of the total Basket Funds allocated for that particular Council (United Republic of Tanzania 2011).

Dissatisfaction with the short-term implementation of the partnerships

One of the most important objectives of PPPs is to promote and strengthen ownership at the national level and the local level. Here, my study points out some major weaknesses. Despite the good intention of key stakeholders to strengthen PPPs with the hope of promoting local ownership, I detected strong dissatisfaction among church health departments and hospital management teams concerning the implementation of the PPP contracts. Several interviewees complained about the Council Health Management Team not fulfilling its obligations in the CDH contract. As an example, the chairman of TEC confirms that the implementations of PPPs face several challenges:

The problem comes when you look into the finances, like with the Bugando Hospital. We never got the full amount we applied for as stated in our agreement. This is the problem. The money is there, but the people are not trustworthy, so we keep shouting. I remember one particular time at Bugando Hospital; we were supposed to get 50 million TSZ. Then I was told that we do not know about this money and it was not given. So, since I know the situation, I wrote a formal letter to the government where I stated: "I want those

50 million TSZ. We need it.” Then we got it. But if I would have kept quiet, the money wouldn’t have come to our treasury (Interview 16).

Even if the church representatives on the national level have perceived the cooperation with public authorities in a somewhat more positive light than at the local level, they also share these problems:

With these service agreements you sign with the government, but then the implementation takes time and that is not good. You might be promised that this year, you will get this amount of money for buying medicine but then it will take time. Therefore, for us this is a negative aspect of the collaborations, but we also have problems with our staff. We can go to the government to say that we have this shortage of staff, please support us, but it can take time for them to compensate. But we keep on waiting and we keep on talking (Interview 21).

Despite this critique and all the national and local challenges, a public health officer from the Ministry of Health still defends the current allocation formula, claiming that it seems to work:

The basket fund is very transparent at the national level. The donors, different development partners tell the ministry what they are going to give for that particular year, and in that they indicate exactly how much will go to the districts, how much will go to the regions and how much will be spent at the central level in terms of the Ministry of Health and the President’s Office. Those funds are based on a formula for allocation and are sent to the regions and the districts respectively. The guidelines for the planning indicate that districts should incorporate church organisations and other private stakeholders during the whole process of planning (Interview 5).

The financial challenges at the council level are thus related to the fact that CHMTs are neither able nor willing to follow-up on their PPP contracts and commitments, or only do so to a limited extent (Interview 43). The question is how much of this is due to the fact that the national level does not make sufficient funds available to the CHMTs to meet their PPP obligations and how much is due to a lack of priority existing at the CHMTs with regard to financing FBOs.

It is evident that church-based hospitals therefore need to compensate financing gaps on their own by relying on external resources as a complement. That is also why the first case hospital in the study continues to practise cost-sharing with patient fees. This probably also explains the consistent use of funding from Vertical Health Programme Funds and friends associations in other countries. It is also possible to interpret this preference as a strategy for church-based hospitals to minimise their dependency on the state.

Interviewees from all three cases reported that the district councils had not delivered financial support in accordance with the agreed contracts. Below I present an overview of this related challenge, case by case:

Case I: St. Francis Turiani Mission Hospital (CDH contract)

Before entering into the CDH agreement, the expectations among several interviewees at the Turiani Hospital were high. As an example of this, a hospital management representative stated:

Our expectation was that when we signed the CDH contract, we would receive full support from the government. We were expecting all our staff to enter the government payroll so the staff could remain in our hospital and that we would be able to increase our stock of medicine without using our own funding (Interview 33).

However, according to the hospital management, there were several times when the CHMT did not deliver financial support in accordance with the agreed CDH contract. A hospital management representative states:

Like the contract has been for almost three years now, but nothing has been done. So what is the meaning of this? Sometimes it is even better if there is no agreement (Interview 32).

After the CDH contract was implemented, the church-based hospital, according to the hospital management, faced severe challenges relating to the contract model and agreed-upon reimbursements of costs were simply not paid out. Two interviewees stated that the CDH contract was not fully implemented (Interview 31–32). The financial challenges continued, and after a few years' time the global partner reacted. One of the Dutch external partners stated in an official report from 2014:

The Government does not meet its obligations. Nothing is paid for, neither the salaries of 138 hospital workers nor for the recurrent expenditures. So the hospital finds it necessary to continue to charge (high) patient fees despite restrictions agreed upon in contract (Burns Turiani Foundation 2014 p. 3).

However, this statement from the hospital management was questioned by the District Medical Officer of the Mvomero District, who stated that St. Francis Turiani Mission Hospital received 25–30 percent of the district basket fund in accordance with the CDH contract (Chiduo 2013). This was also confirmed by the Ministry of Health and the Prime Minister's Office – Health Services Basket Fund (HSBF) report, where the agreed grant was said to be allocated each financial year to Turiani Hospital. For 2012/2013, in accordance with the report, the amount was TZS 200,073,000, which is 30 percent of the total Basket Fund budget for Mvomero District. Before that, in 2008/2009, the CHMT allocated TZS 35,395,200, which was about 10 percent of the total HSBF at that particular time (Chiduo 2013).

Case I illustrates the complexity of the CDH contracts as there seem to be multiple interpretations of the size of the compensation levels from the pub-

lic and the private side respectively. A church hospital management representative summarised his understanding as:

In accordance with the agreement, the government should supply us with medicine and they should pay all expenditures for the hospital. However, up to now there has been no implementation (Interview 33).

The main challenge is most likely related to the fact that the 25–35 percent of the district health basket fund does not compensate for the loss of income from patient fees, which the hospitals partly lose once they enter into a CDH contract, as they need to exempt children under five, pregnant women and elderly people from cost-sharing. The patient numbers also increased dramatically (in some cases doubled or even tripled) once the hospital started exempting patient groups from fees. This is discussed further in the next section.

Case II: Selian Lutheran Hospital (CDH contract)

With regard to the second case, the discontent was even stronger. The hospital director of Selian Lutheran Hospital argues:

Not all the funding according to the basket funding formula has been allocated to the church hospitals. Often, the basket fund is not reaching us in time and the staff grants from the government come in very late. Like today it is the fifth, but I have not been able to pay salaries for August. This is normal because the support from the government is coming in late. It is about paying the salaries at the end the month being a big and difficult challenge, because the patient fees are not adequate and the staff grants from the government are coming in late (Interview 44).

Critique was also raised concerning the lack of staff grants, and a hospital management representative stated:

Our health personnel are not on the government payroll on time, which is partly why we are operating on a deficit since we entered into the CDH agreement (Interview 47).

The lack of funding from the district council to the ELCT Selian hospital was also recalled formally in the annual hospital report of 2012. The report stated:

The statement of financial position shows that the hospital is technically bankrupt with a negative working capital of TZs. 495 million. The Council Designated Hospital (CDH) agreement between ELCT and the Government of Tanzania provides that the government should provide funds for running the hospital. However, for two years consecutive, the government did not release TZs. 538 million and TZs. 479 million to the hospital, being part of the budget support for the financial years 2011/2012 and 2010/2011 respectively.

To cover the financing gap created by funds not released by the government, some of the hospital's operations were financed by creditors to the tune TZs. 900 million. The continuity of the hospital's operations significantly depends on the government honouring her obligations in the CDH agreement by:

- (i) Releasing funds for running hospital as per agreed hospital budget; and
- (ii) Releasing amount withheld on 2010/2011 and 2011/2012 budgets to enable the hospital to liquidate liabilities caused by the government action of releasing fewer funds (Selian Lutheran Council Designated Hospital 2012, p. 22).

This shortage of compensation was also confirmed and acknowledged by the audit report of the same financial year. In the audit financial statement for the year that ended June 30, 2012, it was stated:

There is significant uncertainty on the hospital's ability to continue as a going concern due to the government's failure to honor her obligation as described in Council Designated Hospital (CDH) agreement. The Council Designated Hospital (CDH) agreement between ELCT and the Government of Tanzania provides that the government of Tanzania should provide funds for running the hospital. However, during the financial year, the amount received from the government was less by TZs 541 million compared to the approved budget. In the previous financial year (2010/2011), the amount not released by the government was TZs 479 million. The financing gap created by the government's action of realizing fewer funds than approved budget has resulted into a negative working capital of TZs 524 million (2011 TZs 691 million) (Selian Lutheran Council Designated Hospital 2012, p. 8).

Case III: Mchukwi Mission Hospital (Service Agreement)

Even when it comes to the third case, the hospital management was dissatisfied as the Service Agreement was not implemented in accordance with the agreement. The hospital did not even receive the minimum support level of 10–15 percent of the district basket fund, which for 2012 was to constitute TZs. 60 million per year. A hospital management representative argues that:

We have not received any check for this year, so we are not sure if we are going to receive the expected 15 million quarterly. We don't know yet, but we are still following up on the Basket Fund Grants (Interview 55).

The District Medical Officer from the district council in the third case confirmed the related challenges:

This 10–15 percent of the Basket Funds is not enough for Mchukwi Mission Hospital. It is not enough, because in for instance Rufiji, we are giving the Mchukwi Mission Hospital 60 million (Interview 58).

The interviewees both from the public and private side have identified four main explanations as to why the PPP contracts are not financially compen-

sated: (1) local governments do not receive adequate health funding to comprehensively implement the PPP contracts in the first place, as there is a shortage of public health funding in Tanzania and systemic corruption; (2) local governments lack understanding and full commitment to adequately fulfil the obligations as stipulated in the PPP contracts with regards to the transfer of block grants and basket funding to private facilities; (3) private actors are lacking a legal mechanism to sue the state for uncompensated services as stipulated in the PPP contracts; and (4) there are different interpretations of the PPP contracts from the respective district council and church-based hospital sides.

Regardless of what level of support the three hospitals will continue to receive from the district councils on a quarterly and annual basis, the district councils have to tackle the strong dissatisfaction that currently exists among church health departments and hospital management teams concerning the implementation of the PPP contracts. At the national level, the government must also look into the finance mechanism from a sustainability perspective to allocate and secure more health financing for district councils.

Removal of patient fees as a challenge to PPP entry

A core principle in the PPPs regulations concerns the principle of delivering services for free to vulnerable groups, children under five, pregnant women and elderly people (Ministry of Health 2015). This principle has come into place in order to realise health rights for all. Many interviewees from the Council Health Management Teams argued in favour of this principle from a perspective of affordability and social justice, since many patients were not able to pay for health services before the current PPP reform with the removal of patient fees for some exempted patient groups (Interview 36–38, 48–50 and 58–60). A few of the interviewees from the church organisations were clearly in favour of the principle. As an example, a hospital management representative from the ELCT case study states:

When we were more dependent on donations from the outside, we still had to ask patients to pay for the services they received, and some of our services were really expensive. Women for example had to pay for delivery, so most women did not want to come and deliver. It pushed people away from coming here. In the new system, the government promises to subsidise services as long as we give free services to these groups, especially children under five, pregnant women, etc. So now, everybody comes here to deliver. So we're trying to promote women to come and deliver here at the health facility because we don't have to ask them to pay (Interview 44).

Patient fees critical for securing long-term funding

The removal of patient fees for certain patient groups is a principle in the CDH contract template. Similar paragraphs are included in the Service Agreement contracts (Ministry of Health 2011a). However, interviewees from all three church organisations in the study find the PPP principle of removing patient fees a bit unfair, or at least very challenging for the church-based hospitals, as the new PPP funding they receive from the district councils is lower than what they used to earn from patient fees. An ELCT Health Department officer discusses this:

Some faith-based and private health facilities find it unfair that they are required to provide free services for pregnant women, infants, children under five and the recognised poor in order to comply with the public health policies (Interview 25).

In fact, when the removal of patient-fees principle is implemented at the church-based hospitals, it leads to a loss of a significant income for the hospitals. This takes place as the PPP funding from the district council is lower than what the hospitals formerly earned from patient fees. Hence, this risks leading to an annual budget deficit for the church-based hospitals.

Lack of financial compensation (for these patient groups) is closely related to the challenge of lack of comprehensive health insurance for the rural population and the fact that church-based hospitals to a high extent serve the uninsured rural population, as many are not included in the community health funds and as church-based hospitals are in most cases unable to benefit from the community health fund. When the three church hospitals of this study signed the PPP contracts, they all agreed to change their policy regarding patient fees for disadvantaged groups. To compensate, local governments on the other hand agreed to provide financial support in accordance with the agreed contracts they signed. However, as I show below in several instances, the local governments have not released sufficient funds to cover up for the loss of patient fees and the church hospitals have therefore remained without agreed or at least expected compensation.

Despite the fact that the PPP reform has led to increased public funding for church-based hospitals channelled at the local level, counted in percentage of public funding annually allocated to health, it looks as if the funding has not met the loss of the church-based hospitals in terms of patient fees. In particular when you also take into account that the number of patients has increased at the church-based hospitals after the removal of patient fees. This challenge was frequently discussed by the interviewees from the umbrella organisation for the church-based hospitals, the Christian Social Services Commission (CSSC). A CSSC officer makes it clear that:

Our facilities are providing free services while waiting for the government to top off. Unfortunately, we do not receive the compensation agreed upon and in time, so it takes quite a long time. Even if some bishops are threatening by saying: “We will close our facilities since the government does not fulfil its promises”. We cannot continue since we are running short of resources and we can no longer go on providing these services for free (Interview 7).

According to the Ministry of Health guidelines, the PPP reform with the related health basket funding was never intended to cover all uninsured patients at the church-based hospitals, but rather to provide a funding mechanism to complement the Tanzanian government’s efforts in the health sector in the realisation of health rights (Ministry of Health 2008). Despite this, all three church-based hospitals were charging patient fees before entering into PPPs. The patient fees constituted approximately around 40–50 percent of the total church-based hospital budgets, as illustrated case by case below.

Case 1: St. Francis Turiani Mission Hospital (CDH contract)

After signing the Council Designated Hospital contract, Turiani Hospital entered into a vulnerable situation as the bulk of income before the contract was signed (52%) came from patient fees (Interview 31–32). Because of the PPP contract, the hospital in fact lost its most important source of income. The dependency on patient fees before the CDH contract was implemented was officially stated in the 2011 annual hospital report of St. Francis Turiani Mission Hospital to be 52 percent out of the total financial input.

During an official meeting with external Dutch donors, the hospital administrator of the Turiani hospital expressed this as a concern, since the hospital was not receiving its full compensation grant in line with its Council Designated Hospital status (Participant observations 1a and 1ca). The delay was said to have been caused by the fact that the health block grants and basket fund grants were not yet submitted by the central and regional level to the district council level (CHMT). This situation meant that the hospital management concluded that they could not by any means meet the costs required for treating the additional patients for free, which is why they declined the condition of offering services for free while waiting for sufficient funds from the CHMT. In response, the hospital received a letter from the District Medical Officer, where he demanded that the hospital exempt several groups from paying patient fees. Due to this agreement, the hospital management estimated that the number of patients increased threefold at that particular time. A hospital management representative from TEC says the following:

We are trying to balance our budget, which is why we are still dependent on the income from the patient fees. The situation is not good. But we are trying our best, although we are still dependent on the money from the patient fees (Interview 32).

Case II: Selian Lutheran Hospital (CDH contract)

Similar figures were identified for the second case study (ELCT case) before they started implementing the CDH contract. A hospital management representative from the ELCT case reported:

When we signed the CDH contract, we started to provide services freely to all children under five and all pregnant women. All chronic diseases like cancer, diabetes, etc. we would also treat without any payment and all services to everyone above 60. So in order for us to give free services to all these groups, because these groups comprised about 75 percent of all our clients, we were relying on the compensation from the local government, but they didn't give us any money. No money at all. For six month, no salaries, nothing, so it was a very difficult moment for us. Well, we did endure this period that lasted for six months (Interview 43).

Another ELCT Health Department officer from the second case also expresses similar views:

The national policy instructs us to provide services for free for vulnerable groups and for those with chronic illnesses like HIV/AIDS, diabetes and hypertension. If you look at the segment of the total population that receives our services at our facilities, you will notice that the majority are women and children under five [...] Who will pay for the staff overseeing them? Who will pay for the health infrastructure that is needed? We have been saying to the government that we need more resources to provide services for free (Interview 24).

A challenge brought up in the second case study is that if the church-based hospital continues to practise cost-sharing (patient fees), both the district council and the community will officially complain as the hospital has agreed to deliver these services for free to exempted groups in accordance with the CDH contract. A hospital management representative from the ELCT elaborates on this challenge:

If you charge them, you will get in trouble with the government and even from the community, because they know about the PPP principle and the exemption policy (Interview 45).

Case III: Mchukwi Mission Hospital (Service Agreement)

In the third case study (FPCT), patient fees constituted about 40 percent of the hospital income before they started to implement the Service Agreement. This was confirmed in the 2011 annual hospital report and by a hospital management representative:

Moreover, after we entered into the service agreement with the CHMT, we were supposed to deliver services for free to pregnant women, which is challenging since 40 percent of our income came from patient fees. Currently the

hospital is unable to replace aged vehicles and other hospital equipment [...] the DMO wants us to implement this policy of giving free service to patients who are children under five, pregnant women and elderly people. So even if we have only been charging those groups small amounts until now, the DMO tells us we must offer these services for free. It is challenging (Interview 55).

Looking at this challenge from the district council perspective, the District Medical Officers partly agreed that this principle has caused a challenge for the church-based hospitals. This was in particular clear in the third case study. The DMO in Rufiji district clearly admitted that the PPP funding is less than what the Mchukwi hospital needs in order to cover all of the patients they treat for free:

However, they are supposed to provide free services for maternal services and for children under five. Moreover, when you come to check the cost for these maternal cases or under five cases, it is more than the funds we are giving them. Therefore, we direct them to supply the services for free because we are giving them funds. Nevertheless, these funds are not enough for them to supply the services for free (Interview 58).

For the FPCT as a church organisation at the national level, during the time of the study, patient fees on average represented 65 percent of total income for the church organisation's healthcare delivery (hospitals, health centres and dispensaries) (Interview 30). For the specific case hospital of the FPCT, Mchukwi Mission Hospital, patient fees represented 40 percent of the total hospital income, as shown above (Interview 55).

Several interviewees from the three church-based hospitals also suggest that more research is also needed on comparing public and private health facilities in order to examine which types of services are included in "free treatment". Many interviewees from the church organisations stated that it is a clear difference between church-based hospitals and public hospitals. According to these interviewees, in spite of being obliged to provide free treatment, at public hospitals patients have to pay many small fees related to materials and administration (Interview 24–26, 42, 53 and 55).

A hospital management representative from the FPCT case study elaborates on this:

We also have experiences from government centres – even if they say they are giving their services for free, they at the same time ask pregnant women to bring gloves and many other things. I do not know if you count that as a free service, if you ask pregnant mothers themselves to bring everything for a delivery. When patients come here, they get everything, so I think, in reality we are the ones giving free services. When we give services for free, we mean it, because we are compensating. It is so that we can give beautiful services (Interview 55).

This finding was in fact confirmed in another PPP study by Joseph Itika from 2009. He found that church-based hospitals provided poor and marginalised patients with free drugs in several cases, which was not found to the same extent at public or private for-profit facilities (Itika 2009).

Considering the discussed related challenges regarding the removal of patient fees, some interviewees argue in favour of keeping the patient fees in order for the hospital to generate its own income instead of increasing its dependency on outside funding from the state and external donors (Interview 42). Worth noticing is also that a World Bank study from 2013 confirms that a vast majority of church-based hospitals are in fact still financed by user fees, even after the signing of PPP contracts (World Bank 2013).

Lack of comprehensive health insurance makes free healthcare difficult

The challenge of patient fees is closely related to the question of universal health coverage, as the vast majority of the rural poor remain uninsured. The Tanzanian government is officially committed to move towards universal health coverage and ensure that all citizens have access to quality services and are protected from financial risks. As part of the Health Sector Strategic Plan III, a government decision was made to develop a Health Financing Strategy to ensure that the vision of universal health coverage may be realised. There were to be special efforts in terms of reaching out to the poor, as they cannot afford services and are frequently unable to afford prepaid health insurance (Ministry of Health 2009). Most interviewees from the three case studies would favour universal health coverage. Other studies have confirmed popular support for the introduction of health insurance schemes through the development of community health funds and TIKA (Mtei & Makawia 2014).

A World Bank study showed that only 17.7 percent of the Tanzanian population is currently covered by health insurances and a majority of those, 9.2 percent, are insured through the formal private sector (Hazeen 2012). The number one explanation for such low figures is the simple fact that the rural population cannot afford health insurances. Secondly, the current incentives are too low. The reason mentioned here is the generous exemption policy as part of the PPP contracts (World Bank 2013). The World Bank suggested that the best would be to improve health insurance schemes rather than increasing out-of-pocket expenditures by patients, and the World Bank would also like to increase social health insurance coverage to eventually reach universal coverage (Hazeen 2012).

Church-based hospitals currently receive only small amounts reimbursed from the National Health Insurance Fund, as the majority of their patients are not included in the insurance scheme. Still, the current compensation from

insurance companies constitutes an important, albeit small, part of the hospital budgets. A related challenge is that available health insurance schemes do not guarantee access to medicines and do not cover medicines purchased in private pharmacies (World Bank 2013). Currently, the issues of health insurance are only to a certain extent regulated between church organisations and the National Health Insurance Fund (EPOS Health Consultants 2007).

A recent report from the Global Network for Health Equity brought forward obstacles to the realisation of universal health coverage:

The high dependency on donor funding poses a challenge to the achievement of universal coverage. As donors need to see more direct result delivery, which is why they are re-directing resources to project funding where results can be quantified. Without reliable donor funding the government will not be able to meet its current service commitments. The limited coverage of health insurance schemes in Tanzania poses a further threat to financial protection (Mtei & Makawia 2014, p. 11).

Several interviewees from the church health departments argue that they would benefit if universal health coverage were to be realised. As an example, a World Bank policy specialist argues:

If we could fund delivered services, the money could flow from the health insurance funds, from the payer down to the facility. There is no pocket it can go into along the way and then the facilities could determine what they need in order to operate their services efficiently and effectively (Interview 10).

Other interviewees also stress several challenges in how to interpret the PPP principle concerning free services when treating patients with insurance. A hospital management representative explains that:

The people we ask to pay are the marginalised, and those are often uninsured. When they hear that the services at our hospital are free of charge, we do not know if they are insured. However, we try to insist that if a patient has a card, we try to get the services subsidised. But the current policy is not clear as to whether we can be refunded (Interview 45).

There are, however, ongoing efforts by the Ministry of Health, with assistance from development partners, for developing a new strategy for health financing of comprehensive health insurance (World Bank 2013).

Misappropriation of funds

Corruption is widespread in the health sector. However, it is surprising that when PPPs are discussed, challenges related to corruption are in most cases not addressed directly. If church organisations and church leaders are to col-

laborate more closely with public authorities, questions related to resource dependency, power relations and corruption must be addressed more clearly. According to the 2015 Global Attitudes Survey, there is a widely shared perception that the Tanzanian government does not serve everyone equally. In a recent study, over half of the informants (60%) accused the government of not offering the same levels of service delivery to all citizens (Pew Research Center 2016). The latest findings from the Afrobarometer (2015) for Tanzania reveal that the level of corruption has increased in the last years. In particular, it has been harder for Tanzanians to access medicines and special treatments. Despite significant government anti-corruption efforts, a majority of Tanzanians perceive that there has been a recent increase in corruption and that the fight against corruption is stagnating. The Afrobarometer indicates that this is true for the health sector, as 20 percent of the interviewees stated that they had paid a bribe in order to access treatment at a public clinic or hospital (Afrobarometer 2015).

A TEC church representative admits that there is a widespread culture of corruption even in the church-based health sector; however, he argues that it is slightly lower than in comparison with public health facilities:

You might find some cases of corruption in our hospitals. However, you cannot compare that with what you will find in public hospitals. I can say that in the church, we are not 100 percent perfect but we are still trying to be careful and faithful with what we are doing. That is a big difference. However, the challenges are still there. There are so many people in need of services, and we fail to deliver good services to them. So sometimes even we find ourselves in that situation (Interview 14).

A hospital management representative also expressed a similar view:

Well, personally I like to work for an FBO because of our policies. Actually, the transparency in working with cooperation is good compared to the government. I think that as far as the FBOs are concerned, people are very straightforward regarding the rules and regulations. You should abide by them, but when you go to the government, they sometimes view them differently. Therefore, if you work somewhere just because you need the salary or you do not want someone to follow-up on your activity, then the government will be a good place to work. But here, we are actually committed. So it is better if you come to the FBOs (Interview 43).

In general, several interviewees from the church organisations discuss the challenge of corruption. Due to corruption in health, some of the interviewees from the church organisations favour earmarking funding. This would facilitate accountability when you can relate the funding back to a specific person, stakeholder or hospital. The legitimacy of the state as the guardian of the “public interest” is also contested. As an example, a national health department officer argues:

The decentralisation of the PPPs encourages accountability. Usually we get a lot of visitors coming and saying: “We’ve been funding Nkoaranga Hospital. Let us go and see, because we funded a maternity ward there, so let us go and see how the money has been spent. Instead of just putting all the funds in the hands of the Ministry of Health and saying we are going to fund maternity wards for the whole country” (Interview 25).

The corruption issue remains extremely complex due to the fact that it is not possible to tackle corruption in the health sector separately, as District Executive Directors are in charge of all district funding.

