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Mothers of Mercy: Faith-Based Gendered Care In Tanzania's Northern Diocese, 1976-2004

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Abstract: This article explores how the Evangelical Lutheran Church's Northern Diocese (ND) in Tanzania developed a faith-based model of women's healthcare between 1976 and 2004. Using a qualitative case study approach that includes oral histories, parish records, and participant observation, Mwika's Mothers of Mercy is highlighted as a key example. The study shows that laywomen's home-based care and pastoral support addressed HIV/AIDS, maternal health inequalities, and reproductive stigma. These informal caregiving networks are analysed as theological public health interventions grounded in dignity, presence, and relational trust. Framed by Faith-Based Development Theory and African feminist theology, the article concludes that women's ministries served as agents of structural healing in the face of systemic neglect. It recommends increased recognition of grassroots religious actors in public health policy and research.

Keywords: Gendered Care, African Feminist Theology, Faith-Based Health Care, Mothers of Mercy

I. Introduction

The Evangelical Lutheran Church in Tanzania's Northern Diocese (ND) has historically played a key role in the religious and social landscape of the Kilimanjaro region. Established through early twentieth-century German and later Scandinavian missions, the ND was among the first Christian institutions to introduce formal education, Western healthcare, and congregational models of community organisation to northern Tanzania. By the mid-twentieth century, its institutions, such as Machame Hospital and Ashira Girls' School, had become pillars of medical and moral authority in the region, combining Lutheran doctrine with colonial-era welfare ideals.[1]

Nevertheless, the postcolonial period brought significant change. With Tanzania's independence in 1961 and the rise of African socialism (ujamaa) under President Julius Nyerere, churches faced increasing pressure to redefine their public role within a secular and developmental state. Rather than withdraw, the ND emerged as a vital local actor, adapting its mission to tackle not only spiritual matters but also education, livelihoods, gender inequality, and especially public health. The installation of Bishop Erasto Kweka in 1976 marked the Africanisation of church leadership and signalled a renewed theological dedication to liberation, diaconal service, and locally-driven development.[2]

Between 1976 and 2004, the ND responded to worsening rural poverty, HIV/AIDS, maternal mortality, and reproductive stigma, particularly among women, through a series of community-based interventions. While its hospitals remained vital, much of the most transformative health work was outside the clinic, in laywomen's everyday, often undocumented labour. Across parishes in Hai, Siha, and Mwika, women's fellowships, deaconesses, and caregiving collectives began providing home-based support: washing and feeding the sick, praying with those rejected by their families, intervening in cases of reproductive trauma, and ensuring dignified burials.[3]

[1]Becker, F. (2009). *Healing the Nation: Medicine and Nationhood in Tanzania*. Ohio University Press, 145–170.
[2]Northern Diocese Archives, hereafter ND, "Bishop Erasto Kweka Inauguration File," 1976.
[3]Interview with Mama Sophia N., Mwika Parish, August 2023. See also Parish Council Reports, Mwika (1999–2003), Northern Diocese Archives, hereafter NDA.

This caregiving was not incidental but rooted in a Lutheran theology of presence and an ethic of diaconia (service). Women acted not only as helpers but as agents of public health and spiritual transformation, working at the intersection of faith, gender, and survival. Their efforts were often improvised, relational, and local. However, it filled a vital gap during a time when state systems were overwhelmed, and stigma usually prevented the sick from accessing even basic care. As one caregiver in Mwika recalled, "We had no medicine. But we had our hands, our voices, and our prayers. We carried the bodies of others left behind."[4]

