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BEYOND AN INSTRUMENTAL APPROACH TO RELIGION AND DEVELOPMENT – CHALLENGES FOR CHURCH-BASED HEALTHCARE IN TANZANIA

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Beyond an instrumental approach to religion and development – Challenges for church-based healthcare in Tanzania

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Find and download the full thesis at http://uu.diva-portal.org/smash/get/diva2:1148322/FULLTEXT01.pdf

Read more about Josephine's current research work on religion and development, public-private partnerships in health and global civil society at the Uppsala Religion and Society Research Centre, http://katalog.uu.se/empinfo?id=N10-692_1

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Introduction

Public Private Partnerships have become increasingly common in global health. Since health systems in development contexts tend to be weak and fragile, they are still dependent on receiving contributions from FBOs (Pallant 2012). Hence FBOs are given increasing space in policy-making and access to contractual agreements for accessing public health funding (Williams et al. 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). 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).

This raised interest at the global level can partly be explained by a shift in global politics and partly by a discursive transformation, a religious turn, within the social sciences and in international aid. 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). 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).

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).

There are of course many reasons to work for an increased knowledge about the role of religion in development cooperation. Among the major reasons are questions linking to ownership, sustainability and the effectiveness of development cooperation. It is not possible to make any broad generalisations on the role and function of religion since it differs from one societal context to another. By understanding the role of religious actors, new economic and political reforms can become more effective, legitimate and sustainable.

The Public Private Partnership reform (PPP) in health, which is in focus for this brief represents an example of an economic and political reform whereby religious actors are central. 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 notfor-profit actors (World Bank 2013; Itika et al. 2011).

It is therefore with great joy that I take on EBA's invitation to share with you the main contributions, findings and implications of my dissertation "Beyond an instrumental approach to religion and development – Challenges for Church-based healthcare" (November 24, 2017). If you are curious about religion and development, public private partnerships in health and the implications they have on the realisation of SDG3: the right to health, this report is for you.

Research design and general contributions

This dissertation is a contribution to the ongoing debate on the role of religion in development (Beckford 2017; Tomalin 2012; Bompani & Frahm-Arp 2010). My doctoral

research, as a first of its kind, deals with specific dimensions of Public Private Partnerships (PPPs) in health in Tanzania.

I have studied 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 were 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. 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?

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-forprofit type of agent (Bandio 2012).

Three theoretical perspectives were 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 were 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 has been 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 has been 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.

At the general level I found that 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. 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.

In particular, my dissertation presents a dilemma whereby Sida and other donors have come to strengthen and support privatisation reforms for service delivery in bilateral aid and a politics for a strengthened global civil society as two separate areas within development co-operation. My study has found though that these reforms are interlinked to a high extent as the same actors who are entering PPP are also to some extent human rights defenders. Consequently PPPs in health may have negative effects on the possibility for civil society organisations to raise a critical voice in response to a shrinking democratic space in a country like Tanzania.

Conclusions and Findings

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.

In the Tanzanian context, PPPs 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, is about to change under the rule of the current president, John Magufuli. 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.

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).

Increased competition between the state and church organisations

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 facilitates. 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 forprofit 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 Christo)" 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 associations 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

Within the PPPs, some church organisations believe that their critical voice function in the public debate is 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. 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 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). 255 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.

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. 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.

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). Churches and other 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 2016). 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 2016).

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