Lack of trust between partners in PPPs

For a system such as PPP to function as intended, there has to be a culture of trust between the collaborating partners. However, I found that there is a lack of trust between the partners in PPPs. I have already discussed the mistrust of the church-based hospitals concerning the lack of compensation from the local councils according to the PPP agreements. Similarly, church-based hospitals are not informing the local councils about all forms of external funding they receive, since they fear cuts in public funding from public health authorities within PPPs. Several Council Health Management Team (CHMT) members say that they do not trust church hospitals, especially when it comes to data on their cooperation with external donors. CHMTs also continue to argue that Vertical Health Programme Funds need to be more integrated into the planning and programming systems in order to improve transparency at the local level. A hospital management representative from the TEC case notes that when entering PPPs, church-based hospitals need to become more transparent concerning sources of funding:

You see, the idea of PPPs is that both parties should be transparent in whatever we do. Whenever we receive funds from abroad, we should tell our partner (Interview 31).

It was also reported in the ELCT case that the government does not trust church hospitals, especially when it comes to the cooperation with external donors:

People were suspicious of one another and thought that we were given a lot of money from donors. So why should we get the government’s money? However, this is a hospital treating sick people. It is the government’s responsibility to actually provide these services; we just help them. Therefore, this is our right. The CHMT members have been the biggest problem. There has been no problem with the Ministry of Health (Interview 43).

This challenge was also discussed by interviewees at the Ministry of Health. As an example, a public health officer at the Ministry of Health stresses:

You know that FBOs are sometimes not open enough. The government is sharing the CCHP guidelines in the planning process, so why are FBOs not telling us what resources they have? (Interview 3).

The interview with the District Medical Officer of the Arusha District Council from the ELCT case related that the government and the CHMT members are sceptical:

If we disclose the funds we are giving and then you don't want to disclose how much you received, then don't you think that the relationship is unequal and sometimes we have to feel sceptical? Why should we give all this money when they do not want to disclose what they are getting? This is actually a big challenge (Interview 48).

Several representatives from the church-based hospitals also express that it is hard to follow the budget procedures after the council health plans have been drafted. A hospital management representative from the ELCT case explains:

But at the end of the day, you are told – instead of getting 100 million, you are going to get 82 million. The reason behind this decision is a revision of the budget and this is what we will get instead. Now, it is difficult for us to trust that this is what happened. It might be difficult because they took the budget from the district level to the regional level. Then the regional level is the one to process the entire budget for every council before referring it to the Ministry of Health, so I do not know whether it will be possible to see the document or not. Therefore, that is the challenge (Interview 43).

For this reason, some representatives of church-based hospitals argue that if all their funding would go through the local government and if Vertical Health Programme Funds would be integrated, less would trickle down to the population on site (Interview 54). A hospital management representative from the TEC case also reports:

They have no official explanations. You see, we have to wait for the budget. You see, even the Member of Parliament (MP) came here and asked why we did not involve him [If you involved me, this could be settled years ago]. However, we responded: "You as an MP, why don't you come here to see the problems for yourself. This is your hospital and the people who voted for you are coming here." After that visit, he promised that within one month, we would get his answer. Still I have not seen a response from him, we are just waiting for that. I think he will do what he promised us (Interview 32).

The Ministry of Health and the Prime Minister's Office – Regional and Local Government have been encouraged by the donor group in health to agree on a target for the percentage of the public health budget to be allocated and

accompanied by improvements in systems and procedures for tracking budget allocation and expenditures (Ministry of Health 2015).

Lack of comprehensive auditing

A key explanation for why CHMT members lack confidence in church-based hospitals is the lack of comprehensive financial audit reports of church-based hospitals. CHMT members request a more comprehensive overview of all the inflows of funding to the church-based hospitals, including support from key individuals, friends associations, international FBOs and global health funds. These figures are not accessible in most cases (Interview 49–52).

An ELCT Health Department officer admits that this is the case:

Another problem was regarding transparency and this was our problem. Initially, most of our facilities were a little bit secretive; they could tell how many patients they had, but they were not ready to say how much money they raised from this or how much money we are charging per patient. Therefore, we started working together with the CSSC to do this cost analysis, so now it is no longer a secret. Now we know how much a malaria patient will cost and we will know exactly how much it will cost for someone to be admitted to our hospital (Interview 25).

A TEC Health Department officer confirms this:

So for each part it became more tangible, more transparent when we talked about the actual costs for health; how to do the budget and if the government could afford to pay for that? So all these things have been done through dialogue (Interview 16).

Church-based hospitals view the collaborations as more challenging. A health department officer from the FPCT case study confirms that the District Medical Officer has been sceptical:

One of the most significant challenges is the reluctance of some of the district council officials. It is difficult for them to understand and to get the message across, because it is as if they have been taught or maybe learnt in a wrong way which perspective they have of us and against us. It is a wrong conclusion that we are well off. It is true that we have Europeans who support us. However, the scepticism from the public official also depends on who is the representative from the council. You might find a DMO resisting us and who is not ready to cooperate with us, but in another district you find a DMO who is very cooperative and very understanding (Interview 30).

Representatives of church-based hospitals find both distrust and scepticism challenging (Interview 42). However, according to an FPCT Health Depart-

ment officer, there are ways of dealing with both mistrust and scepticism at the local level. He presents his view of best practices:

Actually, initially we couldn't find out what to do. However, later on we found that we had to provide evidence that we are having a deficit in our budget just like any other institution, and the best way we found was effective. We included officials from the government in our hospital board, particularly the DMOs, and even the PPP guidelines directed us to do so. When the DMO joined, he got into the depth of our situation and our economy. It has helped us a lot even to air our views and even to present them with our other challenges. Apart from involving them in our structure, we also use the opportunities they gave us, particularly during the CCHP, because as you know each year the district has a planning session. They sit for weeks, they invite us to bring our reports, we bring our situation there and we also copy them our annual hospital report, so that they can see and read the reality (Interview 30).

If the partnerships between church-based hospitals and CHMTs are to be more effective, considerable work needs to be carried out to develop accountability, transparency and the mutual trust necessary for partnerships to succeed. In these processes the District Medical Officers (DMOs) and the District Executive Directors (DED) are key agents.

Shortage of human resources

In their effort to implement the PPP policy, church-based hospitals and CHMTs are experiencing a serious crisis in terms of human resources for health. All three case studies indicate that the critical shortage of trained health staff constitutes a major challenge for the implementation of these partnerships. This is also highlighted in the second Health Sector Strategic plan, Act 3.7.2. (Ministry of Health 2003a). According to some reports, the trained staff shortage at private facilities is as high as 87.5 percent, and 67 percent for public facilities (Bioline 2016). The staff shortage is said to be the result of both population growth and the increased burden of disease, in addition to increased ambitions in the health sector (Kimambo & Lieser 2009).

Being a low-income country, Tanzania faces a severe human resources crisis in general, and in health in particular, with significant deficits in terms of both quantity and quality. The human resource shortage is not uniform, but differs a great deal within Tanzania (Ministry of Health 2016). The problem is particularly severe in rural areas, where church-based hospitals are responsible for their own strategic plans and coordination with regard to human resources. Over the last years, the size of the health workforce in Tanzania, both health professionals and other health staff, has declined in

both absolute numbers and relative to the size of the population (Kwesigabo et al. 2012).

Human resources transferred from the private to the public

Church-based hospitals are mostly based in rural areas, which is where public authorities find it the most difficult to attract and retain health staff. An ELCT Health Department officer stresses:

We have a big challenge in our rural areas where the environment is not very conducive for staff to stay. 95 percent of our facilities are in rural areas, and we are registering a staff shortage of nearly 70 percent in these areas. Most of our staff in rural areas have been trained several years ago and they need continuous training, so that is a big challenge. There is a competition between ourselves and the government in securing the limited amount of staff. There is also competition among faith-based organisations regarding getting a hold of that small part of the cake of human resources that is available. I would also say there are even times when there is a competition among ELCT facilities and you want to deliver quality services (Interview 24).

Several hospital management representatives confirm that the most serious problem is how to find staff:

This is the biggest problem we are encountering right now (Interview 43).

Despite the fact that church organisations are major employers of human resources in health, they typically have minimal resources allocated for the development of strong human resource management skills, policies, procedures and systems. On top of this, church-based hospitals have been faced with a radical increase in staff salaries (Interview 54–57). Church-based hospitals have furthermore lost professional staff to the public sector based on the better salaries and conditions offered there. There are also examples where church-based health facilities have been forced to close down due to a lack of staff (EPOS Health Consultants 2007).

Several interviewees refer to the shortage of staff as a result of the church-based hospitals not being able to offer market wages, which leads to staff members looking for better conditions in the job market (Interview 25). I also found evidence for what the World Bank refers to as a “brain drain” from the private to the public sector (World Bank 2013). A hospital management representative from the first case study says:

We do not have enough staff because they are leaving us on regular basis. They come but they only stay for a few months and then they go away. Some of them come here waiting for a new better paid position, so when they come here, it is just to get the experience. But when they get this, they go (Interview 34).

An ELCT Health Department officer confirms this:

We have been writing to the government. We tried to explain that we are lacking human resources. It is a challenge for our facilities to access human resources (Interview 24).

Salaries constitute the largest part of costs for church-based hospitals. In the third case, for example, 61.8 percent of the total income was used for staff salaries and wages in 2010 (Free Pentecostal Church of Tanzania 2015). Several interviewees in the study suggest that if all employees could be on the government payroll, then the problems connected with human resources migration would be solved. A hospital management representative from the TEC case confirms this:

We would like to have a common payroll for all employers, with support from the ministry. I think many things would be smoother then. Now we are expecting to receive more staff from the government. Thereafter, we will not have the problems of human resources. If this will work properly, then the community will benefit in particular. Because when they come here, they expect to obtain reliable, cost-effective services, which is not expensive. That is, if it works properly. However, if it does not, that is a big problem. But we are sure it will work properly (Interview 32).

There are several examples where CHMT members and DMOs support the views of the management of the church-based hospitals. There are also examples of support given to church-based hospitals from DMOs. As an example, a hospital management representative from the first case study argues:

The DMO in his capacity is very much constrained trying to get staff to our hospital, though he is also in need of them. I have about 22 staff members who have been entrusted to our hospital by the District Medical Officer (Interview 31).

The same is stated in the FPCT case study by the District Medical Officer of Rufiji District:

These are the challenges. We cannot manage because of our shortage of staff. Even we in the public hospitals are facing a shortage of human resources. Therefore, it is very difficult to take your skilled health personnel and transfer them to private hospitals. However, in rare cases where we see it as the problem, we try to help. For example, in the case of maternal mortality. There we have decided to take our health staff and to post them at Mchukwi Hospital because of their high burden. However, if it is a normal HR burden, we do not transfer staff because of the shortage and since we need them ourselves (Interview 58).

A public health officer from the Ministry of Health says that:

The incentive packages became more attractive in government institutions and this resulted in many of our workers in the hospitals and our health facilities running away to seek employment in public or government institutions. This has really disturbed us very much. At different times, we have been trying to communicate with the government about this. But there have been good promises and in principle the government has agreed that it will pay salaries and other incentives and terminal benefits to all workers in the health sector, including those working in church health facilities, so we remain waiting, and if that comes, it will help us (Interview 2)

Differences in social benefits for state and church health staff

There are clear differences in social benefits for staff based at church-based hospitals in comparison with public health staff and government-supported staff at private hospitals. Health staff based at church-based hospitals are the lowest paid in the Tanzanian health system, in comparison to both public health staff and those working for private for-profit. This is a major source of frustration. Several interviewees express that the more attractive incentive packages for government institutions have resulted in many of the staff at church-based hospitals leaving to seek employment in public health institutions. Several interviewees explained that they have been trying to communicate this with the government. However, some hospital management representatives show signs of optimism when stating:

But there have been good promises and the government has in principle agreed that it will pay salaries and other incentives and terminal benefits to all staff in the health sector, including those working in church health facilities. So we keep waiting and if that comes, it will help us (Interview 33).

Due to the lack of financial resources in church-based hospitals, the management is unable to offer the staff sufficient incentives to ensure their loyalty to the facilities (Boulenger & Criel 2012). The high staff turnover, referred to by some as “brain drain”, has contributed to persisting perceptions of “low-quality personnel” retained at the church-based hospitals and other private facilities (World Bank 2013).

A hospital management representative at Selian Hospital discusses this:

Most of the staff members are running from the FBOs to the government. They say that there are some benefits they cannot get from the FBOs. That is another problem or a big challenge. But I think when the FBOs get their act together and find resources to take care of their staff and find some incentives for them, then I think it will be possible (Interview 45).

Social benefits of public civil servants include retirement allowances, health insurance, a social protection fund and pension funds. Once staff are on the government payroll, they receive all the benefits even if they work in private facilities. A hospital management representative from Turiani Hospital describes this:

We are sure that the staff coming from the DMO are going to stay. Because they are already appointed by the DMO. Because of this, we are sure they will stay here for a long time. But those we are recruiting ourselves at the hospital are not staying for a very long time [...] If salaries are not increased for the staff, some are going to leave and go work for the government and the public hospitals. Some might also go work in other private institutions, where they are paid a bit higher (Interview 32).

Another interviewee from the hospital management in the TEC case study expresses similar views:

We know that the staff left our compound due to a lack of motivation and because their salaries are low compared to the government salaries. Maybe we are expecting that if the government could implement the contract, that would be a proper solution and the entire staff would enter the government scheme (Interview 33).

Due to these problems, they advocate increasing the number of health staff in FBOs on the government payroll (Interview 9). The national church leadership sees the staff crisis as a national crisis, affecting both public and private actors. As an example, a church representative of TEC says:

In our health centres, we lack personnel, but the government is ready to give us nurses and the government is paying them. Nevertheless, it can also be a resource exchange in the opposite direction. One day the Regional District Medical Officer (RMO) came to see me and said: "I am in trouble because I do not have medical doctors. You have so many that have graduated. Perhaps one of them can come to work at our place." I replied that I needed them but then I said: "Okay, I'll give them to you for some time" and then we gave them some doctors and then the RMO said, maybe we should train these doctors, but we could not get scholarships from the government. Then I told him that I would try to help him through the CSSC, which would provide some funds. So I would put that doctor in my diocese to help him, so we are working together with the government (Interview 15).

At the time of the study, the human resources gap was in all three cases filled by foreign visiting nurses, midwives and doctors, which is not considered a sustainable solution to the lack of human resources.

Key results

The analysis of the public private partnerships from a financial and organisational dimension identifies both benefits and challenges related to the partnership. New forms of secular-based friends associations and complementary funding approaches, such as the Vertical Health Programme Funds, are developing in order for church-based hospitals to broaden their resource base and lessen their resource dependency. Hence, funding ultimately originates both from the external environment of church organisations and, in the case of PPPs, from the government through donor contributions to the Basket Fund Grants (BFGs) and the state's own resources. It seems as if church organisations to a high extent seek to engage in contractual partnerships in order to access and secure long-term funding for their healthcare provision. If the church organisations included in the study are to survive in the health sector, then they need to manage both cooperation and compromises with the government and external partners in order to get the necessary resources. In the table below, I present an overview of empirical findings related to research question 2, as described in this chapter.

Table 11. Overview of empirical findings related to research question 2

Research question 2: How do church organisations and public authorities perceive the contractual partnerships in health from a financial and organisational perspective? <i>Found themes and categories</i>	
<i>1. Increased state dependency</i>	
	Shifting dependency from international partners to the state
	Sustainability and affordability - contradictory goals
<i>2. PPPs accompanied by complementing financing mechanisms</i>	
	New forms of secular-based friends associations
	Key individuals as gatekeepers to external funding
<i>3. Partnerships constructed to secure long-term funding</i>	
	Partnerships perceived as necessary for long-term stability
	Dissatisfaction with the short-term implementation of the partnerships
<i>4. Removal of patient fees – a challenging condition for PPP entry</i>	
	Patient fees critical for securing long-term funding for church-based hospitals
	Removal of patient fees without adequate financial compensation
	Lack of comprehensive health insurance makes free healthcare difficult
<i>5. Misappropriation of funds – a hidden and sensitive factor</i>	
	Lack of trust between partners in PPPs
	Lack of comprehensive auditing
<i>6. Human resources for health crisis</i>	
	Human resources transferred from the private to the public
	Differences in social benefits for government-supported and church-employed health staff

9. Political and social dimensions of the partnerships

This chapter includes a presentation and analysis of the main research findings from the three case studies related to the third research question: *How do church organisations and public authorities perceive the contractual partnerships in health from a political and social perspective?* The research question is analysed from a social and political perspective, or what Beckford refers to as a bottom-up perspective. Local processes of social and religious mobilisation are analysed in relation to the level of church-state collaboration with regards to service delivery (i.e. scale, scope and nature of health services). The legitimacy of the state and the church leadership at the local level has also been considered. A bottom-up perspective seeks to recognise churches' unique historical, social and religious embeddedness in local cultural contexts. It goes beyond the fact that churches have health institutions and have become naturalised as parts of the local landscape in local communities. This perspective acknowledges that churches are deeply integrated with other societal structures, including party politics, local administration, culture and family and that they act as important arenas, such as in civic education (Alava 2016).

The church-state relationships in Tanzania vary between different Christian denominations. I have found that the status of the church-state relationship is a decisive factor for the outcome of the PPPs in health sector development. It looks as if the more established and structured the church-state collaboration, the more effective the public private partnership in health. At the local level, the church-state relationships are still significantly influenced by the legacy of traditions inherited from the missionary societies and shaped by their aid policies, like in the case of the PPP frameworks. From the perspective of public authorities, since the introduction of the current PPP framework, Council Health Management Team members find health policy-making increasingly internationalised, where local policy-making organs such as the CHMTs play a more passive role, primarily implementing directives from the central level. Despite the fact that international aid agencies acknowledge the importance of strong national policies and local ownership, Tanzania is still encouraged to adopt approved international health agendas (Global Partnership for Effective Development Co-operation 2017). In fact, several of the interviewed Council Health Management Team mem-

bers at the local level argue that in order to keep receiving recognition, funding and be at the forefront of development trends, they need to accept these partnerships (Interview 59, 60, 62).

When analysing the involvement of the three church organisations in health service delivery partnerships from a political and social perspective, it has been useful to revisit Kramer's typology of voluntary organisations as social agents (Kramer 1981). Kramer developed his typology in the stormy political climate of the early 1980s, when enthusiasts of small government were putting more emphasis on the non-profit sector. The political discourse of that time in many ways resembles the current global political economy debate in development contexts concerning the relative effectiveness of markets, governments and civil society in coping with social challenges through innovations.

Central themes

In this section, I present the main research findings from a social and political perspective. Five central themes have been generated from the categories found in the qualitative analysis of the three main data sources: policy documents, interview transcripts and field notes. The five themes are: 1) PPPs are built on established linking social capital; 2) new forms of linking social capital; 3) ambiguous ecumenical relations; 4) service provider and vanguard roles strengthened by PPPs; and 5) PPPs regarded as politically and religiously sensitive.

The relation of PPPs to “linking social capital”

Church organisations have a long history of serving the Tanzanian population. The role of church organisations in the development process at large has recently received increased attention in the broader scholarly debate in Tanzania (Ndaluka & Mapunda 2015). An interesting finding is that decisions on where, how and when to enter into collaborative agreements under the PPP reform are neither based on base-line studies in health nor comprehensive health planning. Instead, it seems as if the strongest factor for determining whether a church-based hospital receives a Council Designated Hospital status is the level of existing church-state relationship. The church-state relationship also relates to how well-established the church organisation is with regards to infrastructure and the level of “linking social capital” between the church organisation and the local and the central government.

Church-state relationship – a decisive factor for PPPs

Many church representatives believe that the official status and the type of church-state relationship is a decisive factor for how well the partnerships are working. The more institutionalised and structured the church-state collaboration, the more effective the partnerships (Interview 14, 19–20, 24 and 27–28). When comparing the three case studies, interviewees representing the Catholic Church say that the PPPs work better in comparison with both the Evangelical Lutheran Church and the Pentecostal Church (Interview 15–16). The Pentecostal Church, which has the weakest church-state relationship, has faced the most significant challenges related to the implementation of the partnerships. Even though this is not a comparative study, this difference comes out as a central theme in the study. The more institutionalised and established the church-state relationship, the easier it is to negotiate, agree upon and implement these partnerships.

Over time, the Catholic Church has developed a very strong relationship with the Tanzanian state, and many people in the government have received their education in Catholic institutions. Several interviewees within the Roman Catholic Church (case I) at both the national and the local level raise this factor as a comparative advantage for the Catholic Church (Interview 15 and 16). Some reflect upon the fact that this relationship is strong due to its well-established organisational structure (Interview 14 and 16). Several interviewees from the TEC case suggest that the national Catholic leadership and the national government are well-connected and interlinked. As an example, a national TEC Health Department officer brings up that:

The president is very close to me. He even helped me launch the Bugando Catholic University. When he was in New York as the Minister for Foreign Affairs, he assisted us with fund-raising for this initiative. In fact, we are very close and he knows exactly what we do (Interview 16).

A TEC church representative argues that the Catholic Church has a close and direct relationship with the national government:

The structure being there doesn't ban me from meeting the minister of health myself. There are issues that are not necessarily of ecumenical interest for the CSSC to address; for example, not all churches talk about Catholic social ethics regarding natural family planning or abortion. So, if there are issues specific to the Catholic Church, we are not banned from seeing the government ourselves on those issues (Interview 15).

For the second and the third case studies, representatives of both church organisations acknowledge that they are less connected to the state compared to the Catholic Church and that they both on the one hand wish to strengthen their partnership with the state, but that they also wish to safeguard their independence (Interview 20, 21, 26–28 and 30). Some interviewees of the

ELCT case study admit that they are to some extent connected with the national government (Interview 24–25).

Church organisations are used in the legitimisation of public health policy

I found that church organisations are needed in the legitimisation of public health policies. This was particularly noticeable in the interview material from the Ministry of Health. Several interviewees perceive national church organisations as assisting in the shaping of moral health discourse and the promotion of health-seeking behaviour and action from the grassroots up to the national level. Locally, more clashes over values between public health goals and religious values are acknowledged, as well as local resistance due to religious authority and its influence on political legitimacy. Still, according to most national public health officers, church-based hospitals are seen as having the personnel, financial resources, equipment and local knowledge needed for implementing the PPPs. Beyond the material aspect, several interviewees argue that church organisations can be useful in providing religious legitimacy to government health policies (Interview 1–5).

To illustrate to what extent this is emphasised, I quote a public health officer from the Ministry of Health:

There is a consensus that we should do this together with the FBOs. You can't conclude any big decision without involving the FBOs and if they think something won't work, they will share this with us (Interview 3).

Representatives from the Christian Social Services Commission believe that the positions of church organisations on various economic, social and health issues have a great impact on the implementation of health policy reforms in Tanzania (Interview 6–9). A general conclusion from the policy analysis is that it seems as if church organisations are considered effective tools for the legitimisation and implementation of public health policy. A clear illustration of this finding is a sermon guide published by the Ministry of Health, which one of the interviewees refers to as a good example of this phenomenon by (Interview 11). In the foreword of the sermon guide, an official representative of the Ministry of Health writes:

The objective of this Sermon Guide is to increase the knowledge of religious leaders on Maternal, Newborn and Child Health (MNCH) issues and assist them in developing sermons on MNCH for Sunday worships. The biblical scriptures provide rationale from the faith perspective, in support of the evidence based messages that are promoting reproductive and child health. Hearing these messages from their trusted religious leaders helps the faithful to practice healthy behaviours (Ministry of Health 2012)

Several public health officers at the Ministry of Health confirm that they consider church leaders important. They repeatedly address the fact that church organisations are needed in the legitimisation of public health policies. In conversations with representatives of public authorities at the national level, it seems as if there is a strong emphasis on the importance of religious authority. This is something frequently seen in national media, such as: “Government to engage religious leaders” (Citizen 2016) or “Bishops Cooperate with Magufuli government” (Citizen 2015). There are also examples of churches at the national level supporting the government. Soon after the current president, John Pombe Magufuli, was installed, the Catholic bishop, Right Rev. Rogath Kimaro, praised the government in an official national media statement:

The Catholic Church is behind what the president is doing and will continue to support him (Daily News Tanzania 2016, p. 5).

At the local level, however, the interviewees paint a slightly different picture (Interview 13, 49–52, 59–62). Council Health Management Team members are mainly concerned with how to increase their own legitimacy and prefer to expand public rather than private healthcare. This phenomenon is discussed further below.

My analysis shows that the state is dependent on church organisations for the full implementation of its national health policy. Several public interviewees express the dependency on the church organisations for health service delivery in rural areas and for the realisation of health rights more comprehensively (Interview 1–3, 36, 48 and 58). To some extent, the state seems to realise its dependency on church organisations for health service delivery to vulnerable groups in rural areas, and part of the reason for this is that there are several districts without any well-functioning public health facility at the district level (district hospital). The national public authorities tend to view the performance of church-based hospitals in PPPs as good, with two exceptions: (1) hospital pharmacies frequently run out of stock, which leads to utilization of expired medicine; and (2) staff shortages as a result of public health facilities offering better salary packages (social benefits, pension savings, etc.), as discussed in Chapter 8.

Several national public officials argue that the state by itself is unable to deliver, develop or maintain services at an adequate standard (Interview 3–4), and church organisations in Tanzania are thus currently faced with a similar challenge as the one faced by the first missionary societies before independence: to what extent should they take on the mission to engage in health sector development. Missionary societies made the decision to engage, expand and develop a close relationship with the colonial state.