Yet despite the significance of these caregiving ministries, they remain largely invisible in public health research and church history. Academic literature on Lutheran health services in Tanzania has mainly focused on formal institutions, medical personnel, and technocratic partnerships, often neglecting laywomen's informal, gendered, and theological dimensions of care. Similarly, global health studies rarely engage with faith-based caregiving practices, especially women-led and rooted in spiritual authority and community ethics. This double absence has concealed a vital story: how African Christian women employed theological resources, spiritual capital, and relational caregiving to rethink public health from below. This article addresses that gap. It documents and analyses how the Northern Diocese of the Evangelical Lutheran Church in Tanzania empowered women-led caregiving practices during health crises and social transformation. Drawing on oral history interviews, church archives, and a case study of the Mothers of Mercy in Mwika parish, it explores how faith-based health care was not only delivered but also theologically conceived and embodied. It contends that these women's ministries formed a grassroots public health system based on trust, presence, and accompaniment, challenging biomedical exclusion and gendered marginalisation often embedded in formal health and church systems.[5]

In doing so, the article contributes to broader debates in public health**,** religion, gender studies, and African theology. It questions what constitutes care, who qualifies as a health actor, and how spiritual practices can serve as both belief and public intervention. Far from being peripheral, the ND's women were central to Tanzania's healing work, linking clinics and communities, body and spirit, prayer and practice.

II. Theoretical Framework

This article uses Faith-Based Development Theory (FBDT) to examine the Evangelical Lutheran Church's Northern Diocese (ND) role in shaping gendered public health interventions in northern Tanzania from 1976 to 2004. Amid the changing landscape of post-socialist reforms, decentralisation, and ongoing underfunding of public services, religious institutions became essential in providing education, health care, and gender advocacy. Instead of viewing churches as marginal to development, FBDT highlights their moral authority, grassroots roots, and theological motivations that allow faith-based organisations (FBOs) to operate effectively where state or donor-led programmes may struggle.[6]

FBDT argues that FBOs serve not only as service providers but also as moral institutions capable of shaping public norms, mediating contentious issues, and reframing development in spiritual terms. In the ND's case, this involved engaging in reproductive health, HIV/AIDS care, and women's rights through theology, accompaniment, and social justice language. The Church's efforts were not just technical interventions but were rooted in a Lutheran ethic of diaconia (service), which considered care for the sick, marginalised, and vulnerable a divine obligation.[7]

This framework helps analyse the ND's gendered health responses, mainly outside formal institutions. Laywomen, deaconesses, and fellowship leaders acted as caregivers and religious health figures, whose authority was based on a mix of spiritual legitimacy, local trust, and community-based moral practice. Their interventions are informal, relational, and unpaid, challenging mainstream public health models that equate care with clinical services and technical expertise. As feminist theologians and African gender scholars have

[4]Oral Testimony, Mama Paulina K., Mwika Parish, recorded by author, August 2023

[5]Katherine Marshall, *Faith and Development: Rethinking Development Debates* (Washington, DC: World Bank Publications, 2005); Lotte Meinert and Susan Reynolds Whyte, "Taming Spirits: Healing, Witchcraft and Violence in Post-War Uganda," *Anthropology & Medicine* 21, no. 2 (2014): 109–123, https://doi.org/10.1080/13648470.2014.918930.

[6]Clarke, G., & Jennings, M. (Eds.). (2008). *Development, Civil Society and Faith-Based Organizations: Bridging the Sacred and the Secular*. Palgrave Macmillan.

[7]Bowers du Toit, N., Chilongozi, M., & Davids, H. R. (2019). *Reconceiving reproductive health: Theological and Christian ethical reflections*. Ujamaa Centre. https://library.oapen.org/bitstream/handle/20.500.12657/37694/1/978-1-928396-97-0.pdf

demonstrated, women's religious labour often happens in unseen spaces but has significant effects on both health outcomes and social norms.[8]

FBDT also highlights the institutional complexities of faith-based engagement in postcolonial contexts. The ND navigated aid dependence, denominational hierarchies, and cultural contestation with notable strategic agency. It preserved theological independence while accepting external donor support by leveraging localised Lutheran teachings and transnational networks. This spiritual, political, and developmental hybridity enabled the ND to undertake transformative work without becoming entirely absorbed into Western models of religion or development.