It looks as if the current church leadership in all three cases is currently considering what price they are willing to pay for maintaining or even ex-

panding their health facilities, in addition to how they should relate to the state in a long-term perspective when seeking to find their place in the current development process. An interesting finding, however, is that it seems as if the church-state relationship in all three cases has deepened and been strengthened following the introduction of the current partnership framework in health. A national ELCT church representative says:

We as the church have tried to talk to the government so that the government can support our hospitals since we are serving Tanzanians. So why has this job been left to the church? We did advocacy work with the government, so now at least some of our hospitals are given grants, more grants compared to ten years ago or some years back. Nowadays, the relationship between the government and the church is good and that is better. The government is trying to pay for the doctors, and we have signed an agreement for some of our hospitals. So to us, these are major changes (Interview 21).

There are some significant differences between the church organisations. With regard to the TEC, it looks as if they take their position in the health system a bit more for granted. However, the three church organisations share a similarity in that most of the interviewees in leading positions see the church-state collaboration as important for sustaining their healthcare facilities.

A hospital management representative from the second case study says:

In order to serve the poor, somebody has to pay for it. However, despite that, we are churches in a developing context and our international partner churches are not able or willing to support our healthcare and patient care any longer. Therefore, we either have a choice of eventually closing this part of our ministry or to find other funding. Our long-term question concerns this dilemma on how to sustain our health facilities in the future. Sustainability really requires a sophisticated planning process and financial planning (Interview 42).

As far as the state is concerned, the question is whether it is able to develop a comprehensive health system for its citizens and to what extent the church organisations should take part in the realisation of health rights in Tanzania. The closer the church representatives are to the actual health service delivery and the target groups (patients, marginalised groups, etc.), the more likely they are to favour a stronger engagement in health sector development. This is of course particularly true for those who are medical professionals within the respective church organisations, who in all cases favour a strong health sector engagement (Interview 16, 24 and 30).

Locally, the Council Health Management Teams primarily look upon the partnerships with church organisations in financial terms, while the public health officers from the Ministry of Health clearly emphasise the importance of integrating church-based hospitals into the national health infrastructure

and the comprehensive health planning in the districts. The very capacity of church organisations to act in their collective interest is critically dependent on the quality of the formal state institutions, which they relate to and depend on. It is therefore crucial to consider the role of the state in social service delivery, and it is evident that the health service delivery of church organisations has much to gain from being analysed within the larger context of church-state or FBO-state relationships.

New forms of “linking social capital”

With the introduction of partnerships in health, it looks as if a new form of contract-based church-state relationship is being developed in Tanzania, where church organisations are increasingly becoming more politically and financially dependent on the state. In fact, when addressing the fact that the Catholic Church and the government in light of the PPP framework to a high extent form the same elite, the country director of an FBO makes the following claim:

If you look at the CSSC as an organisation, you see a lot of people in their management who come from the government side. You maybe have the bishops who provide the overall governance, but what is interesting is when you go inside and look at the practitioners and the managers and where they are from. They come from the same educational system and some of them have been in the government together for a long time. So that’s an interesting dynamic within the organisation, that they have this calling to be faith-based and at the same time they are also structured from the core group of people who are brought from the same system. So I think that if the bishop wants to say something about healthcare, people will listen and there is no question of that (Interview 11).

Some interviewees identify risks with the new forms of contract-based church-state relationships, in particular at the central level. As an example, interviewees from the Lutheran and Pentecostal church organisations stress the importance of not losing their organisational identity when entering into partnerships (Interview 11, 24–25 and 30). However, surprisingly few interviewees mention the need for church organisations to ensure that they come out clean when it comes to anti-corruption and transparency. Their fear of losing their ability to act as a critical voice in the public debate was mainly addressed by the leadership in more informal conversations during the participant observations, and was not outspokenly stated in the recorded interviews.

Relatively few interviewees are ready to publically admit that PPPs carry a real danger of disabling church organisations in terms of playing a critical role in speaking out against social injustices (Interview 6–9, 24–25, 30

and 55). It is in fact a bit surprising that so few interviewees publically raised the issue of the autonomy of church organisations and whether they are really pursuing their original agenda while being so closely related to the state (Interview 43 and 53). This could be because church organisations in Tanzania in many cases form the same elite as the one found within national and local politics and have to safeguard both their positions in the system and their economic privileges. However, many interviewees are still officially saying that if it was necessary, they would stand firm and safeguard their independence (Interview 16, 25, 27–28). It seems as if their arguments are related to the fact that dependency goes both ways and that the state is dependent on the churches for service delivery. A common opinion officially raised by several church leadership interviewees is that “you have a stronger voice when you also deliver more services”. As an example, an ELCT Health Department officer argues that:

When you raise your voice, the government understands that you are a stakeholder; you are wearing those shoes. Other FBOs say that you are raising your voice because you want money to support your own structure and not for the interest of your own people. But they forget that your interest is to serve the community. You have a stronger voice when you also deliver services, because you have a stake, you speak from experiences and from your own health data. If you are not providing services, you do not know the situation (Interview 24).

Some interviewees make it clear that there can be tension between, on the one hand, the church as a prophetic and critical voice defending the weak and vulnerable, and, on the other hand, a more collaborative attitude towards the state. The developments after this study was completed in 2014 indicate that this tension has increased in the period leading up to the 2015 election. In the follow-up conversations that took place in 2015–2017, after the new president was inaugurated, this tension was highlighted when the data was validated. This is related to the broader question of how church organisations are able to combine being both a free agent and a critical voice, whilst simultaneously being a church representing a great portion of the population while increasingly being dependent on the state.

When engaging in public partnerships, church organisations are said to more generally take on two main kinds of advocacy strategies in their efforts to be a critical voice: (1) *Insider advocacy tactics* are those intended to change policy by working directly with policy makers and institutional elites. These tactics may for example include participating in government committees and meeting with elected officials. (2) *Indirect advocacy tactics* refer to a wide range of different advocacy activities that generally do not require the same type of inside connections. Indirect advocacy tactics may include initiatives such as public education, writing letters to the editors,

working with advocacy coalitions, issuing policy reports and organising demonstrations (Mosley 2011).

When looking at the different strategies used by the three church organisations in the study when implementing partnerships, it looks as if they have primarily used insider advocacy tactics (Interview 6–9, 11–12, 14–16, 21, 24–25, 30 and 53). As a complementary strategy, they have also utilised indirect advocacy tactics (i.e. sermons by bishops, published books and written advocacy letters).

Several interviewees refer to insider advocacy tactics in particular when referring to the advocacy work conducted by the Christian Social Services Commission. As an illustration of this, a national ELCT church representative says:

They now know and they see what we are doing. They are not only hearing about it, but they are also witnessing. When we have our meetings, we have our partners meeting once a year and then we even invite people from the government to participate and hear what we are doing and to hear our challenges, and sometimes they can even encourage us and advise us on how to overcome some of our problems (Interview 21).

It is possible to conclude that service delivery seems to be an important source of legitimisation of advocacy. When church organisations actively contribute, they are listened to and their credibility as an advocate is strengthened.

The study has also looked into how church organisations and public authorities view each other's mutual relationships with regards to subcontracting and healthcare provision in Tanzania. This includes a look at relationships that may stem from personal relationships of the individual government representatives, as well relationships at the organisational level. Therefore, both formal and informal relationships are taken into consideration.

Formal relationships with public health authorities strengthened

According to some of the interviewees from the Ministry of Health, church organisations and public authorities share common responsibilities in health service delivery (Interview 3 and 5). The formal relations between church organisations and public authorities at the national level are in all three cases said to have improved since the introduction of the current PPP framework (Interview 7, 14, 19, 21, 24 and 30). As an example, a national TEC church representative says that:

I think it has changed over time, especially when they introduced this PPP (Public Private Partnership) reform. I think that has been a big change, which has opened the door for a stronger collaboration with the government. Only

that it sometimes lacks stability, but it implies that we can have a bright future if we stabilise our relationship (Interview 14).

It seems as if when the partnerships are put in place, there is an increased level of participation by church organisations in public health forums. To give an example of this, a national ELCT Health Department officer argues that:

The Public Private Partnership exercise is working well in the church healthcare facilities. At the district level, you find that our church health facilities are well-represented at the district or at the Council Health Management Teams. Let us say in terms of explanations that the government is very willing. I can say that the relationship is very healthy as we speak (Interview 25).

As discussed in the previous chapter, the church organisations have to varying degrees participated in policy dialogues and comprehensive health planning sessions. However, it is worth noting that several interviewees from both the public and private side acknowledge that there is room for improvement. In particular public health officers from the Ministry of Health stress this viewpoint (Interview 2–5). Some representatives from the church-based hospitals at the local level express that they partially feel excluded from comprehensive health planning at the district level. Conversely, some local public officials from the Council Health Management Teams argue that the church-based hospitals in some cases exhibit a low interest in the planning process (Interview 49–52 and 59–62). Some interviewees from the church organisations admit that there is room for improvement, such as a national ELCT Health Department officer:

There are times when church-based hospitals do not give a plan to the leading agent. That is a challenge from our side and there are also times when the person who is elected is not technical and professional enough to represent us, so that is also a challenge (Interview 24).

There are examples from all three case studies of structured dialogues between government authorities and representatives of the church organisations taking place on a regular basis, albeit with room for improvement. The bulk of the examples given in the interviews are related to dialogues offered by the Christian Social Services Commission. In fact, the commission comes out as a key player in relation to the implementation of the PPP framework.

Even though the central leadership of all three church organisations stresses the promotion of good relationships with the central government, there are at the same time examples of political tensions, in particular within the third case study of the Free Pentecostal Church of Tanzania (FPCT). One of the identified tensions concerns their role in policy-making and party poli-

tics in general. There are also examples where FPCT pastors have accused the government of open discrimination. One example comes from the last months of the study, in 2014, when the secretary-general of the FPCT accused the government of failing to appoint members from the Pentecostal Council of Tanzania (PCT) to the parliament. The government reiterated that the PCT never nominated candidates for consideration (IDEA 2014). Nevertheless, the presiding bishop of the FPCT publicly stated:

President Kikwete considered CCT (Protestant Christians), TEC (Catholics) and the Muslim Council of Tanzania but there was nobody from the PCT, which still makes up of 75 independent Pentecostal churches and followers numbering millions. We have been isolated on matters of this country (Mbashiru & Mwangonde 2014).

It was found in the interviews that the central leadership of the FPCT expresses somewhat of a distance towards the central government (Interview 27–28), in particular in comparison with the TEC but also in comparison with the ELCT.

Informal relationships with the government kept in place

I found that there are cases of well-established interpersonal relations between the public and private actors in the partnerships at the national level. It looks as if this is particularly true when it comes to the Catholic Church and the state. However, at the local level, there is a greater separation between the church organisations and the local governments, and they seem to form more of two separate elites. This quote from a national TEC Health Department officer may serve as a good example of this:

It is worth noting that unlike with us at the church hospital, representatives of church organisations seem to communicate with the government quite well. Thus, it is very important to note that a good relationship is noticed at the top level, where the government and church organisation representatives meet on a more regular level (Interview 16).

Several other scholars in the field, such as Kramer, have brought forward the relative importance of informal relationships. Mutually dependent relationships between voluntary agencies and senior civil servants in the central government often rest upon unspoken agreements on the rules of the game and an exchange of needed resources (Kramer 1981). My study indicates that both religious and ethnic identities matter for the quality of interpersonal relationships, in particular at the local level (Interview 42–43 and 54–55). The importance of informal personal relationships seems to be particularly true for the Tanzania Episcopal Conference (TEC). A national TEC church representative expresses this clearly:

We are trying to work together to see what we can do. They won't force us but we have to complement each other. We also conduct lobbying towards the members of parliament (MPs) and sometimes we meet the president himself on health issues (Interview 15).

The involvement of the church leadership is to some extent a sensitive issue in party politics. Some interviewees, such as those from the third case study (FPCT), stress the importance of not getting involved in party politics (Interview 27, 28 and 30). However, surprisingly few interviewees point to the difficulty of drawing a line between a religiously motivated prophetic role and being directly involved in party politics, perhaps since this study has a particular focus on health policy and not civic education and other areas of advocacy.

Ambiguous ecumenical relations

It seems as if the PPP reform has brought increased collaboration between different church organisations when it comes to policy-making dialogues and advocacy towards the government. However, when it comes to how well the services of church-based hospitals are integrated and how they collaborate in their health service delivery, we get a different picture. The three local hospitals included in my study had very poorly developed collaborations with hospitals, health clinics and dispensaries of other denominations in the same district. This was an unexpected finding in the local case studies. It almost felt as they if saw each other as potential competitors. This could be explained by the fact that all church-based hospitals within a district share the same district health funding. However, whenever health advocacy was discussed all three church organisations stressed the importance of joint ecumenical advocacy through the Christian Social Services Commission (CSSC). When health advocacy was discussed, several of the church leaders participating in the study portray themselves as quite influential in health policy-making and argue that they have an impact on society's caring functions. Interviewees from both the public and the private side, including the CSSC representatives themselves, confirm this.

The CSSC – a key arena for promoting PPPs

The CSSC is perceived as the key arena for public and private collaboration between church organisations and public authorities in the health sector. The CSSC is a very influential actor (Interview 2–5). Some interviewees even suggest that if public health policy does not reflect the underlying agenda of

church-organisations through the CSSC, then the health reforms are likely to result in resistance and implementation failure (Interview 6–9).

The influence on health policy-making at the national and regional level was said to have increased through the CSSC; for example, through membership in various public official committees and working groups at the national level. It therefore looks as if the ecumenical collaboration between different church organisations has been strengthened as a result of the PPPs in health. In several interviews, the central leadership of both the TEC and the ELCT case study argue in favour of the CSSC. An ELCT church representative emphasises the central role of the CSSC:

The government cannot listen to Lutherans only, so we normally take our issues to the CSSC and they are the ones to combine the report, to combine the data. And if we need something we need to advocate for, they are the ones to take all church organisation issues to the government. They are the ones to go to on behalf of all of us (Interview 21).

Several interviewees argue that the CSSC plays a central leadership role in service provision in general. Officially, at the national and regional level, the CSSC represents its members in policy and planning initiatives at the central and regional levels, by advocating for financial grants from basket funding and sharing staff through staff secondment. As of 2013, according to a World Bank assessment, the CSSC worked through five zonal offices, administering and linking 897 church-based hospitals and health units with local and central governments (World Bank 2013, p. 27).

Internal power struggles within the CSSC

I also identified some challenges related to the role of the CSSC. One of the more critical points stressed by a CSSC officer concerns the fact that the CSSC is not given enough time and notice to prepare itself before structured health policy dialogues with public health authorities. As an example of this point, a CSSC officer says:

They bring the draft and they ask whether we have something to add or change within a very limited amount of time. As we have facilities all over the country, gathering input from our facilities on how they are thinking in the districts in order to include it in the reforms takes much more time than what we have been allotted. When the draft is already written, they come to a stakeholder meeting to just get some final input from faith-based organisations (FBOs). But sometimes it is very difficult, because they do not include us from the beginning but only at the last minute, and now they want to call us before finalising the CCHP. So that it is very difficult for us (Interview 9).

Another challenge related to the CSSC is that not all church organisations share equal power over the organisation. The Roman Catholic Church (TEC)

is considered the most influential actor in the CSSC, followed by the ELCT. A national TEC Health Department officer makes the following point:

Through the CSSC, we as the Catholic Church were able to air our views about whatever we like, including policy development, the development of the national health policy, where we actively participate. The CSSC represents all of us (Interview 16).

The national church leadership from the FPCT case feels partially excluded from the work in the CSSC, which is not surprising considering that the FPCT was not a formal member at the time of the study. A national FPCT church representative discusses this:

You know these big churches form some organisation called CSSC, which we as Pentecostals are not part of. We try to ask them if we could join because our doctors also go to the Ministry of Health to ask for some help, but then the ministry tells our doctors that they prefer to talk with us Pentecostals through the CSSC. However, when we go the CSSC, they tell us we are not yet a formally approved member, so somehow we are not getting the profit. Currently, we are only an observing member. We came together as Pentecostals and we talked to the chairman of the CSSC and the chairman of the TEC. We told them that we as Pentecostals also have social and health work, and because the government wants to channel their policies through the CSSC, we asked to become formal members of CSSC. They told us they are working on it. But until now, we are still discussing it, and up to now, we are still waiting. I wrote the letter as the chair of FPCT. I sent it to them six months ago, and we have not yet received an answer (Interview 28).

A few of the interviewees from the ELCT point out some related questions concerning the work of the CSSC, even though interviewees from the ELCT are generally arguing more in favour of the collaboration than those from the FPCT. One common point of critique is that the coordination between the CSSC and the respective national health department of the church organisations is not good enough at the zonal level. Partly for this reason, the ELCT and the FPCT have taken their own initiative to complement the advocacy work carried out by the CSSC, even though most initiatives still go through the CSSC. As an example of how the ELCT conducts its own advocacy work, a national ELCT Health Department officer says:

In advocacy there is never one way or one channel. We have now adopted the evidence-based advocacy strategy. At the local level, we have been advocating at the district level because the CHMTs are the ones who know what we are doing and we have been sharing what services we are offering, what challenges we are encountering and how we can move on in providing those services at the district level. This has worked out very well in many hospitals and in many areas (Interview 24).

However, in general terms it looks as if the ecumenical collaboration, as well as the formal links between church organisations and public authorities, is strengthened as a result of the PPPs. In spite of this, I can conclude that it seems as if further integration and collaboration is needed in order for church-based hospitals to work more effectively to complement each other in the realisation of health rights.

Service provider and vanguard roles strengthened by PPPs

On a general level, church leaders express their view that church organisations are acting as a complement to the state in its limited capacity to implement health policy in remote areas. However, some interviewees and policy texts point to the wishes of church organisations to be a primary service provider or parallel resource to the state through their support to vulnerable groups, whereas others would rather include an out-spoken criticism of the failure of the state when it comes to providing quality health services to the broader Tanzanian population in remote areas. A public health officer at the Ministry of Health brings forward critique of local politicians who instead of strengthening the pre-existing church health infrastructure advocate for establishing new public health facilities (Interview 3).

CHMT members argue that they are primarily implementing the National Health Policy containing the vision of establishing one health unit per village and district (Interview 59–62). It is worth noting, however, that some interviewees from the national church leadership refer to themselves as doing the duty of the government (Interview 28). A few of the interviewees even argue that the government should be responsible for all costs related to operating the hospitals, staff salaries and costs for drugs (Interview 43).

Analysis according to Kramer's typology

When entering the PPPs, church organisations can make active choices and take on different roles in the health sector depending on which type of partnership contract they sign and how they choose to act. As mentioned in the introduction to this chapter, one way of categorising and analysing the relationship between church organisations and the public sector has been developed by Kramer. This framework, which I utilise here, is based on the notion that non-profit organisations can take on different roles as service providers. These roles can be combined where there is not an either-or but a more complex reality. Kramer has highlighted four main types. (1) As a *vanguard*, the purpose of the voluntary agency is to innovate, pioneer, experiment and demonstrate programmes, some of which may eventually be taken over by

the government. (2) As an *improver* or *advocate*, the agency is expected to serve as a watchdog and a critic as it pressures a governmental body to extend, improve or establish needed services. (3) As a *value guardian* of social justice, a voluntary agency is expected to promote citizen participation, develop leadership and protect the special interests of social, religious, cultural or other minority groups. (4) As a *service provider*, the voluntary agency delivers certain services, some of which may be a public responsibility that the government is unable, unwilling or prefers not to assume directly or fully (Kramer 1981).

(1) The vanguard role – giving priority to marginalised patient groups

In the ELCT case study, the interviewed church representatives describe the church as having a vanguard role. Interviewees from the CSSC confirm that the ELCT plays this role. As an example, the ELCT launched the first organisation to coordinate donations of drugs and supplies to church-based hospitals, which is called the Mission for Essential Medical Supplies. A national ELCT Health Department officer says:

ELCT introduced the PPP in Tanzania. We piloted for one hospital and from there the Catholics and Pentecostals followed. We are also the founders of palliative care, and in collaboration with the Ministry of Health, the ELCT has been the one initiating this work. We also started community health funding and then the government picked it up and developed it further. We are also the founders of telemedicine. So these are all examples of how the government, through the ELCT, influences a lot of changes within the health sector (Interview 25).

Another ELCT Health Department officer confirms this role:

As ELCT, we introduced pilot projects on distance learning, and usually the Ministry of Health comes to learn from us. Last year, the Ministry of Health visited our Selian Lutheran Hospital to learn about the health management information systems, and now the government is computerising its services and in this process they are learning from us (Interview 24).

However, in a broader interpretation of the vanguard role in line with Kramer's description, all three hospitals of the case studies are to some extent acting as a vanguard for the state in terms of identifying new areas of health needs and prioritising vulnerable patient groups. It looks as if the vanguard role is both encouraged and strengthened as a result of the PPPs.

(2) The improver role – the enhancement of existing health service provision

As an improver, the focus is on the enhancement of existing health service provision in order to improve different aspects related to quality. In this role, church organisations pursue pioneering work in a particular area or discover new challenges and then ensure that the public sector takes on this work.

There is a potential for religious groups, such as the church organisations in the study, to contribute to an alternative way of looking at health sector development beyond the hegemonic view of the private for-profit sector. Some church leaders are already expressing reservations concerning the uncritical embrace of privatisation of healthcare, in particular in the FPCT case study. It is worth noting, however, that in none of the three cases does the central church leadership wish to hand over the ownership of its facilities to the public authorities in the near future or for the government to take on this work. That being said, the FPCT tends to put more emphasis on the central role of the state in service provision compared to the two other cases. One way of interpreting the data is thus to say that the FPCT possibly plays an improver role. As an example, a national FPCT church representative emphasises:

It is the responsibility of every government to make sure that their people are in good health. Because if they are in good health, they will work hard and bring income. Therefore, the PPPs can be helpful and give us good relationships, and they encourage us to continue our work, but it is the government's responsibility to make sure that people are living with a good health. I think it is better that our government encourages us as FPCT, as an organisation, if we run this hospital to make sure that we cooperate more in providing services to our people. So I think the government should help people in providing healthcare and even encourage Christian churches to continue to provide good health to the people (Interview 28).

However, in general terms it seems as if an increased participation of the private sector in health service delivery tends to be stressed under the current PPP framework, rather than the public health system being expanded, thus making this role more complex.

(3) Value-guardian role – advocating for the realisation of health rights

The active presence of churches in the public space in Tanzania includes religious communication, such as preaching and praying, as well as communication in secular genres, such as public statements and diverse forms of advocacy. The churches' actions range from diaconal intervention and com-

munity-based action for development and justice at the local level to working for institutional change at the local and national level.

As a value guardian, the church acts as a defender of, and advocate for, various human values in shaping a moral discourse and by promoting the “right to health”. The role of the value-guardian is to put pressure on the government and to speak on behalf of oppressed or marginalised groups in society. Several interviewees ascribe this role to all three church organisations. However, several interviewees at the same time argue that the church should avoid party politics; indeed, it should not become overly politicised and preferably not create or get involved in political conflicts. Social groups like women, children under five and the elderly are the most likely to suffer the consequences of systematic corruption and widespread poverty, while at the same time being the least capable of advocating their health rights. For this reason, some church leadership representatives consider themselves voices on behalf of marginalised groups. As an example of this, a national ELCT Health Department officer says:

It comes from the community outcry. It is a community that is making its own voice heard. Citizens stating that they are also part of the government and the government is responsible for ensuring that they are getting the services others are getting despite the fact that they have a voluntary agency nearby or another health facility. For this reason, the government should support these services so that the prices go down so that they can access services in an affordable way (Interview 25).

Another ELCT church representative confirms this argument:

Our role is not only to be in the urban areas, because in urban areas, there are many other hospitals. But in the rural areas, there are no other hospitals. So the role of the church is to say that everybody, regardless of their religion, should have access to health facilities (Interview 21).

From both participant observation and interviews, I found that in all three case studies, healthcare services are generally offered to marginalised patient groups independent of the patient’s tribal or religious identity. When discussing the developmental role of the church organisations in terms of empowering citizens, a few interviewees inevitably raised the question of enlightened self-interest among local politicians. There is a tendency for several church leaders in the study to bring forward criticism towards the government on the issue of representation, whereby local governments are said to sometimes establish new public health facilities in order for local politicians to gain political legitimacy instead of strengthening the pre-existing health infrastructure (Interview 32, 43 and 55). For that reason, it is hard and problematic to overgeneralise the social function of church organisations

without taking existing power relations into account. To give an example, a CSSC Health officer expresses this kind of frustration:

For us FBOs, we are still fighting for more resources. We see that we are doing a lot to complement the government and sometimes the government receives a lot of support from donor funds, but you find that most of it goes to their facilities alone and not to other health facilities that are there to complement their efforts. We usually need to fight a lot to get those resources, but we think that we deserve to get some, otherwise the donors can set aside some money to support us for the work we are doing. But for the health services the FBOs are doing, a lot goes to complement the government, so if we do have donors supporting the country, some of their resources need to go to our facilities as well (Interview 7).

When analysing national health policy, it is clear that the legal right to health is not yet incorporated into the national constitution, as there is no expressed provision on the right to health. However, Article 30(2)(b) of the national constitution calls for the enactment of laws to defend public health, and Article 9 in fact obliges the state to direct policies and programmes to use national resources for development, especially poverty and disease eradication (United Republic of Tanzania 1998). The constitution has a provision on the right to life in the form of Article 14, which states that every person has the right to life and to the protection of their life by society in accordance with the law. Article 13 makes a provision for equality before the law. It states that all persons are equal before the law and, without any discrimination, are entitled to protection and equality (Päiväsalo 2013).

There are several examples from all three case studies that health rights have been addressed and also examples of how the church organisations have described their work from a rights-based approach. A national TEC church representative says that:

We are beneficiaries of grants from the government. However, we are also trying to lobby and advocate for what we have. Sometimes, we might not seem to be vocal enough in health justice, but we believe that through the ways and means we are using, especially that of entering into dialogues with the government in trying to highlight which areas we think are not well-served, we do talk of health justice. Of course, this is very sensitive and critical. We still have the opportunity to present critical voices of the church (Interview 14).

The ELCT Health Charter refers to the Universal Declaration of Human Rights when addressing the issue of patient rights (Evangelical Lutheran Church in Tanzania 2010). A national ELCT Health Department officer expresses similar views:

Right now, we are no longer focusing on opening new health facilities, but we are more trying to educate people about their health rights. We also have

an element of advocacy and mobilisation where the churches are trying to raise community awareness regarding health services in the country. So we have more taken the role as a participant (Interview 25).

In fact, several interviewees from all three church organisations argue that the church has a duty to speak out on moral issues, and for most interviewees, this is seen as a theological issue reflecting the very nature of Christianity and the role of the church in society in general. The interview material contains several more concrete examples, where the three church organisations use health activities to influence the religious beliefs or behaviours of the beneficiaries.

However, in the ELCT and the FPCT cases, it partially looks as if the central church leadership sees the government as having the main responsibility for the realisation of health rights. I have found several benefits and added dimensions brought by the church organisations to the health sector, which answer the special needs of people. One example of this is spiritual services. To give an example, a national ELCT Health Department officer highlights that:

Spiritual care is part of our care and that has proved very helpful in services for HIV/AIDS care. In these services, there is a demand for counselling services, where the patients can trust us spiritually that this is helpful for them. So that is what we mean by a Christian ethics (Interview 24).

Another example is a raised awareness of HIV/AIDS. To give a second example, a national FPCT church representative stresses that:

Specifically, we are focusing on HIV/AIDS where we disseminate material and educate young people in schools but also in the streets and together with young people in the church. So, all those are our target groups with whom we are working (Interview 29).

(4) Service provider (primary, complementary or supplementary provider)

It follows that the organisation providing services has to work according to the standards laid down by the public authorities; for example, removing patient fees for vulnerable groups. When the three church organisations engage in partnerships and establish agreements and contracts with public authorities, they are to some extent acting as primary providers of health services. Subsequently, control mechanisms are built into the partnership contracts in order for the state to guarantee the quality of these services. Such standards, however, may restrict the church organisation or oblige it to change its own policy, such as in the case discussed in Chapter 8:

The government is committed to Public Private Partnerships since we have already seen that the public sector can't work alone without the support from the private sector, so we depend on each other and the private sector will complement the government efforts (Interview 1).

This way of arguing for mutual dependency is also expressed by the church organisations. To give an example, a national ELCT Health Department officer points out that:

To me, the PPP is a very good approach for the country and a very good opportunity for FBOs to work closer with the government. However, PPP is not a quick ride and it is not a quick solution. PPP is a very delicate relationship and partnership. It needs watering, it needs care and regular meetings. It needs dialogue. It needs flexibility. It is not primarily about policy and guidelines, but it is more about a local understanding of what the nation wants to achieve and the way to use the resources available in the district to ensure that this goal is being met (Interview 25).

When it comes to the role of service provider, the first case study could easily be described as a primary service provider in accordance with Kramer's framework. The Roman Catholic Church alone represents about 20 percent of all health services delivered in the country. Interviewees from the national headquarters of the TEC express this view by suggesting that the Catholic Church should strive to have a hospital in each district and to reach patients with the more serious illnesses, like "a state within the state" (Interview 14–19).

The hospital in the second case study could also be described as a primary service provider, as the ELCT delivers close to 15 percent of all health services. However, most interviewees from the ELCT tend to argue that they instead play more of a complementary role in relation to the state. As an example, an ELCT Health Department officer says:

We are trying to ensure that people and local communities get accessible and affordable quality health facilities with good health services throughout the country and we are doing this as part of complementing services to the government, because we know that the government is the main duty bearer and the government is the one supposed to be responsible for health services. So we are morally responsible to provide health services as part of the government services (Interview 25).

Several other interviewees from the ELCT stress that the partnership is mutual, since the government is dependent on the church organisations in fulfilling its mission to deliver services to all citizens. An example of this comes from a national ELCT church representative:

If we take one hospital in the rural area, the government is happy because we are doing their work and that is why they are ready to support us (Interview 21).

An ELCT Health Department officer expresses a similar view:

It is now a partnership. Within these last ten years, we have developed a partnership whereby we now enter into an agreement; a formal agreement whereby everyone should fulfil their obligations. And it is not just resources we share, it is also how we work together to deliver agreed results. So we have strengthened our partnership (Interview 24).

In some instances, all three church organisations describe themselves as a parallel resource to the state within the framework of Public Private Partnership regulations by offering more choices for healthcare. However, it is clear that the FPCT in particular considers itself more of a complement or even a supplement to the government (Interview 27). This is how a national FPCT church representative discusses its role:

Because every country has the responsibility to provide social services for its people. Of course we are open to receive any kind of assistance from abroad, but I prefer that the government of Tanzania takes its responsibility (Interview 27).

With regards to the question of whether the church organisations wish to expand their health services, both the TEC and the ELCT are to some extent willing to expand their health services. To give an example, a national ELCT church representative argues:

So because the population is increasing, there is also a need for increasing our services and we also have new problems like HIV/AIDS, so the expansion of our services is there (Interview 21).

There may be areas where private non-profits would be preferred; not so much because of a unique philosophy of care or approach to healthcare, but because they offer specialised care at a lower cost. For decades, there has been a fairly acute awareness concerning the difficulty of maintaining church health facilities without external support. This has been a concern raised in all interviews by both church organisations at the national level, the local level (church-based hospitals) and by public authorities (nationally and locally). Several interviewees have suggested that church organisations should strive to develop a business model where the services could be completely free for poor and marginalised groups and also more economically sustainable. A key concern in the PPP policy, however, is that it is not clear how the government should prioritise between supporting church-based health activities and simply investing more in the public sector. Several in-

interviewees seem to believe that some Council Health Management Team members think of church-based organisations as competitors and not primarily as partners in the realisation of health rights (Interview 32–33, 42–44 and 53–55).

The fact that both the TEC and the ELCT have developed their own health policies strengthens the argument that they act more as primary service providers, or at least complementary service providers. However, when it comes to the FPCT, there is no health policy in place. The secretary-general of the FPCT confirms that although the organisation lacks a health policy regulating all their services to be conducted in line with public health policy, all staff members are instructed to follow state regulations. To give an illustration of how this works, a national FPCT church representative says that:

No. We do not have a health policy, but it is part of our constitution, where our social welfare work is explained, but we do not have a special document just for health work. Healthcare itself is part of the services carried out by the government, so we're part of that, which makes it enough to include in our constitution (Interview 27).

It looks as if the private for-profit sector has sometimes come to see church organisations as a threat. When private health clinics are vying for the same resources as church organisations, then the latter has an advantage over the private sector, as they do not need to make a profit (Interview 2 and 4). Church organisations are also favoured by public health officers in comparison with private for-profit. However, private for-profit actors prefer to operate their facilities in urban areas where they can make profits, while most church organisations are located in more remote areas in the country. To give two examples, here are some views from public health officers at the Ministry of Health:

I would say concerning faith-based hospitals that people generally have faith in those kinds of hospitals. They are not the business kind like other private hospitals, although they are still private hospitals. I think it is tricky nowadays, because people want to make money, so the chance of really getting the right treatment, the right investigation, and now with upcoming of the National Health Insurance, it is even smaller, because someone who needs a small investigation will get the full investigation, so it is tricky. The private for-profit have good hospitals, but they are doing this so much for the business purpose (Interview 4).

We come from socialism, so the faith-based organisations were the only ones accepted and the government trusted them and they were seen as genuine and faithful. But you know the business people, they were seen as if they are just after money. You know they can cheat. They can do anything, so the government was not sure of the quality of services provided by the private for-profit (Interview 3).

A developmental and theologically motivated role discovered

In light of the PPP reform, there also seems to be a theologically motivated role based on the social doctrine and mission of the church; the mission to be a faith-centred development actor. This potential role needs to be considered and explored further in new developments of typologies for church-state relationships. This viewpoint is linked to the wider discussion on how to safeguard the autonomy of church organisations in contractual partnerships. In the more informal interviews, as part of the participant observation, a few of the interviewees expressed that the partnerships might lead to church organisations becoming domesticated by the state. Most church leaders agree that their organisations need to be clear about their purpose and intent in terms of sustaining a faith-distinctive character and distinctive faith practices, while being alert to the risks of institutional isomorphism. Otherwise, they risk compromising their autonomy and their role as a critical voice in regard to the state and as a faith-actor in the communities where they serve. It is also clear that an agenda on advocacy, human rights, democracy and sustainability has been developed over time symbolising a move from a primary focus on service delivery to an orientation towards including advocacy and lobbying. Building on internal resources, churches have started encouraging citizens to take action for the realisation of human rights. These dynamics have also been found in welfare and religion studies in Europe and comparative studies with South Africa (Bäckström et al. 2011; Pettersson & Middlemiss Lé Mon 2012).

PPPs regarded as politically and religiously sensitive

It looks as if even if the PPPs have brought along many positive developments, they are also faced with several bottom-up challenges. This comes up as a central theme in most interviews. Through the partnerships, new funding models have been introduced, which has resulted in confusion and complications since there is a lack of knowledge at the local level concerning both the PPP policy and the Local Government Reform Programme (Interview 49–52 and 59–62). The CHMTs in all case studies are lacking the necessary autonomy, since policy development is perceived as externally driven. This could perhaps explain why some of the interviewees from the CHMTs are so sceptical towards the PPP policy and health sector reforms in general. It might be that some of the resistance against these partnerships is built into the system itself, since they are perceived as more of a global reform than something that is owned locally.

Religious authority perceived to challenge state legitimacy

All three case studies show that it is important for local CHMT members and District Medical Officers to strengthen the legitimacy of the local government in the local implementation of the partnerships. This leads me to believe that it is critical to understand that a resource exchange between public and private actors is closely related to questions of both accountability and legitimacy. Some interviewees touch upon this question concerning the legitimacy of the state as the guardian of “public interest”. Church organisations are guided by theologically motivated values and beliefs, which legitimise their actions. However, if church leaders become more legitimate than public authorities, a further integration of church-based hospitals into the national health system could potentially undermine the legitimacy of the state and its mandate as a guarantor of social and health rights.

When analysing the material, I considered the fact that since the privatisation era, the state has been unable to provide much of the needed services to its citizens. This, in turn, has led to a potential loss of legitimacy (Mallya 2008) and a situation where people in some cases trust church organisations and other religious agents more than they trust the national government. Some public health officers from the Ministry of Health (Interview 1–3) raise this argument. Lack of health justice and health rights has a further negative influence on the legitimisation process for the state.

At the same time, it looks as if increased capacity in healthcare delivery tends to allow church leaders to strengthen their legitimacy and authority at the grassroots level, in addition to their ability to shape people’s opinions and mobilise congregations for different purposes. A large challenge for church organisations is that some interviewees regard church-based hospitals as a potential economic resource for the church organisation rather than an expense. I observed this both among church members and clergy whom considered the church-hospitals as economic ventures. This has mainly been expressed in conversations that are more informal in nature, during participant observation, and it seems to be a very sensitive issue. This seems to be the case even if the management of church-based hospitals at the local level directly opposes this perception by stating that all facilities provide services with a deficit and should not be used as assets for bank loans or national investments in general. I found one concrete example from the second case study whereby church leaders utilised a hospital as an asset for a bank loan.

Several interviewees bring up another important bottom-up challenge to the PPPs; namely the fact that CHMT members lack knowledge of the partnership framework. Several interviewees from the church organisations express frustration with regard to this matter. This is in fact the most frequently expressed complaint and critical comment by the interviewees from the church organisations. To give an example, a national ELCT Health Department officer says:

There are those in the government who do not understand the PPP concept. They are the ones who should facilitate, but you have to start to explain to them. And I would say that it is not a coincidence, because when we started advocating for PPPs, we had an understanding of them even before the government (Interview 24).

An FPCT Health Department officer expresses this frustration in a similar way (Interview 30). Some representatives of the church organisations want the government to invest more in PPP education. An ELCT Health Department officer argues:

The government at the national level needs to address the PPP with proper and sustainable sources of funding to the districts. For me, resources don't only mean money but also the skills to negotiate, the skills to lobby, the skills to work together, the skills for partnership developments. That's how PPPs should really work, otherwise they will only work on paper and in guidelines, but never work in practice. Sometimes PPPs work very well, even in districts with no resources, but that is because we sit and we talk and we share the small resources we have. This works in this friendly environment, so it is not only funding alone but also the skills and understanding (Interview 25).

Some other interviewees acknowledge that it will take time to conduct training for local level staff on how to understand the partnerships. However, it looks as if there is one helpful component already in place. In all three cases, the hospital directors are also members of the District Medical Boards, while the District Medical Officers (DMOs) are at the same time members of the church-based hospital boards. Due to these structures, there is a special and close relationship between hospital directors and DMOs and thus a possibility for a two-way process for learning more about the PPP reform itself.

PPPs interpreted as a privilege for certain faith groups

A final bottom-up challenge addressed by several interviewees concerns increasing incidents of religious tensions. This challenge is related to Tanzania's secular policy of keeping a neutral balance between the public influences on different religions present in the country. My analysis shows that according to some church leaders and representatives of public authorities, some Muslims perceive the PPPs as mainly benefitting church organisation. Interviewees indeed provide different comments with regard to this question. Hospitals are obligated to provide culturally competent care for Muslim patients by taking the requirements of the cultural group served into consideration. This means considering their religious preferences.

Resources gained from partnerships are said to be distributed unevenly between different religious groups (Interview 14). This is considered a very sensitive issue and some participants in the study mainly brought it up during participant observations. One argument used is that since church organi-

sations are better equipped for entering into contractual partnerships compared to Muslim organisations, these partnerships do not benefit all non-profit actors on an equal basis. In the FPCT case study, the Pentecostal hospital is situated in an area predominantly populated by Muslims, which is why its interaction with Islam is particularly prominent. According to the interviewees at the MMH, they encounter many challenges based on religious tensions. A hospital management representative says the following:

Some of the Muslims don't like this hospital unless they themselves are in need of our services. Then they come here and tell us: "Our children are sick". However, despite that you help them, they do not like the fact that the church is behind the service delivery (Interview 54).

The matron at the MMH also shares these views on the encounter with Muslims at the hospital:

The Muslims know that we are a Christian hospital, but since they need help from us and we offer good healthcare, they come and seek services from us and we are providing them accordingly. We have to provide services to them. We are not looking into religious identity, but we are looking into how to provide a high quality of care and how to follow the public health policy, which gives us instructions on how to offer health services for all (Interview 56).

An officer at Tanzania Council for Social Development says:

For the two main groups, Christians and Muslims, the government has to ensure that there is a balance. Whether it is for an institution or something else, they have to ensure that there is a balance for the purpose of their own interest. Muslims and Christians are the largest groups and if you miss them when it is time for election, this one group might not support you and that's why there is such a close relationship with these faith-based organisations (Interview 13).

Some interviewees fear that since subcontracting primarily involves church organisations, this may threaten the stability and pluralism of Tanzania, whereas other interviewees argue that since health facilities are open to all patients independent of faith or religious affiliation, this is not perceived as a problem. Already the Memorandum of Understanding from 1992, the starting point for the current PPP framework, was interpreted by some Muslim groups as an instrument for the government of Tanzania to favour church organisations over Muslim organisations. Scholars in Tanzania have reported that during the last decades, tensions have been growing in discourses related to the state and in the secular model for negotiating religious pluralism in Tanzania. Part of the Muslim complaints involves the dilemma that there is less development assistance support from international donors (secular and

religious) for Muslim FBOs. However, some representatives from church organisations, in particular the Roman Catholic Church, argue against the views presented by Mfumo Kristo. As an example, a national TEC church representative argues that:

It was the state itself that gave room for others to expand. Therefore, these stories about Mfumo Kristo are a very big misconception. Because you do not find in our constitution that this is Christianity. There are the basic laws that are not Christian laws, but instead secular principles. So, I think there has been a big misconception (Interview 14).

On the one hand it looks as if the three church organisations in the study are perceived as more sustainable and more broad-based in comparison with other non-profits. On the other hand, it looks as if they suffer from conflicts in competing for resources and influence with Muslim organisations. Returning to Beckford's bottom-up perspective, it is evident that one needs to further look upon PPPs in light of religious and social mobilisation locally, while considering state legitimacy and identity politics in order to avoid a polarisation of society along religious lines (Beckford 2017). A common challenge here is that while Christian umbrella organisations, such as the CSSC, the TEC and the CCT, are autonomous and enjoy strong support from their believers, it seems as if the Tanzanian Muslim organisations have a weaker organisational structure and little support from their members. I can thus conclude that religion plays an increasingly important role in governance in terms of church organisations strengthening their institutions for delivery of health services.

Key results

The official status and the type of existing church-state relationship is a decisive factor for how well the public private partnerships are working in the local contexts. The more structured the church-state collaborations at the national level, the more effective the partnerships at the local level, which is likely the result of the more established church organisations being needed in the legitimisation of public health policy. PPPs bring about new forms of contract-based church-state relationships as church organisations increasingly challenge state legitimacy. At the same time, the case studies demonstrate an increased tension between the role of a critical voice and a more collaborative attitude towards the state both at the national and local level, not least since the religious and political elites are interlinked in complex ways. In some cases, it looks as if local governments seek to increase their legitimacy at the expense of implementing the PPPs more effectively. PPPs are interpreted as a privilege for certain faith groups, which complicates the Tanzanian model of secularism. There is not one particular developmental role for

churches, as church organisations simultaneously take on many different roles in relation to public authorities in Tanzania. However, in relation to the roles categorised by Kramer, it seems as if the vanguard and the service provider roles are strengthened by PPPs. Church leaders are expressing a theologically motivated role based on social doctrine and the mission of the church, whereas the mission to be a faith-centred development actor is discussed further in the next chapter. In the table below, I present an overview of empirical findings related to research question 3, as described in this chapter.

Table 12: Overview of the empirical findings related to research question 3

How do church organisations and public authorities perceive the contractual partnerships in health from a political and social perspective?
<i>Found themes and categories</i>
<i>1. PPPs are built on established linking social capital</i>
Church-state relationship – a decisive factor for PPPs
Church organisations needed in the legitimisation of public health policy
<i>2. New forms of linking social capital</i>
Formal relationship with public health authorities strengthened
Informal relationship with the government kept in place
<i>3. Ambiguous ecumenical relations</i>
The CSSC – a key arena for PPP promotion
Internal power struggles within the CSSC
<i>4. Service provider and vanguard roles strengthened by PPPs</i>
PPPs facilitates an innovator/vanguard role
The primary service provider role is strengthened
A developmental and theologically motivated role discovered
<i>5. PPPs regarded as politically and religiously sensitive</i>
Religious authority perceived to challenge state legitimacy
PPPs are interpreted as a privilege for certain faith groups

10. Significant religious dimensions

This chapter includes a presentation and analysis of the main findings from the three case studies related to the fourth research question: *How does religion appear as a factor of significance in the contractual partnerships in health?* Significant religious and faith dimensions of PPPs are analysed from an integral perspective (Beckford 2017). Analysing my data from an integral perspective means looking at religion more deeply than just an “add on” to the social services. I have been looking for specific situations where religious meaning is highlighted, constructed, attributed or challenged (Beckford 2003; Hill 1973).

As part of the integral perspective, social doctrine, faith and the everyday activities at the church-based hospitals are analysed. Religion as a significant factor is thereby discussed in a broader context as an integral part of life, as it informs the material, moral and spiritual aspects of people’s life. The role of the church leadership and the local congregations is also taken into account. When analysing the findings, the concept of intangible Religious Health Assets is also discussed, as this concept covers what many interviewees talk about (Gary & Cochrane 2012). Finally, I discuss some related religious challenges in the implementation of PPPs as expressed in the three case studies.

Central themes

In the analysis of data, I identified in which contexts religion appear as a factor of significance. Four central themes have been generated from the qualitative analysis of the three main data sources: policy documents, interview transcripts and field notes. The four themes are: 1) social doctrine and theology influence health practice; 2) health provision as a way to witness and glorify God; 3) local congregations – a hidden resource in healthcare; and 4) faith identity as a non-negotiable factor in the partnerships. In the following sections, I present each theme and the specific categories identified under each theme.

Social doctrine and theology influence health practises

Many church leaders and hospital staff stress how belief and holistic approaches are central to healthcare delivery. The case studies demonstrate that faith not only affects a church organisation's health policy, programme and strategies, it is also a key for recruiting volunteers, saving money on staff salaries, developing trust and increasing the health-seeking behaviour of the community. In all three case studies, religion is a significant factor in the health work performed by the church organisations. Religion is expressed formally in national church health policies as well as in interviews with church health department representatives. Faith is also visible in the everyday work at the church-based hospitals, something I experienced during the participant observation. In fact, the hospital directors at all three church-hospitals stress that upholding some basic Christian values is an overriding objective of the health service delivery. In some ways, faith also provides a common language for a more holistic approach to healthcare. As part of the participant observation, I found that local congregations are used for health messages to be communicated to the communities (e.g. during church services, prayer meetings, women's meetings, youth group meetings, etc.).

In all three case studies, the healing mission is emphasised from a theological perspective. The Tanzania Episcopal Conference (TEC) refers to the mission of Jesus Christ in its National Health Policy:

The Mission of the Tanzanian Catholic Church is continuing with the healing ministry of Jesus Christ by providing a holistic, quality, and sustainable healthcare, in line with the Roman Catholic Church moral and ethical values (Tanzania Episcopal Conference 2008, p. 4).

The Evangelical Lutheran Church (ELCT) similarly stresses its mission by even more clearly expressing the biblical foundation of its health policy:

To enable people to know Jesus Christ and gain eternal life. The Church is built on Jesus Christ as its foundation, is guided by the Word of God as found in the Old and New Testaments, and is strengthened by the Sacraments (Evangelical Lutheran Church in Tanzania 2010, p. 3).

The Free Pentecostal Church of Tanzania (FPCT) has no central health policy, but its constitution brings up its healing mission, mainly expressed in spiritual terms. Article 6.13 of the FPCT constitution says:

We believe in the healing of the body by Divine power or divine healing in its varied aspects as practiced in the early Church (Free Pentecostal Church of Tanzania 2008, p. 6).

According to Article 7.2 of the FPCT Constitution, one of the main objectives of the church is to provide special social welfare, including healthcare services (Free Pentecostal Church of Tanzania 2008).

The concept of intangible Religious Health Assets has turned out to be useful when describing the specific role of faith in health service delivery as articulated by the interviewees. Interviewees from the church organisations stress the importance of healing, faith, compassion, Christian health ethics and the promotion of health-seeking behaviour. The theological social doctrines of the church organisations refer to a vision of what constitutes a good society from a Christian perspective, and what the church's place in such a society might be (Ekstrand 2011). On the other hand, intangible Religious Health Assets are not as common when public authorities describe the health services of the church-based hospitals in the study. Interviewees from public authorities tend to put more emphasis on tangible Religious Health Assets, such as church health infrastructure, human resources and human health capital.

The healing ministry emphasised in church health policy

In the first case study (TEC), several interviewees refer to the social doctrine of the global Catholic Church. This is not a surprising finding, as the Catholic Church is a highly centralised and hierarchical church organisation. Under the spiritual leadership of the Pope and curia in Rome, its substantial body of writings has promoted religious, social, economic and political issues. Some TEC church representatives refer to these and stress that they are in regular communication with the Vatican and the Pope. I also observed this when visiting the TEC national office in Dar es Salaam, as several TEC representatives were absent, visiting the Vatican, during several of the occasions I was there. Two key principles in Catholic social teaching are referred to in the interviews: (1) Human Dignity; and (2) The Common Good (Ekstrand, 2011).

The way in which the TEC church leadership refers to the Roman Catholic tradition indicates that their understanding of health rights and human rights in general seems to be both organic and holistic and not separated from the inner mission of the church. The central church leadership also emphasises the wholeness of the human community. As an example, a TEC church representative says:

Our healthcare in Tanzania is part of the mission of Jesus Christ. To provide healthcare is the mission of the church and just like Jesus educated and healed, the church should continue the work here in Tanzania. So, providing healthcare is part of that mission (Interview 14).

In the Catholic Church's own policies in Tanzania, the caring for the sick and suffering as exemplified in the Good Samaritan in the Gospel of Luke is often highlighted (Tanzania Episcopal Conference 2008). The delivery of healthcare is considered a principal moral issue, built on the dignity and respect for the human being. Caring for the sick has a long history in the Catholic Church and has traditionally been based on a desire to participate in the healing ministry of Christ. The Catholic health policy clearly states that the Tanzanian Catholic healthcare system is based on the life and ministry of Jesus.