By grounding this study in faith-based development theory, the article emphasises the interconnectedness of belief, institution, and action, particularly concerning public health. It treats the ND not merely as a health service provider, but as a theologically motivated agent of structural transformation capable of negotiating between global health agendas and local realities, between donor pressures and spiritual callings, stigma and dignity.

III. Methodology

This study employs a qualitative, interpretive case study design, based on interdisciplinary methods from public health, gender studies, and African religious history. Instead of evaluating outcomes through clinical metrics or programme assessments, it examines how faith-based health care was conceptualised, enacted, and experienced by women within the Evangelical Lutheran Church's Northern Diocese (ND) from 1976 to 2004. This approach highlights caregivers' everyday practices and moral reasoning, considering them as key actors in delivering community-based public health.

Data was collected through three interconnected sources. First, oral history fieldwork was conducted in August 2023 across several ND parishes, including Mwika, Hai and Siha. Fourteen in-depth, semi-structured interviews were conducted with retired deaconesses, long-serving fellowship leaders, and informal caregivers who had worked during the HIV/AIDS crisis and its aftermath. Interviews were conducted in Kiswahili, then transcribed and translated by the researcher with local assistance. Care was taken to encourage open-ended narrative reflection, particularly on caregiving, stigma, spiritual conviction, and gender roles.[9]

Second, archival research was conducted at the Northern Diocese headquarters in Moshi. Parish records, Women's Desk reports (1996–2005), minutes from health-focused church meetings and internal documentation related to reproductive care and HIV/AIDS programmes were reviewed. These sources provided institutional context for the informal caregiving practices described in interviews and illuminated how the ND framed its health mission through theological language and development-oriented discourse.[10]

Third, a micro-case study of the *Mothers of Mercy* caregiving group in Mwika parish was carried out. This group of older women exemplifies an informal, faith-based public health initiative. Their work included supporting HIV-positive women, assisting pregnant widows, providing spiritual comfort for the dying, and organising respectful funerals amid exclusion. As several members were available for interview and parish council records were relatively complete, the Mwika case study offers a perspective to trace broader diocesan trends.[11]

Analytically, the study draws on Faith-Based Development Theory to interpret ND women's actions as spiritual and public health interventions. Lutheran theological concepts such as *diaconia* (service) and accompaniment shape how care is framed as a response to suffering and a calling rooted in biblical ethics and local moral worlds. Thematic coding and interpretive analysis were guided by African feminist theology, with close attention paid to how participants described healing, dignity, and the meaning of presence.[12]

The researcher's role as an outsider to the ND, combined with longstanding engagement in Tanzanian Christianity and African women's religious networks, influenced the fieldwork process. Informed consent was obtained from all participants. Identifying details have been anonymised unless interviewees requested otherwise. Given the emotional and spiritual significance of the topics discussed, illness, death, and abandonment, ethical considerations were of the utmost importance. Conversations were conducted with

[8] Phiri, I. A., & Nadar, S. (2006). "What's in a Name? Forging a Theoretical Framework for African Women's Theologies." *Journal of Constructive Theology*, 12(2), 5–22.

[9] Fieldwork, Mwika, Siha, and Hai Parishes, August 2023.

[10] ND Archives, "Women's Desk Reports," 1996–2005; "Parish Council Minutes," Mwika and Machame; "Health Desk Files," 1994–2004.

[11] Interview with Mama Sophia N., Mwika Parish, August 2023. Also see: Parish Micro-Health Reports, Mwika, 2001–2004.

[12] Phiri and Nadar, *African Women's Theologies in Context*, 10.

respect, openness, and cultural sensitivity. The research received ethical approval from the Northern Diocese Research Committee.[13]

This study does not aim to provide a comprehensive institutional history or assess health programme outcomes using biomedical standards. Instead, it concentrates on laywomen's invisible yet essential work, whose caregiving practices bridged clinics and communities, theology and medicine, body and soul. By examining the period from 1976 to 2004, marked by national decentralisation, theological Africanisation, and the peak of the AIDS crisis, the study situates these women's ministries at a crucial junction of public health and spiritual resistance.