The Catholic Church expressed during several of the interviews that social justice is a clear foundation for the promotion of healthcare of a reasonable standard. At the same time, Catholic healthcare is committed to certain ethical and religious principles (commonly referred to as Ethical and Religious Directives), including views on abortion, euthanasia, sterilization and contraceptives. All this is practiced in conjunction with a broader commitment to faith, including caring for the poor, justice for employees, the spiritual care of patients and quality care for dying persons, thus adding to a reasonable balance between scientific medicine and basic human care for the sick (Keane 2002). Different objectives may sometimes come into conflict with one another; generally speaking, however, the Catholic Church does not make official compromises on the Ethical and Religious Directives, even though individuals and certain entities occasionally negotiate these principles (Flessa 2005). All interviewees from the Catholic Church defend their moral positions on sexual and reproductive health rights. Some interviewees from the Catholic Church in Tanzania represented a more pragmatic approach, in particular with regards to the use of contraceptives. Several interviewees from the TEC case highlighted that Catholic health services are provided to people in need regardless of race, religion or gender.

The ELCT case study shows that values and interpretations of faith are not as uniform in Lutheran tradition as in the case of the Tanzanian Catholic Church. From a Lutheran perspective, all churches are called to take part in God's mission, which includes proclaiming the Gospel of Christ, serving the vulnerable (Diakonia) and advocating on their behalf. This is stated in, for example, the World Lutheran Federation policy. The theological concept "diakonia", literally meaning "service", is often used to express the social mission of the church. The ELCT also seems more influenced by surrounding norms and values in comparison with the Catholic Church. To give a concrete example found in the material, the ELCT seemingly incorporates more charismatic elements into the Protestant faith, such as praying for the sick and charismatic prayer elements at the hospitals. This could be explained by the fact that a new Pentecostal-type born-again form of Christianity is on the rise in Tanzania.

There is no church authority similar to the Pope or the Vatican in the Lutheran World Federation. Regarding Lutheran doctrine and theological posi-

tions, some scholars still hold the confessional documents from the sixteenth century in high esteem, even though they were written in a very different social, political and religious context. However, no interviewees in the study refer back to these documents. Nevertheless, out of these writings, four common principles in Protestantism frequently tend to be highlighted, which are to some extent also referred to in the interviews and in the health policy of the Evangelical Lutheran Church in Tanzania (ELCT). These are: (1) Salvation; (2) The Church; (3) The Two Kingdoms;²⁷ and (4) Human Nature (c.f. Ekstrand 2011). Several interviewees from the ELCT case stress that Lutheran health services are provided to people in need regardless of race, religion or gender.

Interviewees from the ELCT also stress that they wish to take part in God's mission. According to the ELCT church leadership, and also according to the views of the Lutheran World Federation, this includes proclaiming the Gospel of Christ's, serving the vulnerable (Diakonia) and advocating on their behalf. It is therefore obligatory to build a strong leadership rooted in the theology of holistic mission (Lutheran World Federation, 2016). ELCT seems to have a very close cooperation with the Lutheran World Federation (LWF), in particular with its Department for Mission and Development.

In the FPCT case study, there is little or no references to global Pentecostalism. When these appear, they are related to the Pentecostal missionary societies that initiated the FPCT mission in Tanzania. More emphasis is put on the Tanzanian context and the Pentecostal Council of Tanzania. More generally speaking, the principle of autonomy comes out as a central feature. However, there are still some signs of unifying global features constituting the basis for contemporary global Pentecostalism. Here we find the centrality of the Holy Spirit, divine power and its presence, as well as the stress on being born again in the search for health-seeking behaviour and in the development of "Kingdom theology". Mission and evangelisation are likewise central for the building and expansion of global Pentecostal identity (Deininger 2013). This is reflected in the constitution of the FPCT, which is based on the Statement of the Faith expressed in Article 6 and relates to the Bible. In Article 6.7, it is written:

We believe that the Bible is the written and inspired Word of God, and is profitable for doctrine, for reproof, for correction, for instruction in righteousness and for encouragement (2 Timothy 3:16–17) (Free Pentecostal Church of Tanzania 2008, p. 6).

In more traditional Pentecostal denominations, like FPCT, holistic ministry built on evangelisation has operated hand in hand with the provision of social services (Nyström 1998). Providing social services based on faith is one

²⁷ More recently the terminology of the "two kingdoms" doctrine has to some extent been replaced by the terminology of "two regimes" or "realms" (Lutheran World Federation 2016).

of the main objectives highlighted in the FPCT constitution. Article 7.1 states:

To uphold practice and promote the Pentecostal faith and doctrine and to preach and propagate the Gospel in Tanzania as well as outside Tanzania through every possible means in accordance with the Great Biblical Commission of Jesus Christ. The local church is the foundation of ministry and testimony (Mark. 16:15; Matthew 28:19–20) (Free Pentecostal Church of Tanzania 2008, p. 7).

It is possible to conclude that social doctrine and theology is central to the health work of TEC and ELCT, in particular within TEC. In FPCT, theology and the faith foundation of the health work is still profoundly expressed, even though interviewees do not refer to a central social or theological doctrine as such.

Theologically motivated restrictions on sexual and reproductive rights

Religious beliefs and convictions appear to be a problem for the realisation of sexual and reproductive health and rights (SRHR). A clear example related to the Catholic social doctrine is the Catholic approach to family planning. According to most Catholic interviewees, the doctrine does not allow them to hand out or promote contraception at their facilities. This topic is reflected in other studies, where theologians and ethicists, particularly those involved in healthcare, argue over whether or not the Catholic Church has an officially articulated position on condom use in relation to HIV/AIDS. Most Catholic professionals simply follow their own conscience or simple common sense (Gifford 2016). This matter, however, is found to be a critical factor to consider for effective implementation of the Public Private Partnerships, as the Catholic Church and the state have conflicting views on the use of contraceptives and the realisation of sexual and reproductive health and rights.

A TEC Health Department officer is one of the interviewees most clearly stating that distributing condoms is not accepted by the TEC (Interview 16). Another TEC Health Department officer agrees in this critique. She also defends the TEC position, even though she also acknowledges some of the related challenges:

Natural family planning is perceived as good and okay, and the government is not opposing but is with us. But many do not understand the method all that well. It is not very clear to many people, so we are trying to educate them, especially mothers. Moreover, this method needs both men and women. Sometimes we face the challenge that most of our people in villages are drunkards, and if he's taking alcohol it is not easy to educate him. And this

method needs both of them in order to be compatible with the preventive system for the mother to work, so they can plan from time to time (Interview 18).

Several public officials raised this issue as critical, in particular at the local level in relation to the Council Health Management Team (CHMT). In the Mvomero District, in the first case study, a CHMT representative for instance brought up a conflict between, on the one hand, the public health goals with promotion of contraceptives and, on the other hand, the Catholic doctrine on natural family planning practiced at the Turiani Hospital (Interview 40). The HIV/AIDS coordinator from the same council expresses similar critique:

They don't allow condoms at their hospital, so in one way or another it affects us in the war against HIV/AIDS. However, what they normally do is that if they have a case of STI or RTA, they used to refer the patient to the nearby public health facility for those who need condoms or contraceptives; for example to the public dispensary or Mtibwa Sugar Hospital (Interview 39).

An interesting finding comes from interviews within the Ministry of Health, where the interviewees are less critical of the Catholic Church and their theological standpoint on contraceptives. According to a public health officer at the ministry, it is acceptable for the Catholic Church to deny women reproductive health services. Although the public authorities acknowledge that these services have to be offered somewhere, in this instance they instead chose to address the importance of public health authorities taking on the role of complementing the church instead of making it a requirement in PPPs. A public health officer says:

Usually they stick to their religious norms, so even if you enter into a service agreement with them and if their religion says that they don't have to offer family planning, then they are not going to offer family planning. It then means that the council or the person who enters into a service agreement with them has to see where these people are going to get reproductive and child health services. So it is not necessarily the case that these regional referral hospitals will have these services, but these services can be offered somewhere else at the council level (Interview 1)

This is a different finding compared to welfare and religion studies in Europe, where church organisations instead need to adjust to public health policy (Bäckström et al. 2011; Pettersson & Middlemiss Lé Mon 2012).

Still, several other interviewees from the Catholic Church stress that they generally follow public health policy. As an example, a TEC Health Department officer says the following:

On HIV/AIDS intervention, there are some areas where we can differ. For instance on the issue of condoms; we say we should concentrate on A and B (Abstinence and Being faithful). So in this instance, there are areas where we can differ but in principle what we implement is in line with what the National Health Policy requires us to implement (Interview 19).

Since this is identified as a tension, one may conclude that these issues need further consideration in order to make the PPPs more sustainable and in order to realise the sexual and reproductive health and rights for women in all contexts in Tanzania. However, it is also important to acknowledge that a new theological discourse has evolved since the Second Vatican Council, with new insights, new language and new praxis. This will most likely influence how the Tanzania Episcopal Conference will position itself in the future debate regarding the realisation of sexual and reproductive health and rights in Tanzania. It is important to note that in this study, mainly male representatives from the central Catholic Church (TEC) have been heard.

Health provision as a way to witness and glorify God

Based on the health policies and strategies of the three church organisations, a holistic approach to health provision is considered a way to witness and glorify God. This was also visible during my participant observation. As a very clear and visible example, the centrality of faith was well-demonstrated through the religious symbols at all three church-based hospital entrances. This was also stressed as a common theme presented in the interviews, that human beings are integrated wholes: spiritual, physical, intellectual, emotional and social beings. Another comment stated several times is that there is more to the concept of “health” than just the “absence of disease”, in particular in the respective official health policy. A TEC Health Department officer also discusses health as a key responsibility of the church’s mission. He says:

Of course there will be people who would argue that it is a government responsibility to provide health services. But if the church does not provide it, it is a sin against the mission (Interview 16).

Holism – a central concept

A common vision with regard to healthcare seems to be to spread the gospel and to evangelise with actions rather than words, by ministering to people in a more holistic way (body, mind and soul). As an example, FPCT refers to their healthcare by quoting Proverbs 31:8 “Speak up for those who cannot speak for themselves, for the rights of all who are destitute”.

From what I could see during my time conducting participant observation, the holistic approach to health is grounded on a close collaboration between local congregations and church-based hospitals. In general, the theological motives for health work are based on the teachings of Christ regarding helping those in need. Christian scriptural values are considered fundamental and most interviewees and policies refer to biblical texts and the complex notion of what constitutes a human being. According to several interviewees, the concern for one's health and wellbeing, as well as for the health of others, is seen throughout the bible. Several interviewees also refer to human dignity. A holistic approach is also stressed in the 2010 ELCT Health Charter:

We strive to treat each individual and family holistically by addressing the critical relationships between them and God, their fellows, and the environment (Evangelical Lutheran Church in Tanzania 2010, p. 5).

Religious values and theological motivations also influence the health services to a high extent in practice; for example, daily devotions for staff members and prayer and counselling for patients is offered at all three church-based hospitals on a daily basis. A chaplain or evangelist is also present at all church-based hospitals on a weekly basis. A TEC church representative has this to say about what a holistic mission means in practice:

Health work is part and parcel of our evangelising work. It sounds more social but we know from the point of view, the biblical point of view, we know that Jesus was preaching the Gospel. And at the same time as Jesus was preaching the word of God, he was healing. Therefore, the healing ministry of the church grows exactly from Jesus himself. So we take our health activities as part and parcel of our mission. In a sense, that a man is a body and a soul. We like to serve the soul but at the same time, we also like to serve the body. Because the body is an essential part of human beings, so we as the church would also like to serve the body, because the body is an essential part of the human being. So we as the church would also like to serve the needy, especially the sick (Interview 14).

Theological motivations and reflections frequently appear when the church leadership expresses the vision and mission for their health engagement. In the TEC case study, there is a strong emphasis on spiritual/psychological support as part of the Catholic healthcare services. A TEC Health Department officer stresses this in conjunction with the centrality of faith in their health services:

First, our role is to give care to the patients and on top of that, we do evangelisation. It is connected as we can follow the teachings of Jesus that he did not only feed the people but also cured them and taught them about the right way. We are trying to follow the same path as Jesus, to teach moral values, to take care of your psychical health as well as your spiritual and mental health. We need to connect to the mental and spiritual health, because sometimes

people don't need real medicine but counselling, so we talk to him or her and after that she or he is feeling better (Interview 18).

An FPCT hospital management representative stresses the centrality of the Christian mission when it comes to preaching the word of God:

The intention of the mission is to preach the word of God and give services to the poorest of the poor. It is true that they are receiving the word of God through our services, and still when you consider them economically, they are poor (Interview 57).

In one of the interviews from the ELCT case study, a church representative develops a line of reasoning around holism. Health ministry in a faith community is an approach to wholeness and health that builds on the strengths of the congregation. Holistic health ministry stresses wellness, health promotion and disease prevention by encompassing congregational partnerships. It focuses on body, mind and spirit for the health and healing of the community:

The general purpose of our health work is to serve a person holistically. If you provide health services to someone, it is our purpose to provide quality services in health. We serve even in rural areas where you have people who do not have the ability to afford medicine or hospital services (Interview 21).

This line of reasoning is also apparent in the official health policies of the respective church organisation. As an example, a long mission statement of the ELCT Health Department begins with a perspective on witness:

To witness and glorify God through provision of holistic, affordable and accessible quality care supported by community and other stakeholders (Evangelical Lutheran Church in Tanzania 2010, p. 4–5).

Many interviewees argue that human beings are created to exist in relationship with God, the creation and other people. They stress that humans are not created to be divided, either within themselves or in relationship to God or the community. Several church leadership representatives say that humans are spiritual beings, created in the image of God with unique gifts to be used for contributing to the surrounding community. Many interviewees address these aspects under the label of Christian people's mission. To give another example of this, a hospital management representative discusses the holistic mission:

We are providing our services as part of the mission of Christ (Interview 57).

Despite the fact that such issues of mixing health and medical care with a religious agenda are controversial in discussions at the global level, they do

not seem to be discussed at all that much in the Tanzanian context, except when Catholic natural family planning is concerned. Some of the interviewees express viewpoints directed towards religious and social change in this field, where they argue that they have moved beyond evangelisation towards a more rights-based approach to healthcare delivery where they primarily advocate for the realisation of health rights. This is particularly true with regard to representatives from the ELCT case study. As an example of this, I include a statement from an ELCT Health Department officer:

Initially, health services within Christianity were about spiritual, mental and psychical care, so all of these were supposed to assist in evangelism. Recently, since 10–15 years back, it has really changed. Now it is not a matter of evangelism but it is a matter of human rights, so it is more part and parcel of the rights of the people. Who initiates? It is the church as part of the civil society or it might be the people themselves. So sometimes even the Lutheran Church has mobilised people to start something, but to leave it for the government. So we are participating in ensuring the rights of the people, the health rights of these people to be realised. Some years ago if you went to a church facility, the first thing you would expect is to get preachers preaching for you, preaching the gospel before they give you drugs and whatever, but now it is a little bit different. Now it is more about the right to health and the rights of people (Interview 25).

An unexpected finding is that the three studied church-based hospitals offer similar holistic and spiritual services, so the differences between Catholics, Protestants and Pentecostals within Tanzania is much less significant than when comparing the Tanzanian churches with churches in similar religion and welfare studies in Europe (Bäckström et al. 2011; Pettersson & Middlemiss Lé Mon 2012).

Morning devotion – an established routine

When conducting participant observation at all three church-based hospitals, I noted that morning devotion took place at all three hospitals with obligatory attendance for all staff. From the TEC case study, a hospital management representative explains the routines surrounding morning prayer:

Every morning we meet here in the meeting room and then we pray, we sing. After that we give our report, and after reporting everybody starts to work (Interview 34).

A hospital management representative from the ELCT case study describes similar morning routines:

They always start with a morning devotion, with a word of prayer. We are in the church. Most of the staff cooperate well. Most of the experienced nurses

here are compassionate, and they know the mission and the vision (Interview 46).

Another hospital management representative in the ELCT case study emphasises that doctors are expected to pray with their patients (Interview 43).

An FPCT hospital management representative confirms that they have regular morning-prayer and that they pray with patients in the different wards:

In the morning after someone has been appointed for morning prayers, they come, the pastor or others, they come to the Outpatient Department (OPD). The OPD is the centre for all patients and other relatives who came there. They preach. After preaching, before the doctors make their round, they go to the wards. Even in the afternoon. Because some of the patients may come after morning, 10 to 12 o'clock. They pass through the wards to pray for patients in their rooms. And to advise them, maybe they can accept their God, and pray for them (Interview 54).

In several of the interviews with the Christian Social Services Commission (CSSC), the interviewees stress the routine of morning prayer. To give an example, one CSSC officer says that:

Usually all FBO health facilities have prayer in the morning. They do morning prays at 8.00 am and they have a church inside the campus. The patients, they like this because the people have this spirit and if people are there and have these difficulties, they value that spirit and this community more than that of the government. In dioceses, you see that within the management, there is a bishop and sometimes the bishop comes there and the staff is also more committed because they work for a religious institution (Interview 9).

Christian health ethics are also addressed by several church leaders and health professionals, but not by all. Several interviewees stress the role of Christian ethics; for instance, a national ELCT Health Department officer explains:

Since faith-based organisations started, they have created a very good public impression that faith-based organisations provide quality care and that the services provided are accompanied by a Christian ethic. Actually, many clients have left even referral hospitals at the government level just to come to a mere hospital in our facilities, because they expect quality services provided by professional people showing professional ethics (Interview 24).

Morning devotion is a central gathering at the church-based hospitals. When considering inter-faith dimensions of the partnerships and other developments at the hospitals, one should take the role of these gatherings more into consideration.

Chaplain – a central agent

All three case studies show that individual prayer and counselling was offered to all inpatients at the church-based hospitals. These services were offered by a chaplain; in the TEC and ELCT case by a priest and in the FPCT case by an evangelist. There was a chaplain or evangelist present fulltime at all three hospitals. In the TEC case study, a national church representative says that:

When one is in need of not only physical support, but also spiritual/psychological support. And as you might have read in our health charter, we're saying that every health facility should have that kind of support. In that way you help the attitude of health workers and if they live in situations where they are not supported psychologically and spiritually, they might not do well because they are constrained by their own problems. So that element of providing spiritually for each of those patients as well as for the providers help them do better. The workers will be reminded that it is not just a scientific process (Interview 14).

The chaplain's spiritual services are emphasised by the interviewees and expressed in the different health policies. The ELCT Health Charter states:

We hold the core value of prayer as a means for continuous improvement, and forgiveness as a means to reconcile when we have failed each other (Evangelical Lutheran Church of Tanzania 2010, p. 5).

I discovered a difference between the cases concerning the chaplaincy. The ELCT case study has a history of running a professional Clinical Pastoral Education that goes back to 1972 when the Kilimanjaro Christian Medical Centre hospital was established in Moshi in northern Tanzania. The program has ever since served to empower pastors, deacons and health professionals in the Evangelical Lutheran Church in Tanzania (ELCT) and other faiths to be able to provide pastoral and spiritual care services to patients, their families and community members at large. Even for the TEC case study, there is a tradition of educating chaplains. However, for the FPCT case study, there is no organised system; instead, the function of chaplain is adopted by the local pastor and evangelist in the nearby congregation.

Local congregations – a hidden resource

The case studies demonstrate that local congregations are used as an important venue for meetings and discussions on challenges that affect the local community (Lutheran World Federation 2016). Members of the different congregations often have the chance to talk about health issues not only from the pulpit, but also in smaller groups. Apart from offering a venue for con-

versations on health matters of shared concern, local congregations play an important role in supporting a holistic approach to health. This was in particular observed concerning ELCT and FPCT during participant observation.

Promotion of health during church services

Since religious messages and sermons often touch people's hearts, minds and actions, they can have strong influence over attitudes and even change behaviour. I found examples whereby local congregations act as a resource for the church-based hospitals and a place where intangible religious health assets can be formed and nurtured. The nearby congregation is critical both for generating resources for the church-based hospitals (human, financial and spiritual) and for the mobilisation of volunteers, promotion of health-seeking behaviour and for creating legitimacy in the local community. Several interviewees stress that local congregations seek to improve the health of their members. As part of participant observations, I spent considerable time visiting nearby congregations and saw that the hospital management teams play a key role even at church; several of them gave testimonies, preached and so on.

Congregations also seem to be particularly useful in terms of mobilising volunteers for the church-based hospitals. Some church leaders refer to performative theology and embodiment of the Gospel. This was also clearly seen in the participant observations. As an example from the interview study, a national TEC Health Department officer confirms and exemplifies this phenomenon:

Of course we cannot say that we have a direct platform, but we conduct advocacy through the opportunities that come out of the implementation process but also in religious ceremonies and during Sunday services. Although we cannot declare that this is a direct platform where the church stands and speaks about this and that, but during religious ceremonies and celebrations, and also during Sunday services and other changes that come around, we conduct some advocacy on healthcare (Interview 19).

A study by the Swedish International Development Agency (Sida) conducted back in 1991 concluded that the potential of the local congregations was not fully utilised in the health work performed by the ELCT and FPCT. The local congregations could be used for outreach activities and community feedback, thereby increasing the sustainability of the health institution. The Sida study also found that a good relationship between the local church and the person in charge of the health facility was another necessary prerequisite for a church health facility to remain self-reliant and to be able to maintain an adequate quality in its services. For a sustainable health facility, the church plays the role of safety net in case of problems. For facilities that are

not self-reliant, the church plays the permanent role of being a lifeline (Dahlgren 1991).

Several interviewees think that people are willing to take instructions from a church leader with a long history in the community who bases his or her message on religious texts and lessons. There are areas where the government is unable to reach communities with relevant information, but where church leaders have the potential of influencing the moral-political climate by mobilising their members to alter their behaviour. In the most remote areas, people primarily organise themselves for livelihood and for religious practice, and several interviewees in the study refer to this potential.

Since religion is so deeply embedded in the lives of people in Tanzania and helps determine attitudes and decision-making, public authorities have tried to take advantage of this fact in their health-related information campaigns. An illustration of this is the example presented in Chapter 9, where the Ministry of Health has developed a national sermon guide in collaboration with religious leaders (both Christian and Muslim leaders) in order to influence what messages are being preached to the public in local churches and mosques. This was done with the purpose of increasing the promotion of health-seeking behaviour in all regions of Tanzania. Church leaders have responded positively to the initiative from its launch in 2011 and thereafter. A representative from the Christian Social Services Commission argues for the importance of utilising the arena offered by churches:

The role of religion is linked with the community. To do advocacy with sensitisation as part of education. Because if you equip the religions leaders well, because they have a broader network since they are meeting a lot of people in their congregations and you can see the frequency of meeting with them. They meet on a weekly basis and maybe sometimes on these special occasions, like marriage and counselling and things like that, we see a big opportunity that they can reach a lot of people no matter whether they are Christians or Muslims. So we need to equip them with adequate knowledge, appropriate knowledge concerning maybe malaria or HIV/AIDS, so when they meet with their congregations they can send the right messages and they can sensitise the people to go for counselling and testing and for people to adhere to treatment (Interview 7).

There are several other findings in the study pointing to the fact that public authorities and church leaderships work together for the promotion of health-seeking behaviour. This was made particularly clear in the interviews with representatives from the TEC case study.

Most interviewees argue that there are clear differences between different stakeholders in health and that there are distinctive ethics and a model of care grounded in faith at the three church-based hospitals in the study that differ from public hospitals. This is particularly true with regard to the TEC case study. A TEC Health Department officer reflects:

If you go to government hospitals, people might be lying on the floor because most of them cannot afford cost-sharing. Moreover, of course the reception. Client reception is better than if you go to government hospitals. The way in which you are received is not the same as when you go to an FBO institution. You also have the infrastructure and it is smaller and friendlier compared to government institutions. So to repeat, drug supply, provision of those services, in terms of surgery and medical care are in general better than in government hospitals. But most of all, I think, it is a question of management, that's what I think. In a private institution, you can afford to be innovative; for example, keeping an environment more acceptable for the people (Interview 16).

From the FPCT case, the patron at the Mchukwi Mission Hospital discusses the issue of abusive language, which he believes is more common among health professionals at public health institutions in comparison with staff at church-based hospitals (Interview 57). A national TEC church representative also brings up the question of abusive language:

The language and the way you see a patient is different. You do not just see them as they are coming for the services, but you must see them as humans created in the image of God. Therefore, we are trying to say in our nursing training that sometimes our nurses use abusive language, but they are not supposed to do that. If a lady comes and she wants to be pregnant and then instead of helping her, you start insulting her – now you're creating another problem and a new disease (Interview 15).

When attending the everyday work at the three hospitals, I found that Christian health ethics are stressed and are still addressed by medical missionaries and visiting doctors. It seems as if this is partly externally driven, but also integrated into the health messages in nearby congregations. I expected to identify a significant difference between the cases with regards to how often faith matters would be addressed, but what surprised me somehow was the similarities between the three case studies. One difference I noted, however, was among the visiting medical missionaries, whereby the Lutheran and Pentecostals were representing local congregations and missionary societies in the North, whereas they had more of a diverse secular-faith background when it came to the Catholics. An interesting finding is also that Tanzanian hospital staff members being engaged in the congregations is a reoccurring theme throughout my interviews.

Spiritual capital used in order to control resources within PPPs

A challenge found in the study relates to the strong collaboration that exists between the church leadership and hospital management. Due to the lack of competence among some of the church leadership regarding key principles and guidelines related to the operation of health facilities, new developments

are slow and hindered. This causes some frustration among health professionals within all three church organisations. Some interviewees stress the lack of knowledge on national health policy among clerics and bishops as being a true challenge.

I found a lack of strong leadership concerning the health work among the secretary-generals of the three church organisations. In all three cases, it looks as if the health work has been delegated to each national health department, whereas it does not seem to be a central priority in the overall organisational long-term strategies (e.g. Strategic Plan of the ELCT 2015–2025). In two out of the three case studies, a few of the interviewees argue that the appointment of hospital directors by the central church leadership is more based on tribal identity and internal politics than professionalism (Interview 43). These views are based on speculations and are thus difficult to verify, but they still tell us something about the perception of the central church leadership in terms of professionalism.

Thereby it looks as if religious authority and leadership on some occasions stand in the way for management development to take place at the church-based hospitals. In particular the interviewees from the Christian Social Services Commission (CSSC) bring forward such arguments when they claim that religious authority can stand in opposition to a professional management culture, as health facilities are governed by bishops and priests. As an example, a CSSC officer argues that:

The facilities are owned by the dioceses. The dioceses are owned by the bishop, and now the bishop is the one who appointed the management teams of the facilities based on his own criteria. So now there is no autonomy between the facility and the diocese. Sometimes the facility itself cannot make decisions without involving and informing the bishop, and sometimes the bishop has his own personal interests, so things are not moving (Interview 6).

The question of representation and power appears to be central in relation to this issue; both to which extent the religious leadership is legitimate, democratically elected and sanctioned by the broader religious membership base in the rural areas, and also who gets the opportunity of being the voice of the church organisations. These issues are crucial, since the church leadership is often linked to ethnicity, family ties, gender, age, etc. There are also some indications in the study that the church leadership might have their own financial interests in operating church-based hospitals. In the TEC case, for instance, since the ownership of the hospital was taken over by the diocese, a critical dialogue began regarding its financial interest in relation to this move. This was confirmed by the hospital director (Interview 31) and a few international visiting doctors from Holland. In these discussions it was suggested that the diocese had a specific financial interest in overseeing the hospital.

Faith identity as a non-negotiable factor

In the previously mentioned WREP project, the researchers found that through the contracting procedure, ideologically driven church organisations risk being forced into adopting methods not suited for their primary identity. Such a development “may end up killing the ideological heart which gives these organisations both identity and legitimacy” (Bäckström et al. 2011, p. 44). In a study focused on churches and Public Private Partnerships in development contexts, including the region of Sub-Saharan Africa, Pallant identified the danger of church organisations becoming domesticated by states in a similar way (Pallant 2012). When analysing the interviews with public health officers, it seems as if religion is frequently interpreted as a source of power to be both used and misused by certain interests. It looks as if religion brings along potential challenges and tensions into the partnerships, even though the faith identity appears to be a non-negotiable factor.

Fear of losing ownership over church-based hospitals

Within the scope of the study, the hospital directors openly discuss how the PPPs are influencing the identity of the church organisations. The representatives from the ELCT case study specifically reflect on this question. A hospital management representative discusses this question in more depth by stressing the risk of losing the identity as a church-based hospital:

Since we are a faith-based institution, we have our own principles and even in the CDH agreement, it is explicitly stated that the hospital is going to be run in accordance with the faith of the organisation. Therefore, we are running the hospital as a Lutheran hospital. Nevertheless, it is a designated hospital; we are not running it as a government hospital. However, the other side of this is that the CHMT does not understand this. They think that now when we are a government hospital, they can treat us like any other institution within the government. So that is what we have been trying to resist. We are a church hospital and we conduct our services and affairs according to our Lutheran faith. However, the other side of the coin is that the CHMT says that now that we are a CDH, we must follow the council regulations. We say yes, but the government, the district council does not own this facility. In fact, they wanted to introduce their government logo, and then I said no: “We will keep our own logo for the hospital, Selian Lutheran Council Designated Hospital. We are in partnership with you but it is our hospital. We provide services for everybody without any discrimination, but we are Lutherans so you have to respect that and that we run our services according to our Lutheran faith” (Interview 43).

Some church leaders, in particular from the ELCT, discuss the fact that church leaders need to stay alert to the risks of institutional isomorphism. What is interesting here is that these concerns seem more general. A Health Department officer expresses concern with regards to this:

There are people who have been very concerned about if the government is paying salaries for the staff, since it could mean that your identity won't be there. But although we are very cautious regarding our identity not being overtaken, we look at details; for example, the authority to recruit and fire is within the FBOs. After all, recruiting the good staff that you need or if you want to fire someone, it is a decision within the ELCT and that gives you more identity. Plus you have to plan and the government supports your plans and you have the governance bodies, and although the government also needs to be part of that in participating in decision-making, the infrastructure is owned by FBOs and therefore the maintenance is your responsibility. This means that looking at those principles, the identity is still maintained (Interview 24).

Despite these examples from ELCT interviewees, a majority of the other interviewees from the two other church organisations are relatively confident or at least hopeful that they will be able to keep their faith identity after entering into a closer relationship with the government based on contractual agreements. The PPP contract represents more secular-based funding in comparison with previous funding from Western churches, which was more grounded in the mission of the church.

Faith identity – an unregulated factor in the partnerships

I found that religion is only discussed and legally regulated to a very small extent within the partnership agreements. When reviewing the Council Designated Hospital and Service Agreement contracts, I found that the contracts neither restrict nor regulate the inclusion of religion and faith in the health service delivery. The guidelines only regulate and ensure a certain quality and standard of the health services delivered, while also ensuring that health services are offered to all patients without discrimination regarding religious identity or any other form of discrimination. As stipulated in the PPP contracts, the church-based hospitals have agreed to:

Treat all persons without discrimination, denominational inclination, or obligation to religious instructions or participation in worship (Ministry of Health 2007b).

In this sense, religion is referred to in relation to matters such as labour discrimination and patient rights. When addressed, religion is also referred to as an ownership component, since the facilities are faith-based and since the ownership will remain with the church organisations for all types of PPP contracts. The specific role of religious values and beliefs in these partnerships is not regulated.

Interviews with church leaders from all three church organisations confirm this interpretation of the contracts and this finding further points to the fact that church organisations are allowed to pursue their beliefs as part of

their health services. It is mainly in one specific area where we find tensions between church-based hospitals and public authorities, and this concerns the realisation of sexual and reproductive health and rights, in particular with regard to the Catholic Church.

The encounter of church-based hospitals with other religions

Another challenge related to the faith-identity found in the material was the encounter with other religions, both in terms of Muslim staff working at the church-based hospitals and in terms of encounters with patients with different spiritual and social needs as a result of not belonging to the Christian faith. Despite the related challenges, all three cases stressed that they were equal employers, and that all positions were open to staff of all faith. Below is an example from the ELCT case, Selian Lutheran Hospital:

At Selian Lutheran Hospital there are few Muslim employees, except for the medical interns receiving training. Among the Christians, there is a mix of Lutherans, Anglicans, Roman Catholics and Pentecostals (Memo 2e). However, the hospital policy states:

“The organisation is an equal opportunity employer. It gives equal access to employment opportunities and ensures that the best available person is appointed to any given position free from discrimination of any kind and without regard to factors like gender, marital status, tribes, religion and disability which does not impair ability to discharge duties” (Selian Lutheran Council Designed Hospital 2012, p. 5).

It is interesting that African traditional religion was perceived as a greater challenge than Islam. In fact, several of the medical professionals raised the challenge concerning African traditional religions, since many patients visit traditional healers before coming to the church-based hospitals, which often leads to mistreatment. A hospital management representative from the FPCT case study refers to African traditional religions and their health practices as:

An unnecessary severe and life-threatening condition (Interview 55).

The TEC case study interviewees, however, tended to view African traditional religion in more positive or inclusive terms.

Providing access to all religious groups is regulated by the government of Tanzania, the contractual agreements and also a result of the ethical and moral implications of the churches' Christian foundation. In the encounter with other religions, one could divide the religious challenge into two main questions: (1) religious challenges related to human resources, the place of Muslim health workers in church-based hospitals; and (2) patient-related

religious challenges, how to accommodate the spiritual and social needs of non-Christian patients.

The PPP contracts contain a clause that the hospitals should hire their staff based on merit and that they are not allowed to discriminate on the basis of religion. In fact, there were Muslims working at all three church-based hospitals, so it looks as if the policy is at least to some extent implemented. Still, it is clear from the study that Muslim health personnel have to adjust to Christian ethics, norms and routines at the respective hospitals. To give an example, an ELCT church representative says:

These doctors who are Muslims know that this is a church hospital, so they have to abide by our rules; for instance, if we are praying they have to be there, but we are not forcing them to lead the services. Although we are a church, our mission is not only to serve Christians, so if you can give services to someone who is not a Christian, why not having a doctor who is not a Christian. We want those who are coming to our hospital to know that our hospital belongs to the church. And if we state our mission, we say it is to serve someone holistically and they don't mind. Because when they come, they see on some of the posters that this is a Christian hospital (Interview 20).

All three church organisations emphasise that they offer their services to everyone, independent of the patient's religious background. From the TEC case, a church representative for instance says that:

The services we are offering are not services intended only for Christians. It is a service given to all Tanzanians, and even non-Tanzanians. It is a service given to a human being. Whether he is Christian or Muslim or something else. The best thing instead of saying that now you are giving money to the church and so on, it would have been if they were doing the same and getting the money from the PPP. Moreover, I am sure they could do it. They can solicit help from outside, even from Islamic countries, which are rich. That could help improve the people of Tanzania. But when we envelop ourselves with these stories of *Mfumo Kristu* and so on, it is a pity (Interview 14).

In the ELCT Health Charter, there are core values and principles, such as serving clients of all religions:

To serve clients with dignity, courtesy and respect and impartiality treating all people as equally deserving of the best quality of care possible (Evangelical Lutheran Church in Tanzania 2010, p. 5).

The implications of these values and principles are expressed by an ELCT Health Department officer:

We are making sure that our staff understands the greatness that individuals have to God. We say that this is an individual created by God like you are created by God and therefore you need to respect these as you respect your-

self. That is what makes our facilities different than other facilities and we see that in a holistic nature, even in our facilities. If there are Muslims, they should receive Muslim spiritual care. If there are those who believe in Christianity, they should receive Christian care from pastors or others and therefore we are saying that spiritual care is part of our care and that has proved very helpful in services for HIV/AIDS care where they need counselling and a belief. They should spiritually trust that this is something that will help them. So that is what we mean by Christian ethics (Interview 24).

To avoid discrimination of patients based on religious identity and affiliation, the Service Agreement contract says: “Through this Agreement the Government wishes to ensure that all members of the community irrespective of gender, colour, religious belief, ideology or economic status from all parts of Tanzania achieve access to high quality medical care. Church-based hospitals are therefore required to demonstrate that this is being achieved by maintaining information and records of clients” (Ministry of Health 2007b, p. 45). Representatives from all three case studies emphasise that they provide a variety of social services to the community regardless of religious affiliation, gender, ethnicity, economic status, linguistic differences, race or disability. This becomes clear when reviewing their activities and by interviewees discussing different spiritual and social needs depending on the patient’s religious background.

Key results

Religion is found to be a significant factor in health sector development in a number of different ways. The chaplains, pastors and evangelists are considered key individuals at the hospitals, offering spiritual services such as counselling, prayer and so on to both staff members and patients. All three church-based hospitals conduct morning prayers for all staff members and visitors, and all three hospitals offer health services to patients regardless of religious affiliation and belief. The local nearby congregations are found to work as a hidden resource in these activities. The case studies demonstrate that the social doctrines of the churches influence health practices. Despite the fact that the three church organisations are influenced by diverse social doctrines and different theological traditions, the role of religion manifests itself in surprisingly similar ways. The faith identity appears as a non-negotiable factor in the partnerships. What is surprising, however, is that the faith dimension is almost entirely absent when the Public Private Partnerships are formally discussed in terms of PPP policy and PPP contracts. Contracts do not recognise religion or faith as a significant factor and it is only brought up as a requirement of non-discrimination when delivering care and recruiting staff.

Table 13. Overview of the empirical findings related to research question 4

How does religion appear as a factor of significance in the contractual partnerships in health?
Found themes and categories
<i>1. Social doctrines and theology influence health practise</i>
The healing ministry of the church emphasised in church health policy
Theologically motivated restrictions on sexual and reproductive rights
<i>2. Health provision as a way to witness and glorify God</i>
Holism – a central concept in church-based healthcare delivery
Morning devotion – an established routine at church-based hospitals
Chaplain – a central agent at church-based hospitals
<i>3. Local congregations – a hidden resource in healthcare</i>
Promotion of health-seeking behaviour during church services
Spiritual capital used in order to control resources within PPPs
<i>4. Faith identity as a non-negotiable factor in the partnerships</i>
Fear of losing ownership over church-based hospitals
Faith identity – an unregulated factor in the partnerships
The encounter of church-based hospitals with other religions

11. The role of churches in development

The aim of this dissertation is to study the role of religious agents in development through the prism of contractual partnerships between Christian church organisations and the Tanzanian government in healthcare delivery. In this concluding chapter, the fifth research question is in focus: *What does the study tell us about the role of church organisations in Tanzania in terms of development beyond an instrumental perspective?* The analysis and discussion links the empirical results to the theoretical and analytical frame of reference presented in Chapter 2.

A new emerging global world order to consider in sociology of religion

It is evident that the role of religion in development is receiving increased academic attention due to changes in social science perceptions of the role of religion. This increased attention is also a result of the analysis of the developmental role of church organisations in the Tanzanian health sector. The public discourse on development has shifted from the role of religion in development being an unknown factor to religion becoming a more accepted and crucial element. This shift can be seen in new types of development research projects receiving attention in the public research domain, from “does religion matter to development?” to more general research projects on “how to systematically study the developmental role of religious agents” (Olivier 2016).

Religion is found to be a significant factor in the health service delivery of Tanzanian church organisations. However, this does not come as a surprise. In today’s Sub-Saharan Africa, an overwhelming majority of people say that religion is very important to them. In Tanzania, where the study was conducted, 95 percent or more of the population share this assessment. The growth of followers within the world religions is presently largely taking place in the Global South outside the West. This reality is increasingly shaping both the new global world order as well as scholarly debates in sociology of religion. Pentecostalism and related charismatic movements represent the fastest growing segments of global Christianity (Freeman 2012). This has been clear in my fieldwork in Tanzania, where charismatic elements are visible and highly integrated into the health services delivered even by main-

stream churches, such as the Evangelical Lutheran Church in Tanzania (ELCT). The increasing presence of charismatic elements in Tanzanian Christianity might explain why the variations between the three case studies were not as significant as I had initially expected.

The combination of a new emerging global world order along with “a religious turn” in development constitutes a new arena for sociology of religion.

Moving beyond a narrow instrumental approach

An instrumental and evidence-based approach concerning the benefit of working with church organisations in terms of gained health infrastructure and health service delivery has dominated research on the role of church organisations in public health systems. Jones, Petersen and Beckford are examples of scholars who question the rational and instrumental criteria advocating for alternative and more holistic perspectives (Beckford 2017; Jones & Petersen 2011). The concept of “intangible Religious Health Assets” has discursively influenced debates on religion and health in this direction and shed light on holistic and integral dimensions of religion and health in new areas and contexts (Gary & Cochrane 2012).

This chapter discusses results of the study that highlight a religious-development nexus beyond an instrumental approach. As found, the actions of church organisations are still to some extent conditioned by political reforms. However, what instrumentalists tend to forget is that a church’s identity is also rooted in principles of faith and social doctrine. Thereby the instrumental perspective is to some degree in conflict with the bottom-up and integral perspectives.

When studying the role of church organisations as developmental agents from an instrumental perspective, it is easy to miss their potential political and social role, their role as critical voices in relation to states and as agents of faith in the communities they serve. Integrating a bottom-up perspective highlights these aspects. One example of the findings from this perspective was that it seems as if religious tensions have intensified, as some Muslim voices are increasingly arguing that the Tanzanian state is favouring Christianity as a kind of “state religion” under the current PPP framework.

I discovered that the religious-health nexus in Tanzania is far more complex, integrated and paradoxical than I initially expected. From an integral perspective, I even question whether it is relevant or possible to distinguish between the entities of “religious” and “secular” as two separate realities in development contexts such as Tanzania. Spending long periods of time at church-based hospitals made me realise that church organisations operate health services based on both social doctrine, church doctrine, health ethics, public health policy and the Sustainable Development Goals. Church-based hospitals are faith-driven and theologically motivated, while at the same time

integrated into the public health system as Council Designated Hospitals. In most cases, these different secular and religious regimes, systems and values seem to go hand-in-hand in an unexpectedly pragmatic manner.

Religion – a significant and integral factor and not just an “add-on”

Religion was found to be a significant factor in health sector development in a number of different ways. This finding needs to be further considered in relation to the PPP reform at large. The chaplains, pastors and evangelists are considered key individuals at the hospitals, offering spiritual services such as counselling, prayer and so on to both staff members and patients. All three church-based hospitals conduct morning prayers for all staff members and visitors, and all three hospitals offer health services to patients regardless of religious affiliation and belief. What I found throughout my participant observation was that a “faith language” was applied on several occasions when discussing health. The centrality of faith was also well-demonstrated by religious symbols at all three church-based hospital entrances.

What comes as somewhat of a surprise, however, is that the faith dimension is almost entirely absent when the Public Private Partnerships are formally discussed in terms of PPP policy and PPP contracts. Contracts/agreements do not recognise religion or faith as a significant factor and it is only brought up as a requirement of non-discrimination, both when delivering care and when recruiting staff. Apart from that, religion or faith is not mentioned as an asset or a challenge in formal public health dialogues. At the same time, it seems as if many staff members at church-based hospitals work based on a holistic approach traditionally adopted by mission societies and medical missionaries.

The qualitative policy text analysis shows that theological motivation is frequently used when church organisations are expressing their vision and mission, as well as in their health performance. As a clear example, the healing ministry of the church is emphasised in two of the analysed health policies. The hospital directors in all three cases stress that upholding Christian values remains important for the hospital management teams. Social doctrine and theology also seem to have a strong influence on local health service delivery, in particular for representatives from the Catholic Church (TEC), whereas social doctrine seems to be less important for the Free Pentecostal Church of Tanzania (FPCT).

Despite the fact that the three church organisations are influenced by diverse social doctrines, the role of religion manifests itself in surprisingly similar ways, such as the routines around morning devotions at the church-based hospitals, the practice of chaplains, the role of prayer and Christian

counselling for patients and through an emphasis on Christian health ethics and faith. A majority of church leaders among the interviewees stress that church organisations are willing to embody the social gospel through participation in health sector development. Spreading the gospel through actions rather than words – in other words, holistic ministering (body, mind and soul) – is a term frequently used by several interviewees. To illustrate this, one church leader from the Catholic Church clearly stated that “if the church does not provide – it is even a sin against the mission” (Interview 16). My case studies also indicate that local congregations surrounding church-based hospitals play a key role in the mobilisation of health volunteers, promotion of health-seeking behaviour and in creating trust and legitimacy. A few of the sermons I attended as part of my participant observation reflected this. This is interesting in the sense that it contributes to a more holistic approach to health.

I have come across some PPP-related tensions between church leaders and health professionals, as it seems as if some bishops and church leaders tend to see the hospitals as a potential asset of the church. In fact, I found that religious authority may on several occasions stand in opposition to a professional management culture, as the health facilities are governed by religious authorities (bishops and priests) at the top and health professionals lower down in the hierarchy. All three hospital directors express this as a challenge, and they say that the church leadership lacks an interest in participating in national health planning and do not support a further integration of the hospitals into the national health infrastructure. I also found an example whereby some church leaders were accused of using a church-based hospital as an asset for a bank loan. The church-based hospital was used as a potential economic resource for the church organisation, which is different from being part of its core mission.

My analysis also found that some public health goals contradict religion-based values concerning sexual and reproductive health and rights, mainly with regards to the right to contraceptives. Restrictions on sexual and reproductive health and rights (SRHRs) are in particular brought up in relation to the case of the Catholic Church (case study I). It is worth noticing that the PPP contracts do not include a condition for the private health facilities to align with the public discourse on family planning. On the other hand, it seems as if Lutheran hospitals are moving faster than the state on some SRHR issues, which could lead to other forms of tension in the long run. However, as discussed above, the availability of these types of services is not discussed nor regulated in the partnership agreements, but is definitely a critical aspect of PPPs in health that needs to be further considered and researched.

Linking social capital strengthened

The partnerships are aiming for a further integration of church health facilities into the public health system, and the study confirms that the health work of church organisations has been further incorporated into the national public health system through the PPP policy. My case studies demonstrate that the strong political support for partnerships with church organisations delivering services on behalf of the Tanzanian state may still be troublesome. The question is finding a good balance between long-term benefits sustained by the churches as well as by the state. However, from my study it can be concluded that none of the three church organisations are sufficiently involved in comprehensive health planning in their respective local district.

The hospital in the TEC case has been integrated into the public health system in the Mvomero District through a Council Designated Hospital (CDH) contract since 2011. The ELCT case study hospital was integrated into the public health system through a CDH contract in 2012 that expires 2017 due to changed directives from the Council Management Team. During the time of the study, the FPCT case hospital has signed both a Grant-in-Aid contract with the Ministry of Health and negotiated and started to implement a Service Agreement, which was signed in 2012 and implemented in 2013.

All three church-based hospitals are strongly engaged in global partnerships outside the Public Private Partnerships. In the TEC case, the global partners are nowadays primarily Dutch and more secular in nature. The core partnership in the ELCT case is with the Evangelical Lutheran Church of America (ELCA) and a core group of medical missionaries, whereas the links in the FPCT case are mainly directed towards Pentecostal movements and other related development organisations in Sweden and Finland. All three cases are also connected with some sort of global friends association. These friends associations need to be recognised to a greater extent, as they seem to be influential.

TEC and ELCT both have more developed health departments within their respective organisation, in addition to an official church health policy, whereas FPCT does not. Public Private Partnerships (PPPs) have increasingly come to be recognised as a factor to take into account in global and national health policies. The three case studies show that the PPP reform in Tanzania has had profound consequences for the developmental role of church organisations. Hence, it is necessary to re-draw the conventional Western boundaries between religion, politics and ideology (Beckford 2003). In the Tanzanian context, these partnerships were introduced as an externally driven reform, primarily by institutional donors and international partner organisations. As a direct consequence, the Tanzanian state has been pushed to rethink both the state-market and the church-state relationship in order to put a greater emphasis on market logic and the role of civil society (Mkandawire 2011; Mallya 2008). By fulfilling the services of the state,

church organisations have moved to centre stage and gained more influence as a consequence of the political and economic reforms. Their potential as service providers, from an instrumental/rational logic, follows from their existing infrastructure, historical experience and capacity in the health sector. This means that the Tanzanian state has been unable to dictate the rules concerning the church-state relationship on its own. The development ideology behind the partnership reform is largely conditioned by donor organisations subject to rational and instrumental criteria (Beckford 2017). This, however, might change under the rule of the current president, John Magufuli, which is discussed at the end of this chapter.

The partnerships in health in the Tanzanian context seem to be an externally driven agenda promoting the participation of private actors in health, including the role played by churches in development. At the same time, the context related to these partnerships has become more competitive. Although international aid agencies acknowledge the importance of a strong national and internally supported health policy, Tanzania has been forced to adopt an externally “approved” approach to health in order to receive necessary external health funding. The background of this is the financial crisis of the 1980s after which Tanzania became dependent on external funds to meet its health needs. I have found that in all three cases, external non-Tanzanian partners are the informal initiators of the PPPs, where the church health departments serve as the advocators and the Ministry of Health serves as the facilitator. The church organisations are the initiators in all three cases and the Council Health Management Teams primarily act as local implementers.

Increased competition between the state and church organisations

The bottom-up perspective to development adopted in this study highlights the possible contributions of church organisations with regard to local level development in “the day-to-day lives of people”. My analysis shows that church leaders challenge state legitimacy, in particular at the local level, and several church-based hospital managers in the study are critical of local politicians who instead of strengthening the pre-existing church health infrastructure advocate for the establishment of new public health facilities. My case studies also demonstrate that Council Health Management Teams (CHMTs) wish to strengthen their legitimacy by expanding public healthcare instead of funding existing private services. Here, I have identified an existing tension between the public and the private within the PPP reform itself. It seems as if some Council Health Management Team officials perceive the strong influence of church leaders on people’s thinking, decisions and behaviour as a potential threat or as competition. Several church-based hospital managers in the study bring forward critique and confirm this observation –

that local politicians advocate establishing new public health facilities. The critique of the local governments might stem from the fact that the idea of PPP was never initiated by them, but was brought to them from national level and international actors.

My case studies demonstrate that the relationships between church organisations and the state are closer at the national level, through the Christian Social Services Commission where church organisations are becoming more and more closely linked to the state. Most interviewees find the collaborations with national public authorities (Ministry of Health) to work better than those with local governments (CHMTs). The ownership debate was brought up in several interviews and conversations concerning PPPs, and several church leaders consider the partnership with local governments important for the long-term security and stability of operating their hospitals. However, the analysis also shows that local governments do not deliver financial support to church-based hospitals in accordance with agreed contracts. It is hard to determine the amount of funding originally planned to reach the faith-based organisations (FBOs) but does not arrive due to this local resistance. There even seems to be ideological resistance from local governments in relation to partnerships with FBOs that most likely affects the level of funding redistributed at the local level.