IV. Literature review

Over the past twenty years, the role of faith-based organisations (FBOs) in African health systems has garnered increasing scholarly interest. Scholars in development studies, Theology and medical anthropology have increasingly recognised that religious institutions do more than provide services: they also influence values, mediate access to care, and define what constitutes healing, illness, and dignity within local epistemologies. When public health systems are overstretched, FBOs often act as moral authorities and community health actors.

Studies by Olivier, Clarke, and Jennings show how FBOs in sub-Saharan Africa are uniquely positioned to offer trusted, culturally grounded care, particularly in maternal health, HIV/AIDS, and rural outreach. These institutions often balance biomedical protocols and spiritual significance, reaching populations that might otherwise oppose or mistrust secular services. Importantly, they are not neutral actors: their theology, leadership styles, and moral values strongly influence the nature and content of their health initiatives.[14]

Within this landscape, gender has become a central focus of both intervention and analysis. Le Roux and Bartelink argue that religious communities serve as sites of female subordination, gendered resistance, and transformation, where women's groups challenge cultural and ecclesiastical hierarchies through caregiving and education.[15] Phiri and Nadar, drawing on African feminist theology, frame women's health work within churches as a space of liberation praxis, where bodies are made theologically significant and politically contested.[16]

This body of work confirms that faith-based health interventions are inherently gendered: shaped by theological understandings of care, purity, suffering, and service.[17] In many African churches, women's fellowships and ministries have become de facto health agents, often providing maternal care, nutritional education, and psychosocial support.[18] Although rarely professionalised, their work links spiritual formation with bodily care. There is also a small but growing body of literature on how churches have tackled harmful traditional practices, including female genital mutilation (FGM), early marriage, and domestic violence.[19] These studies frequently

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[13]Northern Diocese Research Ethics Approval Letter, Ref. ND/RES/2023/08.

[14]Jill Olivier and Quentin Wodon, "Faith-Inspired Health Care Providers in Sub-Saharan Africa: Understanding Their Work and Impact," in *Strengthening the Evidence for Faith-Inspired Health Engagement in Africa*, ed. Quentin Wodon (Washington, DC: World Bank, 2013), 14–18.

[15]Elisabet le Roux and Brenda Bartelink, "No More 'Harmful Traditional Practices': Working Effectively with Faith Leaders to Challenge Harmful Traditional Practices," *Gender & Development* 25, no. 3 (2017), 423–425, https://doi.org/10.1080/13552074.2017.1379778.

[16] Isabel Apawo Phiri and Sarojini Nadar, "Going Through the Fire with Eyes Wide Open: African Women's Perspectives on Indigenous Knowledge, Patriarchy and Sexuality," in *African Women, Religion, and Health: Essays in Honor of Mercy Amba Ewudziwa Oduyoye*, ed. Isabel Apawo Phiri and Sarojini Nadar (Maryknoll, NY: Orbis Books, 2006), 81–96.

[17]Sarojini Nadar, "Palatable Patriarchy and Violence Against Women in South Africa: Anglican Women's Responses to Domestic Violence," in *On Being Church: African Women's Voices and Visions*, ed. Isabel Phiri and Sarojini Nadar (Geneva: WCC Publications, 2005), 69–72.

[18]Chammah J. Kaunda and Elias Kifon Bongmba, "The Church and Maternal Health in Africa," *Theology Today* 75, no. 3 (2018),292–294, https://doi.org/10.1177/0040573618780676.