Local governments question why the external financial support through “Global Health Initiatives” has largely remained outside the planning and priority structures at the local level. This shows an inconsistency between the national and the local governments and the agendas that are pushed, on the one hand, and those implemented on the other. But personal relations and the quality of these relations remain a key to success for collaboration. Hospital managers emphasise the importance of the personal factor, such as the religious background of the respective partners in the contractual partnership; something that might indicate an unhealthy dependency on interpersonal relations. The District Medical Officer (DMO) is often favoured by the church-related hospitals. Still, the executive powers of the DMO seem limited compared to the District Executive Director (DED).

Church-based hospitals look upon external funding from global health funds and other vertical health funds as crucial, as the public funding within PPPs is less than expected and agreed upon and does not arrive on time. Interviewees from all three church-based hospitals perceive these direct links between local church-based hospitals and global actors as crucial for their operations, even though they operate outside state structures and the PPPs. Despite agreements concluded between the government and church hospitals, external donors still play an important role in developing and maintaining church-related health facilities. This needs to be analysed further and taken into consideration in future developments of the PPP reform.

My case studies demonstrate that there is a staff exodus and national shortage of doctors, nurses, assistant medical officers and so on, which leads

to an increased competition for human resources in the health sector. Churches are rarely able to offer competitive wages, and staff at church-based hospitals increasingly look for better terms in the public sector. The obvious differences in social benefits for church-based staff compared to civil servants is a major source of frustration at church-based hospitals. Social benefits for civil servants include retirement allowances, health insurance and a social protection fund. However, my analysis shows that visiting nurses, midwives and medical students from abroad in several cases offset the human resource gap.

PPPs complicate the Tanzanian model of secularism

In the critical secularisation paradigm, some scholars are increasingly pointing towards a condition of tensions (Casanova 2011; Herbert 2003). I identified religious tensions at the Tanzanian national level when analysing the material. Several interviewees brought up the fact that certain Muslim groups believe that the state favours church organisations over private for-profit and other non-profit alternatives. The fact that church organisations dominate health partnerships has implications for the Tanzanian model of secularism with its emphasis on the equal treatment of Muslims and Christians. PPPs are seemingly interpreted by some as a privilege for certain faith groups.

During the years when the study was conducted, there have been growing tensions in the public debate concerning the secular model for negotiating religious pluralism in Tanzania. The fact that church organisations are better equipped when it comes to entering into contractual partnerships in the health sector in comparison to Muslim organisations has led to increasing tensions and frustrations. This might also partly explain why some Council Health Management Team members are critical of the PPP policy in itself. In some informal discussions, the state has been accused of actively favouring church organisations. “State favouritism of Christianity (*Mfumo wa Cristo*)” is a common slogan, which refers to the national debate on religious pluralism. A few critics argue that colonial patterns are reproduced through the partnerships, since they often require existing infrastructure. The result is that PPP reforms are becoming more provocative and complex in religiously diverse countries, such as Tanzania, compared to countries with a Christian majority, such as in Zambia. Another way of looking at this is that the PPPs have enabled the state to gain more control and also affiliate itself more strongly with moderate religious groups, such as mainstream churches willing to deliver services to everyone, regardless of religion.

The sustainability factor in PPPs

The analysis shows that the development role of churches is still driven by actors outside Tanzania. Within the PPPs, the key partnerships are not limited to the church hospitals and local governments, as officially seen in PPP contracts. They also include international missionary societies, global friends associations, Vertical Health Funds, the CSSC and the national level health departments within the church organisations. Church-based hospitals are governed by a complex structure with the church leadership at the top and the health professionals lower down in the hierarchy. Thereby the public private partnerships are multi-layered. This observation shows that it is important to design health policies that address more of the multi-stakeholder reality. Trust and transparency must be strengthened between all agents that are involved in order for these partnerships to be more effective.

Several interviewees express a view that health policy-making is conducted isolated at the national level in negotiations with external donors, where actors at the local level have little influence over health planning, budget priorities and health units. In these arrangements, Council Health Management Teams (CHMTs) and church health facilities at the district level become almost entirely dependent on the agenda set by joint agreements between external donor agencies and the national government. This agenda is based on the concepts of Service Agreements, bed and salary grants, pay for performance and contractual partnerships. These agreements are not sufficiently understood nor sanctioned by the public authorities at the local level. At the same time, several interviewees from the church organisations argue that CHMTs do not involve church organisations the way they should in the full process of comprehensive health planning.

As described above, church organisations do not work with health sector development in isolation, but are in complex ways linked to medical missionaries, church organisations in the Global North, as well as with the more secular friends associations that established the church-based hospitals in the first place. The case studies demonstrate that the prevailing dependency on missionary societies and medical missionaries is still much more significant than indicated in official documents, annual narrative reports, financial hospital records, hospital websites, etc. The transition may be described as having moved from formal decision-making powers to hidden agenda-setting powers and it is not farfetched to refer to it as a hidden influential factor. In all three cases, all new buildings designed and funded during the period of the study have both received financial support and assistance in construction/design from international church-related organisations. I found that there is a new and emerging type of development organisation replacing the traditional missionary societies at church-based hospitals, the so-called friends associations. These are founded in the West and more secular and informal in their organisational set-up, and this transition into friends associ-

ations might indicate a change from religious-based towards more secular-based funding of church-based hospitals from the West.

My analysis shows that churches are still closely associated with Western donors, even though the official purpose of the PPP reform is to strengthen the partnership with public authorities. For instance, it seems as if international doctors are involved in informal negotiations concerning the partnership agreements. A common argument among church-related organisations and other expatriates as to why they are still involved is that as long as health rights are not realised in Tanzania, it is a moral obligation to stay involved. All three case studies demonstrate that foreign missionary societies still to a high extent influence the development of church-based health services in Tanzania, both at the national and the district level. While contractual partnerships with local governments are more formalised, collaborations with external partners tend to be less formal and more based on social capital, such as trust and personal ties. External funding is in most cases earmarked for specific projects, developments and initiatives, as the church-based hospitals no longer receive external core funding for the hospitals. It seems as if external funding is primarily given through an inflow of infrastructure support and human resources like external medical staff.

A conclusion from my analysis of the three case studies is that if the church organisations are to survive in the health sector, they need to manage both cooperation and negotiation with the government and the external partners in order to get the necessary resources.

Increased resource dependency and lack of trust

Once integrated into PPPs, church organisations might on one the hand move their resource dependency away from international donors, while, on the other hand, increase their dependency on the state and private donations of a more ad hoc nature as complementary means. In these processes, church organisations depend on both self-generated and external resources for their survival.

Under the current PPP reform, church organisations are collaborating more closely with a state that is both authoritarian and to some extent corrupt (Mallya 2008). They might have moved from reducing their financial dependency on international partners, but have instead moved towards an increased dependency on the state. The partnerships aim for a further integration of the church health facilities into the public health system. However, my study makes it clear that all three church organisations are still only to a small extent involved in comprehensive health planning in the local districts. Most church representatives stress the fact that local public authorities do not involve private actors, such as church-based facilities, the way they are supposed to according to the contractual agreements with regard to the full process of local health policy-making. According to these representatives, the

partnership dynamics are top-down, where church health facility representatives are not perceived as agents, but rather as executors on someone else's behalf. Council Health Management Teams (CHMTs), on the other hand, argue that church health facilities lack the capacity or interest to engage in health planning at the local level. They accuse church-related health facilities of being more loyal to foreign partners than to the CHMTs, and this is probably true. In relation to these claims, my analysis indicates that church leaders and hospital directors mainly address the public private partnership in financial terms.

A core principle in these partnerships is the principle of delivering services for free to vulnerable groups (children under five, pregnant women and elderly people). This is referred to by the Council Health Management Teams as a regulation of patient fees. My case studies demonstrate that when this is implemented by the three church-based hospitals, it leads to a loss of income in terms of patient fees, for which they do not receive the compensation they are entitled to. All three hospital management teams express that they are not receiving compensation in accordance with the PPP contracts and the formula stipulated for block grants and basket funding. Lack of financial compensation (for these patient groups) has been closely related to a lack of comprehensive health insurance for the population, in addition to the fact that church-related hospitals mainly serve the rural poor population.

There also seems to be a lack of trust and financial transparency in church-state-donor relationships. Local governments have not disbursed agreed funds, resulting in church hospitals subsequently not receiving any patient fees or service compensation. Many CHMT members seemingly exhibit a lack of trust in church-based hospitals, and this is partially due to an absence of comprehensive financial reports and related comprehensive audits of church-based hospitals. CHMT members request that they are given an overview of the inflow of all funding to the church-based hospitals, which the hospitals are generally unable or unwilling to provide. CHMT members furthermore argue that in order to build trust, vertical health programmes need to be more integrated into planning and programming systems in order to improve transparency and subcontracting at the local level. However, this might work itself out in the long run, as the current government wants to introduce comprehensive health insurance for the whole population.

The critical voice function of churches challenged by the partnerships

Sociologists of religion have always been concerned with transformations in church-state relationships. Unfortunately, however, church-state relationships in Europe or the United States have in most cases been used as the key

empirical basis for the development of church-state typologies, even though this is about to change. An increasing number of sociologists of religion from the Global South are debating different tensions that exist between the different possible service providing roles of a church organisation. One example is Ignatius Swart, who argues that a partnership relation with the state represents a real danger of disabling the religious sector in terms of its critical role in speaking out against social injustice (Swart 2010).

As shown in my study, current transformations in church-state relationships in Sub-Saharan countries, such as Tanzania under the PPP reform, are increasingly taken into consideration, as religion more often manifests itself by entering the discursive space of civil society. Within the PPPs, it looks as if church organisations believe that their critical voice function in the public debate will be challenged as they move into more formalised public private partnerships. If the critical voice function is actively expressed and comes into conflict with the state, it may turn into a direct political role: in theological language, this is often called a prophetic critical role. In studies in the field of sociology of religion, this has also been labelled political diaconia, as this term means a demand for political action. This role, however, is complex, as church organisations might simultaneously both promote and restrict the realisation of health justice, depending on which health rights you emphasise.

In my analysis of the political and social dimensions of the partnerships within the bottom-up perspective, I tried to see whether Kramer's analysis on voluntary organisations could be a useful typology in a context like Tanzania. I analysed my material from a political and social perspective by asking whether the development role for the churches is to be service providers, to create good citizens, to be a critical voice in the debate or to create new innovations. Or possibly alternative roles? Just like non-profit organisations in general, church organisation may obviously have different functions in relation to the state and the public health system. I found that in relation to Kramer's typology, mainly the service provider and the vanguard roles were strengthened by PPPs.

However, considering other typologies and debates, like the South African welfare debate, there has been an increasing focus on developmental and people-centred approaches in relation to the concept of health service provision. It has been argued that resources should be directed to support development driven at the grassroots level in order to strengthen local initiatives and self-managing welfare provision. This function of voluntary organisations may be regarded as an additional category in Kramer's typology, a developmental role based on the bottom-up perspective. The developmental approach has an empowering emphasis and perspective on the division of roles between the provider and the people in need. The main task of the service provider is to empower people and to act as a catalyst for the people themselves taking action. This view is necessary in a situation of limited

resources, but is primarily motivated by the conviction that sustainable development must be people-centred and built from below (Pettersson et al. 2011). Nonetheless, state-dependency could make it more difficult to criticise flaws in the existing system and the way these are handled by the state. Something else I found when approaching my material from an integral approach was that there also seems to be a theologically motivated role based on social doctrine and the mission of the church: the mission to be a faith-centred development actor. This potential role also needs to be considered further in new developments of typologies for church-state relationships.

In previous research on FBOs and health, the developmental role of church organisations has largely been considered from an instrumental perspective and reduced to levels of quality and efficiency. But what this study has found is that there is not one particular developmental role for churches, as church organisations simultaneously take on many different roles in relation to public authorities in Tanzania. However, it is worth noting that it seems as if the level of existing church-state relationships is a decisive factor for the outcome of the contractual partnerships and for the different types of roles church organisations take on. This is crucial in order for new private non-profit actors to enter into PPPs and for the PPPs to be more grounded on comprehensive health planning than simply the existing health infrastructure. This is an important field and we need further research on new types of church-state models developed in light of Public Private Partnerships.

Some church leaders, in particular from the ELCT case study, feared losing their full ownership of the church-based hospitals. This viewpoint is linked to the wider discussion on how to safeguard the autonomy of church organisations. The case studies demonstrate an increased tension between the role of a critical voice and a more collaborative attitude towards the state. This could also be because we are currently witnessing a shrinking space for civil society in Tanzania in general.

In 2015, church organisations rejected a proposed new constitution reducing the freedom of media. The former presiding bishop of the Evangelical Lutheran Church in Tanzania (ELCT), Archbishop Alex Malasusa, issued a statement on behalf of the Christian Forum of Tanzania. The statement criticised the constitution-making process for not taking national values, human rights, and rule of law into consideration (Kidanka 2015). At the same time, the Tanzania Episcopal Conference (TEC) issued a pastoral letter signed by 34 Catholic bishops. In the letter, they argued that the constitution-making process had been lacking both integrity and transparency, stating that: “We still remember how the constitution-making process was conducted [...] the members of the Constituent Assembly were forced to act in fear. There was no transparency” (Tanzania Episcopal Conference 2015). The letter was circulated to about ten million Catholics throughout the country (Kidanka 2015).

In these developments, churches have been criticised for raising their voice on constitutional matters, democracy and human rights. The situation is further complicated by an increased financial dependency on the state, not least since the religious and political elites are interlinked and interconnected in complex ways. Due to the health partnerships, church organisations for instance increasingly attempt to influence policy makers through established systems rather than through more confrontational advocacy methods. Several interviewees, in particular from the ELCT and the FPCT cases, argue that it is crucial that churches maintain a critical voice, in particular when they cooperate closely with a state that is limiting human rights. However, the Catholic Church (TEC) does not express the same level of concern in terms of maintaining its independence from the state. This is most likely a result of the Catholic Church being more closely linked to the state.

In the more informal interviews, as part of the participant observation, a few of the interviewees expressed that the partnerships might lead to church organisations becoming domesticated by the state. Most church leaders agree that their organisations need to be clear about their purpose and intent in terms of sustaining a distinctive character and distinctive practices, while being alert to the risks of institutional isomorphism. Otherwise, they might risk comprising their autonomy and their role of being a critical voice and a watchdog with regard to the state.

Areas for further research

After the completion of this study, I have identified six research areas for further research: 1) Church-state relationships in light of shrinking space. This question concerns the shrinking space for civil society with regard to its capacity as a critical voice and the risks of aligning agendas with the demands of the Tanzanian state under the current PPP reform in health. 2) PPPs as a way forward for the state to promote less fundamentalist religious movements. This question is raised based on the fact that not all religions or denominations are promoted to the same extent in terms of participating in the PPPs. 3) Religious illiteracy among institutional donors. Despite the fact that religious agents are the most prominent partners in health partnerships, the donor community still lacks an awareness concerning the role of religion in development and public health systems. 4) Harmonisation of comprehensive health insurance and the influence this will have on the efforts of church-based health facilities in terms of realising health rights and the cost-sharing model regarding patient fees. 5) Religion and social cohesion in light of PPPs and the continued influence of PPPs on the Tanzanian secularisation model. 6) Global-local partnerships and the development of friends associations in relation to the local church-based hospitals, as this could indicate a

shift from religious-based to more secular-based external funding to these hospitals.

Overall, sociologists of religion need to gain a broader understanding of the relationship between religion and development in current health sector developments beyond an instrumental approach. My study serves as an empirical contribution from a specific development field, where I have illustrated different ways in which religion is a significant factor in church-based healthcare within the framework of Public Private Partnerships in Tanzania. Keeping in mind the critical processes of religious and social change brought on by the Public Private Partnerships in health, it is time to take the “religious turn” in development more seriously in sociology of religion. This especially concerns the study of social service provision and church-state relationships, and in particular the need to move beyond a rational/instrumental approach to the religion-development nexus.

Final remarks

Despite the fact that the participation of church organisations in PPPs continues to grow, two out of the three partnership cases in the study have ended as of 2017. The only remaining hospital with an existing PPP contract after June 2017 is the TEC case study, the Catholic St. Francis Turiani Mission Hospital. These changes have taken place after the study was completed in 2014 and are related to a shift towards increased nationalisation driven by the newly elected president Hon. John Pombe Magufuli. A possible interpretation of this development may be that it serves as a backlash to an earlier, more external market-driven model pushed by international institutional donors and sanctioned by former president Hon. Jakaya Kikwete. Another change that has taken place after the study was finalised concerns the local government reform, as the current president has addressed the need for moving back to a more centralised health system. It is therefore likely that the PPP contracts will be handled by the President’s Office for Regional Administration and Local Government (Tamesemu) at the central level in the future instead of the local governments and Council Health Management Teams (CHMTs). However, local governments and CHMTs will likely continue to manage PPP negotiations and structures, so key individuals within local governments will still play a crucial role. More recently, the current president informally announced that a harmonisation of comprehensive health insurance might also be developed. If this were to be implemented, it would likely influence the affordability and sustainability situation for church-based hospitals.

Since the current president Hon. John Pombe Magufuli was sworn in, Tanzania has taken a severe authoritarian turn (Paget 2017). The room for civil society to raise a critical voice against the government has been shrinking remarkably over the last years (Paget 2017; World Alliance for Citizen

Participation 2016). Members of parliament from oppositional parties have found themselves detained in prison for “uttering seditious words”, and other activities that would in other countries fall within the spectrum of standard oppositional politics (Marari 2016, p. 2). Human rights groups are vowing to challenge in court a number of the provisions in the act, which they allege violate rights guaranteed under the country’s constitution (Freedom House 2015).

As described, in response to this new development, some church organisations have strengthened their critical voice function in the public debate. The enactment of restrictive laws has led to a shrinking space for civil society, including church organisations (Legal and Human Rights Centre 2015).

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Appendix 1 – Interview guides

Interview guide A

Target group: *Representatives of church organisations on a national level (bishop, secretary-general, health department officers and CSSC officers).*

Type of interview: *Individuals – semi-structured*

This interview guide is constructed for semi-structured interviews with national level representatives of the health departments within the three church organisations, as well as with the church leadership of each organisation, in order to examine how they view their partnership with public authorities with regards to healthcare delivery. This interview guide is also designed for interviews with national CSSC officers.

The guide contains different types of questions. *The grand tour question* is designed to get the conversation started and is very general in nature. The *floating prompt questions* are questions used by interviewers to continue the conversation. However, identified important categories may not be dealt with spontaneously, which is why *planned prompt questions* are used for prompting the interviewee to consider areas of the topic that do not readily come to mind or speech. *Contrast prompt questions* are value-based with the aim of getting the interviewee to take a position. The prompts included in this guide aim at ensuring that all interviews have comparable coverage in the further stage of content analysis (Leech 2002).

GRAND TOUR QUESTION

- i. How would you describe the purpose and structure of your church organisation's healthcare delivery on a general level?
- ii. Have there been any changes during the last ten years regarding your organisation's role in the health sector?
- iii. Is there anything you would like to see changed regarding the organisation's current role in the health sector?
- iv. How would you describe the role of religion in your organisation's role as a health institution?

FLOATING PROMPT QUESTIONS

- i. What is your role and your responsibilities in the organisation?
- ii. How long have you held your position/been employed by the organisation?
- iii. Are you familiar with the Public Private Partnership policy in the health sector? (If yes) What is your general view on this reform?

PLANNED PROMPT 1: PARTNERSHIP WITH THE GOVERNMENT

- i. How do you view your church organisation's relationship with the government in general and to what extent has it influenced the role adopted by your organisation?
- ii. According to your understanding, has this relationship changed over time and (if yes), in what direction?
- iii. Can you remember any specific negative experience of your organisation's relationship with the government/state authorities?
- iv. Can you remember any surprisingly positive experience of your organisation's relationship with the government/state authorities?
- v. What is the current level of collaboration with public authorities in the field of health services (e.g. Service Agreement, CDH/DDH²⁸)?
- vi. Has subcontracting strengthened your partnership with the government?
- vii. In your opinion, what are the challenges linked to subcontracting with the state in the field of healthcare delivery?
- viii. What is your personal opinion of the cooperation between church organisations and the national and local government? If cooperation is encouraged by the government, which areas do you think are good for cooperation?

PLANNED PROMPT 2: THE POSITION IN HEALTH POLICY

- i. Does your organisation have a health policy and an explicitly expressed theological doctrine concerning healthcare? (If yes) According to your understanding, what is the formal position of your organisation in terms of engaging in not-for-profit healthcare services as stated in your organisational documents or theological doctrine?
- ii. In your opinion, should church organisations contribute to the public debate on healthcare? (If yes) How should the organisation contribute?

²⁸ CDH = Council Designated Hospital

- iii. Does your organisation have an advocacy platform on healthcare? (If yes) Does your organisation have an active voice in the social welfare debate?
- iv. In your opinion, to what extent has your organisation influenced the most recent national health sector reforms (e.g. POW,²⁹ the National Health Policy and HSSP³⁰)?
- v. According to the latest comprehensive Joint External Evaluation of the health sector in Tanzania, church organisations have tended to be relatively excluded from policy formulation. Do you agree with this conclusion? (If yes) What actions are taken by your organisation to further strengthen its role in health policy formulation at the council level?

PLANNED PROMPT 3: ROLES AND RESPONSIBILITIES IN RELATION TO PUBLIC AUTHORITIES

- i. In your opinion, what is the primary mission of your organisation?
- ii. In your opinion, why should your organisation operate healthcare facilities?
- iii. Do you believe that your organisation has a particular responsibility for certain groups of people in society? (If yes) Which groups and why?
- iv. Do all church organisation and denominations have the same role to play in the health sector? (If their roles are different, in what ways?)
- v. What do you think are the expectations of the Tanzanian population in terms of your organisation as a provider of healthcare services?
- vi. What do you think are the expectations of the representatives of the national authorities (e.g. Ministry of Health) in terms of your church organisation's role in healthcare provision?
- vii. What are your expectations in terms of the role of the public sector in the health sector (local authorities, regional authorities and national authorities)?
- viii. Are you familiar with the LGRP?³¹ (If yes) In your opinion, how well has the decentralisation policy (e.g. local government authorities) functioned, and what has the transformation of the Ministry of Health into a facilitative policy organisation meant for your organisation?

²⁹ POW = The National Health Sector Reform Programme of Work

³⁰ HSSP3 = The Third Health Sector Strategic Plan

³¹ LGRP = Local Government Reform Programme

- ix. According to your understanding, what is the current general level of collaboration between Council Health Management Teams/Council Health Service Boards and the local chapters/districts of your organisation?

PLANNED PROMPT 4: CRITICAL VOICE AND SUBCONTRACTING

- i. In your opinion, what are the benefits and risks of formal subcontracting?
- ii. Effective governance within a Public Private Partnership arrangement is a complex subject; what challenges have you and/or your organisation faced so far?
- iii. Given the importance of the strategy of supporting LGA³² in their efforts to strengthen council and district health services, the HBF³³ has been a particularly effective mechanism. Is there available on-budget funding through the HBF for scaling up some of your successful health partnerships within PPP programmes? (If yes) Which opportunities are available for your organisation to expand its current services?
- iv. In addition, are there available off-budget financial resources available for scaling-up your healthcare delivery (e.g. Service Agreements, etc.)?
- v. Which financial model is favoured by your organisation (Service Agreement or subcontracting)? Why?
- vi. In your opinion, does subcontracting limit or support your church organisation's ability to raise a critical voice in health policy-making?
- vii. What does subcontracting mean with regard to your identity as a church organisation?

CONTRAST PROMPT QUESTIONS

- i. In your opinion, what is the greatest difference between the healthcare services provided by your church organisation and other healthcare providers in Tanzania (other FBOs/secular NGOs/private for-profit/public institutions)?
- ii. From a long-term sustainable perspective, what are your ambitions in the health sector (to expand your services and take over more responsibility for healthcare provision from the government and the

³² LGA = Local Government Authorities

³³ HBF = Health Basket Fund

- private for-profit sector, to constitute a complement to other actors or to gradually withdraw and hand over some services to the government or private companies)?
- iii. According to your point of view, are church organisations better candidates for operating healthcare facilities compared to other actors? (If yes) Why?
 - iv. In your opinion, is subcontracting in conflict with your church organisation's ability to raise a critical voice in health policy-making?
 - v. Is it preferable to seek funding and engage in sub-contracting with the government in comparison with church organisations from the global north?
 - vi. Is there anything you would like to add that we have not covered?

Interview guide B

Target group: *Public Health Officers from the Ministry of Health.*

Type of interview: *Individuals – semi-structured*

This interview guide is constructed for semi-structured interviews with official public health officers at the Ministry of Health in order to examine how they view their relationship with church organisations with regard to healthcare delivery and subcontracting.

The guide contains different types of questions. The grand tour question is designed to get the conversation started and is very general in nature. Floating prompt questions are questions used by interviewers to continue the conversation. However, important categories that have been identified may not be dealt with spontaneously, which is why planned prompt questions are used for prompting the interviewee to consider areas of the topic that do not readily come to mind or speech. Contrast prompt questions are value-based with the aim of getting the interviewee to take a position. The prompts included in this guide aim at ensuring that all the interviews have comparable coverage in the further stage of content analysis (Leech 2002).

GRAND TOUR QUESTION

- i. How do you view the healthcare delivery performance of church organisations in general and to what extent has the performance changed with the introduction of the Public Private Partnership (PPP) reforms?
- ii. Have there been any other major changes during the last ten years regarding the role of church organisations in the health sector?

- iii. What are the main successes and constraints in the process of implementing PPP programmes in collaboration with church organisations in the health sector?
- iv. What key interventions are required for further strengthening PPP programmes between public authorities and church organisations in order to make PPPs work for the maximum benefit of all stakeholders?
- v. How would you describe the role of religion in the health services provided by church organisations?

FLOATING PROMPT QUESTIONS

- iv. What is your role at the PMO-RALG³⁴/Ministry of Health?
- v. How long have you held your position?
- vi. What is your area of expertise regarding PPP in health?

PLANNED PROMPT 1: PARTNERSHIP WITH CHURCH ORGANISATIONS

- ix. What is your general view on the government's collaborations with church organisations within the framework of health sector PPPs?
- x. According to your understanding, have these collaborations and relationships changed over time? (If yes) In what direction?
- xi. Can you remember any specific negative experience in terms of your ministry's relationship with church organisations? (What? Why?)
- xii. Can you remember any surprisingly positive experience in terms of your ministry's relationship with church organisations? (What? Why?)
- xiii. What is the current level of collaboration between the government and various churches (e.g. Service Agreement, CDH/DDH³⁵) and in relation to other CSOs and private actors?
- xiv. Has subcontracting resulted in a strengthened partnership with church organisations?
- xv. In your opinion, what are the main benefits and challenges in relation to subcontracting with church organisations in the field of healthcare delivery? Local public authorities and church-based hospitals? If you believe that cooperation should be encouraged further by the state, which areas are more or less suitable?

³⁴ PMO-RALG = Prime Minister's Office – Regional Administration and Local Government

³⁵ CDH = Council Designated Hospital/DDH = District Designated Hospital

PLANNED PROMPT 2: CHURCH ORGANISATIONS' POSITION IN HEALTH POLICY

- vi. In your opinion, to what extent have church organisations influenced the more recent health sector reforms (e.g. POW,³⁶ the National Health Policy and HSSP³⁷)?
- vii. According to the latest comprehensive Joint External Evaluation of the health sector in Tanzania, it is stated that church organisations have tended to be relatively excluded from policy formulation, and also that the CCHP³⁸ has not yet become participatory beyond the boundaries of the Council Health Management Team. Do you agree with this conclusion? (If yes) What actions are taken by the PMO-RALG and the MOHSW to further strengthen the role of church organisations in health policy formulation?
- viii. The PPP reforms in the health sector are closely linked to the Local Government Reform Programme (LGRP), which aimed to decentralise personnel, planning and financing decisions concerning service delivery to the councils. How well did you at the PMO-RALG/MOHSW succeed in aligning your organizational structures, policies and processes to ensure further integration and better implementation for church organisations?
- ix. According to your understanding, do church organisations have their own health policies and an explicitly expressed theological doctrine on healthcare? (If yes) What, according to your understanding, is the formal position and the motives of church organisations for engaging in not-for-profit healthcare services and for entering into service agreements and subcontracting?
- x. In your opinion, should church organisations contribute further to the public debate on healthcare? (If yes) In what areas and at what levels?

PLANNED PROMPT 3: CHANGING ROLES OF THE CENTRAL HEALTH MINISTRY

- i. In your opinion, what has the LGRP³⁹ and the transformation of the MOHSW into a facilitative policy organisation explicitly meant for church organisations?

³⁶ POW = The National Health Sector Reform Programme of Work

³⁷ HSSP3 = The Third Health Sector Strategic Plan

³⁸ CCHP = Comprehensive Council Health Plan

³⁹ LGRP = Local Government Reform Programme

- ii. According to your understanding, what is the current general level of collaboration between Council Health Management Teams/Council Health Service Boards and church-based hospitals?
- iii. In your opinion, why should church organisations operate healthcare facilities within PPP regulations?
- iv. Do you think that these organisations have a particular responsibility for certain groups of people in society? (If yes) Why?
- v. Do all non-profit actors have the same role to play in the health sector? (If their roles are different) How are they different?
- vi. What do you think are the expectations of the Tanzanian population in terms of church organisations as providers of healthcare services?
- vii. What are your expectations in terms of the role of the public sector in relation to church organisations?

PLANNED PROMT 4: CRITICAL VOICE AND SUBCONTRACTING

- viii. In your opinion, what are the key benefits and risks of entering into subcontracting with church organisations?
- ix. Effective governance within a PPP arrangement is a complex subject; what are the main challenges faced by you regarding the integration of church-based hospitals into the national health infrastructure?
- x. Given the importance of the strategy of supporting LGAs⁴⁰ in their efforts to strengthen council and district health services, the HBF⁴¹ has proved to be a particularly effective mechanism. Is there available on-budget funding through the HBF for scaling up successful health partnerships with church organisations within PPP programmes? (If yes) Is there a possibility for church organisations to expand their services?
- xi. Are there available off-budget financial resources for church organisations to scale-up their health service delivery?
- xii. Which PPP model is favoured by church organisations (CDH or SA)?
- xiii. In your opinion, do PPPs limit or support the possibilities of church organisations in terms of raising a critical voice in health policy-making?

⁴⁰ LGA = Local Government Authorities

⁴¹ HBF = Health Basket Fund

CONTRAST PROMPT QUESTIONS

- vii. What public-private mix in health services provision is desired, and what are the concrete steps needed for achieving this?
- viii. In your opinion, what is the most significant difference between healthcare services provided by church organisations and those of other healthcare providers in Tanzania (secular NGOs/private for-profit/public institutions)?
- ix. From a long-term sustainable perspective, what are the ambitions of the government in the health sector (to expand public health institutions, to constitute a complement to other actors or to gradually withdraw and hand over additional services to private actors)?
- x. In which health services and in what ways do church organisations present comparative advantages compared to other public providers?
- xi. According to your point of view, are church organisations more or less suitable candidates for operating healthcare facilities in comparison with other actors?
- xii. According to your point of view, does religious involvement in service delivery affect state-building or state failure?
- xiii. Is there anything you would like to add that we have not covered?

Interview guide C

Target group: *Representatives of the health institutions of church organisations at local level. The management of each hospital (for example hospital director, hospital administrator, hospital accountant or/and hospital matron)*

Type of interview: *Individuals – semi-structured*

Due to the fact that Tanzania has decentralised the implementation of public-private partnerships through the Local Government Reform Programme, I want to gain more insight into variances of local collaborative forms, sub-contracting and informal stakeholders' relationships at the local level, which is why I for each church organisation integrate one local hospital for deeper study. With regard to each hospital, I examine financial policies and sub-contracts concluded between the church organisation, CSSC and district local government authorities and also conduct semi-structured interviews with the management of each hospital.

The guide contains different types of questions. *The Grand tour question* is designed to get the conversation started and is very general in nature. *Float-*

ing prompt questions are questions used by interviewers to continue the conversation. However, important categories that have been identified may not be dealt with spontaneously, which is why *planned prompt questions* are used for prompting the interviewee to consider areas of the topic that do not readily come to mind or speech. *Contrast prompt questions* are value-based and with the aim of getting the interviewee to take a position. The prompts included in this guide aim at ensuring that all the interviews have comparable coverage in the further stage of content analysis (Leech 2002).

GRAND TOUR QUESTION

- v. How would you generally describe the purpose and the structure of your hospital's healthcare delivery?
- vi. Have there been any changes during the last ten years regarding your hospital's role in the health sector?
- vii. Is there anything you would like to see changed regarding the hospital's current role in the community?
- viii. How would you describe the role of religion in your hospital services?
- ix. What are the current challenges facing the hospital (social, medical, financial, etc.)?

FLOATING PROMPT QUESTIONS

- vii. What is your role and responsibilities within the management of the hospital?
- viii. How long have you held your position/been employed by the hospital?
- ix. What made you decide to work at this hospital (Turiani, Selian, Mchukwi)?
- x. Are you familiar with the Public Private Partnership regulations in the health sector? (If yes) What is your general view on these regulations?

PLANNED PROMPT 1: PARTNERSHIP WITH THE LOCAL GOVERNMENT

- xvi. How do you view your hospital's relationship with the Council Health Management Team and to what extent has it influenced the development and management of your hospital?
- xvii. According to your understanding, has this relationship changed over time? (If yes) In what direction?

- xviii. Can you remember any specific negative experience in terms of your hospital's relationship with the local government? (What? Why?)
- xix. Can you remember any surprisingly positive experience in terms of your hospital's relationship with the local government? (What? Why?)
- xx. What is the current formal level of collaboration with the CHMT (e.g. SA, CDH/DDH⁴²)?
- xxi. Do you wish to develop and extend the current level of collaboration with the CHMT?
- xxii. Has subcontracting strengthened your partnership with the CHMT?
- xxiii. In your opinion, what are the challenges related to contractual partnerships with the CHMT in the field of healthcare delivery?
- xxiv. Have you faced any personal challenges when interacting with CHMT?

PLANNED PROMPT 2: THE POSITION IN HEALTH POLICY

- xi. Does your organisation have a health policy and an explicitly expressed theological doctrine on healthcare?
- xii. (If yes) What, according to your understanding, is the formal position of your organisation for engaging in not-for-profit healthcare services as stated in your organisational documents?
- xiii. What are the current challenges with regards to implementing health policy?
- xiv. In your opinion, should church organisations contribute to the public debate on healthcare? (If yes) What should this contribution look like?
- xv. Does your organisation have an advocacy platform on healthcare? (If yes) Does your organisation act as an active voice in the social welfare debate?
- xvi. In your opinion, to what extent has your organisation influenced the more recent national health sector reforms (e.g. POW,⁴³ the National Health Policy and HSSP³⁴⁴)?
- xvii. According to the latest comprehensive Joint External Evaluation of the health sector in Tanzania, church organisations have tended to be relatively excluded from policy formulation and the CCHP.⁴⁵ Do you

⁴² CDH = Council Designated Hospital/DDH = District Designated Hospital

⁴³ POW = The National Health Sector Reform Programme of Work

⁴⁴ HSSP3 = The Third Health Sector Strategic Plan

⁴⁵ CCHP = Comprehensive Council Health Plan

agree with this conclusion? (If yes) What actions are taken by your hospital to further strengthen your role in health policy formulation at the district council level?

PLANNED PROMPT 3: ROLES AND RESPONSIBILITIES IN RELATION TO THE LOCAL GOVERNMENT

- x. In your opinion, what is the primary mission of your hospital?
- xi. In your opinion, why should your organisation operate healthcare facilities?
- xii. Do you think that your organisation has a particular responsibility for certain groups of people in society? (If yes) Why?
- xiii. What do you think are the expectations of the population in this district in terms of your organisation as a provider of healthcare services?
- xiv. What do you think are the expectations of the representatives of the CHMT in terms of your organisation's role in healthcare provision?
- xv. What are your expectations in terms of the role of the public sector in the health sector (local authorities, regional authorities and national authorities)?
- xvi. Are you familiar with the LGRP?⁴⁶ (If yes) In your opinion, how well has the decentralisation policy (e.g. local government authorities) worked out in your district and what has the transformation of the Ministry of Health into a facilitative policy organisation meant for your hospital?
- xvii. According to your understanding, what is the current general level of collaboration between your hospital and Council Health Management Teams?

PLANNED PROMT 4: CRITICAL VOICE AND SUBCONTRACTING

- xiv. In your opinion, what are the benefits and risks of formal subcontracting at the local level?
- xv. Effective governance within a public-private partnership arrangement is a complex subject, what are the challenges faced by your hospital so far?
- xvi. Given the importance of the strategy of supporting LGAs⁴⁷ in their efforts to strengthen council and district health services, the HBF⁴⁸

⁴⁶ LGRP = Local Government Reform Programme

⁴⁷ LGA = Local Government Authorities

⁴⁸ HBF = Health Basket Fund

has been a particularly effective mechanism. Is there available on-budget funding through the HBF for scaling up some of the successful health activities at your hospital?

- xvii. In addition, are there available off-budget financial resources for you to scale-up your healthcare delivery?
- xviii. Which financial model is favoured by your hospital (Service Agreement or subcontracting)?
- xix. What does subcontracting mean for the identity of your hospital?

CONTRAST PROMPT QUESTIONS

- xiv. In your opinion, what is the most significant difference between the healthcare services provided by your church organisation and those of other healthcare providers in Tanzania (secular NGOs/private for-profit/public institutions)?
- xv. From a long-term sustainable perspective, what are your ambitions in the health sector (to expand your services and take over more responsibility for healthcare provision from the CHMT and the private for-profit sector, to constitute a complement to other actors or to gradually withdraw and hand over some services to the CHMT)?
- xvi. According to your point of view, are religious organisations better candidates for operating healthcare facilities in comparison to other actors? (If yes) Why?
- xvii. As far as you know, does faith play a role in the everyday duties at the hospital and in your staff's interaction with patients (nursing, treatment, counselling, etc.)? (If yes) What do you think of the religious services offered at the hospital?
- xviii. In your opinion, what are the responses from Christian patients who share the same faith tradition (how do they perceive religious services at the hospital)?
- xix. As far as you know, what are the reactions from patients who are not Christians and who belong to other faith traditions (how do they perceive religious services offered at the hospital)?
- xx. In your opinion, is subcontracting in conflict with your church organisation's possibilities for raising a critical voice in health policy-making?
- xxi. Is there anything you would like to add that we have not covered?

Interview guide D

Target group: *Representatives of the Council Health Management Teams, including the District Medical Officer for the respective council.*

Type of interview: *Individuals – semi-structured*

Due to the fact that Tanzania has decentralised the implementation of PPPs through the Local Government Reform Programme, I wish to gain more insight into variances of local collaborative forms, subcontracting and informal stakeholders' relationships at the local level, which is why I examine sub-contracts concluded between the church organisation, CSSC and district local government authorities and also conduct semi-structured interviews with representatives of the district local government authorities.

The guide contains different types of questions. *The grand tour question* is designed to get the conversation started and is very general in nature. *Floating prompt questions* are used by interviewers to continue the conversation. However, important categories that have been identified may not be dealt with spontaneously, which is why *planned prompt questions* are used for prompting the interviewee to consider areas of the topic that do not readily come to mind or speech. *Contrast prompt questions* are value-based with the aim of getting the interviewee to take a position. The prompts included in this guide aim at ensuring that all the interviews have comparable coverage in the further stage of content analysis (Leech 2002).

GRAND TOUR QUESTION

- vi. How do you view the healthcare delivery performance of church organisations in general and to what extent has this performance changed since the introduction of the Public Private Partnership (PPP) reforms in this council?
- vii. Have there been any other major changes during the last ten years regarding the role of church organisations in the health sector?
- viii. What are the main successes and constraints in the process of implementing PPP programmes in collaboration with church-based hospitals in this council?
- ix. Which key interventions are required for further strengthening PPP programmes between the Council Health Management Teams and church organisations in order to make PPPs work for the maximum benefit of all stakeholders?
- x. How would you describe the role of religion in the health services provided by church-based hospitals in this district?

FLOATING PROMPT QUESTIONS

- xi. What is your role within the Council Health Management Team?
- xii. How long have you held your position?

PLANNED PROMPT 1: PARTNERSHIP WITH CHURCH-BASED HOSPITALS

- xxv. What is your general view on the council's collaboration with church-based hospitals within the framework of health sector PPPs?
- xxvi. According to your understanding, have these collaborations and relationships changed over time? (If yes) In what direction?
- xxvii. What is the current level of collaboration between the CHMT and various FBOs (e.g. Service Agreement, CDH/DDH⁴⁹) and in relation to other CSOs and private actors?
- xxviii. Has subcontracting resulted in a strengthened partnership with church organisations?
- xxix. In your opinion, what are the main benefits and challenges related to contractual partnerships with church organisations in the field of healthcare delivery?
- xxx. What is your opinion on the cooperation between the CHMT and church organisations? If you believe that the government should encourage further cooperation, which areas are more and less suitable?

PLANNED PROMPT 2: CHURCH ORGANISATIONS' POSITION IN HEALTH POLICY

- xviii. In your opinion, to what extent have church organisations influenced the more recent health sector reforms (e.g. POW,⁵⁰ the National Health Policy and HSSP3⁵¹)?
- xix. According to the latest comprehensive Joint External Evaluation of the health sector in Tanzania, it is stated that FBOs have tended to be relatively excluded from policy formulation, and also that the CCHP⁵² has not yet become participatory beyond the boundaries of the Council Health Management Team. Do you agree with this conclusion? (If yes) What actions are taken by the council to further

⁴⁹ CDH = Council Designated Hospital

⁵⁰ POW = The National Health Sector Reform Programme of Work

⁵¹ HSSP3 = The Third Health Sector Strategic Plan

⁵² CCHP = Comprehensive Council Health Plan

strengthen the role of church organisations in health policy formulation?

- xx. The PPP policy in the health sector is closely linked to the Local Government Reform Programme (LGRP), which aimed to decentralise personnel, planning and financing decisions concerning service delivery to your local authorities. How well have you succeeded in the implementation of these policies in this district?
- xxi. According to your understanding, do church organisations have their own health policies and an explicitly expressed theological doctrine on healthcare? (If yes) What, according to your understanding, is the formal position and the motives of churches for engaging in not-for-profit healthcare services and for entering into Service Agreements and subcontracting?
- xxii. In your opinion, should churches contribute further to the public debate on healthcare? (If yes) In what way?

PLANNED PROMPT 3: CHANGING ROLES OF THE LOCAL GOVERNMENT

- viii. In your opinion, what has the LGRP⁵³ specifically meant for church organisations in your district?
- ix. According to your understanding, what is the current general level of collaboration between the CHMT and church-based hospitals?
- x. In your opinion, why should not-for-profit organisations, such as church organisations, operate healthcare facilities within PPP regulations?
- xi. Do you think that these organisations have a particular responsibility for certain groups of people in society? (If yes) Why?
- xii. Do all non-profit organisations have the same role to play in the health sector? (If their roles are different, how are they different?)
- xiii. What do you think are the expectations of the local population in this district in terms of church organisations as providers of healthcare services?
- xiv. What are your expectations in terms of the role of the public sector in relation to churches (local authorities, regional authorities and national authorities)?

⁵³ LGRP = Local Government Reform Programme

PLANNED PROMT 4: CRITICAL VOICE AND SUBCONTRACTING

- xx. In your opinion, what are the key benefits and risks of entering into subcontracting with church organisations?
- xxi. Effective local governance within a public-private partnership arrangement is a complex subject; what are the main challenges faced by your council regarding the integration of church-based hospitals?
- xxii. Is there available on-budget funding through the HBF for scaling up successful health partnerships with church organisations within PPP programmes? (If yes) What are the possibilities for church-based hospitals for expanding their current services?
- xxiii. In addition, are there available off-budget financial resources for church-based hospitals to scale-up their delivery?
- xxiv. Which financial model is favoured by church-based hospitals in this council (SA or CDH)?

CONTRAST PROMPT QUESTIONS

- xxii. What is your vision for the future in terms of the desired public-private mix in health services provision, and what are the concrete steps needed for achieving it?
- xxiii. In your opinion, what is the greatest difference between the healthcare services provided by church organisations and those of other healthcare providers in Tanzania (secular NGOs/private for-profit/public institutions)?
- xxiv. From a long-term sustainable perspective, what are the ambitions of the CHMT in this district (to expand public health institutions, to constitute a complement to other actors or to gradually withdraw and hand over additional services to FBOs, CSOs and private companies)?
- xxv. According to your point of view, are churches more or less suitable candidates for operating healthcare facilities compared to other actors?
- xxvi. As far as you know, does faith play a role in the everyday duties at the church-based health facilities in this district (nursing, treatment, counselling, etc.)? (If yes) What do you think of the religious services offered at the hospitals?
- xxvii. As far as you know, what are the responses from Christian patients who share the same faith tradition as the church-based hospital (how do they perceive religious services at the hospital)?

- xxviii. As far as you know, what are the reactions from patients who are not Christians and belong to other faith traditions (how do they perceive religious services offered at the church-based hospitals)?
- xxix. Is there anything you would like to add that we have not covered?

Appendix 2- Semi-structured interviews

Semi-structured interviews at the national level

Interview	Coding title	Official title
	Ministry of Health	
Interview 1	Public Health Officer 1	PPP Coordinator
Interview 2	Public Health Officer 2	Assistant Director of PPP
Interview 3	Public Health Officer 3	Former PPP Coordinator
Interview 4	Public Health Officer 4	Health Sector Reform Officer
Interview 5	Public Health Officer 5	Coordinator Regional Health Services
	Christian Social Services Commission (CSSC)	
Interview 6	CSSC Officer 1	Competence Centre Manager
Interview 7	CSSC Officer 2	Programme Director
Interview 8	CSSC Officer 3	Programme Manager
Interview 9	CSSC Officer 4	Technical Supportive Officer
	World Bank Tanzania	
Interview 10	World Bank Policy Specialist	Lead Health Policy Specialist
	IMA World Health	
Interview 11	IMA Country Director	National Director in Tanzania
	Tanzania Council for Social Development (TACOSODE)	
Interview 12	TACOSODE Officer 1	Executive Secretary in Tanzania
Interview 13	TACOSODE Officer 2	Policy Analyst
	Tanzania Episcopal Conference (TEC) HQ in Tanzania	
Interview 14	TEC Church Representative 1	Secretary-General
Interview 15	TEC Church Representative 2	Executive Secretary
Interview 16	TEC Health Department Officer 1	Chairman of Health Department
Interview 17	TEC Health Department Officer 2	HIV/AIDS Coordinator
Interview 18	TEC Health Department Officer 3	Maternal and Child Care Officer
Interview 19	TEC Health Department Officer 4	Policy and Advocacy Officer
	Evangelical Lutheran Church in Tanzania (ELCT) HQ in Tanzania	
Interview 20	ELCT Church Representative 1	Secretary-General – Social Welfare Department

Interview 21	ELCT Church Representative 2	Former Secretary-General – Social Welfare Department
Interview 22	ELCT Church Representative 3	Secretary-General Mission & Evangelisation
Interview 23	ELCT Church Representative 4	Deputy Secretary-General Mission & Evangelisation
Interview 24	ELCT Health Department Officer 1	Director of Health Department
Interview 25	ELCT Health Department Officer 2	Health Advocacy Officer
Interview 26	ELCT Health Department Officer 3	Technical Adviser
Free Pentecostal Church of Tanzania (FPCT) HQ in Tanzania		
Interview 27	FPCT Church Representative 1	Secretary-General
Interview 28	FPCT Church Representative 2	Bishop
Interview 29	FPCT Church Representative 3	Head Administrator
Interview 30	FPCT Health Department Officer	Head of Health Department

Semi-structured interviews at the local level

Interview	Coding title	Official title
Case I: St. Francis Turiani Mission Hospital (Local level)		
Interview 31	Case I Hospital Management Representative 1	Hospital Director
Interview 32	Case I Hospital Management Representative 2	Assistant Medical Officer
Interview 33	Case I Hospital Management Representative 3	Matron
Interview 34	Case I Hospital Management Representative 4	Reproductive Child Health Officer
Interview 35	Case I Hospital Management Representative 5	Ass. Reproductive Child Health Officer
Mvomero District (CHMT)		
Interview 36	Case I District Medical Officer	District Medical Officer
Interview 37	Case I CHMT Representative 1	District Health Officer
Interview 38	Case I CHMT Representative 2	District Health Secretary
Interview 39	Case I CHMT Representative 3	District HIV/AIDS Coordinator
Interview 40	Case I CHMT Representative 4	District Reproductive Health Officer
Interview 41	Case I CHMT Representative 5	District Social Welfare Officer
CASE II: Selian Lutheran Hospital		
Interview 42	Case II Hospital Management Representative 1	Foreign former Director of the Hospital
Interview 43	Case II Hospital Management Representative 2	Former Hospital Director

Interview 44	Case II Hospital Management Representative 3	Hospital Director
Interview 45	Case II Hospital Management Representative 4	Hospital Secretary
Interview 46	Case II Hospital Management Representative 5	Patron
Interview 47	Case II Hospital Management Representative 6	Treasurer
Arusha Rural District (CHMT)		
Interview 48	Case II District Medical Officer	District Medical Officer
Interview 49	Case II CHMT Representative 1	District Health Officer
Interview 50	Case II CHMT Representative 2	District Health Co-Coordinator
Interview 51	Case II CHMT Representative 3	District Laboratory Officer
Interview 52	Case II CHMT Representative 4	District Vaccination Officer
Case III: Mchukwi Mission Hospital		
Interview 53	Case III Hospital Management Representative 1	Acting Hospital Director
Interview 54	Case III Hospital Management Representative 2	Accountant
Interview 55	Case III Hospital Management Representative 3	Hospital Administrator
Interview 56	Case III Hospital Management Representative 4	Matron
Interview 57	Case III Hospital Management Representative 5	Patron
Rufiji District (CHMT)		
Interview 58	Case III District Medical Officer	District Medical Officer
Interview 59	Case III CHMT Representative 1	District Child Health Coordinator
Interview 60	Case III CHMT Representative 2	District Environmental Health Officer
Interview 61	Case III CHMT Representative 3	District Pharmacist
Interview 62	Case III CHMT Representative 4	District Laboratory Technologist

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