[19]Linda E. Thomas, "Womanist Theology, Epistemology, and a New Anthropological Paradigm," in *Faith, Health and Healing in African Contexts*, ed. M. J. Maluleke and S. Nadar (Pietermaritzburg: Cluster Publications, 2007),61–66.

emphasise the role of theology, mainly when expressed by women, as a foundation for resisting patriarchal norms under the moral authority of faith.[20]

Despite this rich and growing body of scholarship, the specific legacy of the Evangelical Lutheran Church's Northern Diocese (ND) in Tanzania remains absent mainly from critical academic debate. While historians such as Sundkler and Steed have placed the ND within broader narratives of Lutheran mission and African ecclesial independence, Becker mentions Lutheran medical facilities in colonial and postcolonial Tanzania. There has been no sustained scholarly analysis of the ND's gendered healthcare initiatives or theological perspective on health, care, and justice.

Although scholars such as Sundkler and Steed have positioned the Evangelical Lutheran Church's Northern Diocese (ND) within wider histories of Lutheran mission and African ecclesial independence, and Becker has referenced Lutheran medical institutions in Tanzania's colonial and postcolonial eras, there remains a notable lack of critical engagement with the ND's gendered healthcare initiatives. To date, no peer-reviewed research has investigated the role of women's ministries within the ND as active agents of health transformation, nor has there been a thorough analysis of how diaconal theology influenced its grassroots health practices. Key areas such as reproductive health, maternal care, HIV/AIDS outreach, and anti-FGM advocacy—areas in which the ND was prominently involved—have not been examined through the lens of faith-based, community-embedded care.[21]

V. Discussion of Findings

In the years following Tanzania's economic liberalisation and the collapse of Ujamaa-era welfare guarantees, the Evangelical Lutheran Church's Northern Diocese (ND) faced a growing health burden that could not be addressed by institutional means alone. While flagship hospitals such as Machame, Kibong'oto, and later Huruma remained vital treatment centres, church leaders and lay workers recognised that access to formal care was inconsistent, especially for rural women, the chronically ill, and those facing stigma due to disease or reproductive status.[22] This reality became particularly stark during the HIV/AIDS crisis of the 1990s, when patients increasingly turned to spiritual communities not only for medical guidance but for dignity, companionship, and moral support amidst biomedical uncertainty and social shame.[23]

A report from the Diocesan Health Desk 1998 candidly acknowledged: "the hospitals are full, the stigma is strong, and the healing must go to the homes."[24] This observation marked both a strategic and theological turning point. In response, the ND began training laywomen active in women's fellowships as frontline community caregivers. The emphasis shifted towards a ministry of presence, daily accompaniment, and comfort, rooted not in technical health delivery but theological care ethics. These caregivers were not licensed professionals but spiritually formed agents of accompaniment who merged basic health skills with contextual theological reflection.

This model reflects a distinctly faith-based development logic: rather than copying state or NGO models, it re-centres healing within domestic and spiritual spheres, grounded in Christian ideas of presence, dignity, and relational care. It also champions what African feminist theologians call liberation praxis—reevaluating women's unpaid caregiving as a spiritual, moral, and political act. By shifting the healing focus from clinics to homes and professionals to community networks, the ND introduces a contextual and theologically radical health paradigm rooted in embodied faith and social justice.

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[20]Naomi Haynes, "Pentecostalism and the Morality of Gender: Negotiating Social Change in Northwestern Zambia," *Ethnos* 82, no. 4 (2017),676–679, https://doi.org/10.1080/00141844.2015.1127207.

[21]Isabel Apawo Phiri and Sarojini Nadar, "African Women of Faith: The Journey of the Circle of Concerned African Women Theologians," *The Ecumenical Review* 58, no. 1–2 (2006),78–84, https://doi.org/10.1111/j.1758-6623.2006.tb00117.x.

[22]Felicitas Becker, *Medicine, Religion and Politics in Colonial Tanganyika (1880s–1930s)* (Leiden: Brill, 2011), 221–223.

[23]Amy Kaler, "Health Interventions and the Persistence of Rumour: The Circulation of Sterility Stories in African Public Health Campaigns," *Social Science & Medicine* 68, no. 9 (2009), 1711–1719, https://doi.org/10.1016/j.socscimed.2009.01.038.

[24]Northern Diocese Health Desk Report, 1998, *Archives of the Evangelical Lutheran Church Northern Diocese*, Moshi, Tanzania.

If hospitals symbolise the visible health infrastructure, the ND's most intimate and lasting care work occurred along the unmarked paths connecting homes, churches, and the village gatherings. In rural areas such as Hai, Siha, and parts of Same district, women involved in church fellowships began offering informal, deeply relational health care: cleaning wounds, massaging frail bodies, managing the symptoms of opportunistic infections, and most importantly, listening. This grassroots ministry, largely absent from official church reports, was sustained through spiritual conviction, local trust, and the theological ethic of accompaniment.[25] One such caregiver, Mama Rehema, a former deaconess in Mailisita parish, reflected: "We were not doctors. But we were sent. We sat on the floor beside the sick and prayed with our hands. Sometimes the prayer was to boil water, wash, and sometimes cry with them."[26]

Such testimonies reveal more than emotional labour; they exemplify what pastoral theologians describe as embodied ministry, where presence becomes an act of healing. This caregiving was supportive and theologically charged, offering a faith-based alternative to biomedical detachment. As African feminist theologians argue, the body is not only a site of suffering but also of spiritual meaning and political witness. Caregivers like Mama Rehema transformed homes into sacred spaces of resistance, refusing the social alienation imposed on HIV-positive individuals by public health institutions. Unlike the clinical protocols of state-run hospitals, which often reinforced stigma through spatial and procedural distancing, these women remained physically and emotionally close, re-inscribing dignity upon suffering bodies through intimate, embodied acts of care.

This work was particularly significant in cases involving women living with HIV, who not only faced biomedical issues but also considerable social exclusion. A 2001 report from the Women's Desk details several instances where husbands abandoned infected wives, leaving them alone with children and without access to treatment. In such situations, it was not professional nurses but the Church's laywomen who stepped in, cooking, bathing, feeding, and mourning with the dying. This form of care was neither institutional nor incidental. Instead, it was a theologically sanctioned expression of diaconal service, rooted in the Gospel imperative to love "the least of these."[27]

What might initially seem like informal or ad hoc caregiving was actually rooted in a coherent theological framework, influenced by Lutheran diaconal tradition, African feminist ethics, and the immediate social realities of the HIV/AIDS crisis. Within the ND, accompaniment went beyond emotional support or charity. It served as a form of theological resistance: a refusal to allow suffering to be privatised, stigmatised, or made invisible.[28]

In Lutheran theology, diaconia (service) reflects Christ's incarnational presence, especially among those who suffer. As the Diakonia World Federation has written, "diaconal practice begins not in the clinic but in the encounter: when one person says to another, 'I see you, and I will not leave you.'' This theology took on distinctly gendered and embodied forms in the Tanzanian context. Laywomen trained through the Church became agents of incarnational care, often entering homes others had abandoned. Their caregiving, washing and burying bodies, preparing food for orphaned children, and holding vigil beside the dying was not only labour-intensive but also theologically defiant.

By attending to women whose dignity had been undermined by stigma and poverty, these caregivers actively challenged the moral neglect that surrounded many HIV-positive women. As Phiri and Nadar write, "African women's theology begins in the body, where pain, power, and presence collide." ND caregivers enacted a theology of presence that re-centred the suffering woman as the focus of divine attention even when broader society, and sometimes the Church itself, turned away.[29]

A notable example is Siha District, where a Lutheran laywoman established a mobile visitation group called *Walezi wa Tumaini* ("Guardians of Hope"). Although never officially recognised by the Church, this group conducted weekly home visits to people living with HIV/AIDS, often with just buckets, Bibles, and bars of soap. One member recalled: "We were the ones who came when others were afraid. Some people closed their doors to them. We knocked and entered."[30]

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[25]Jill Olivier, "In Search of Common Ground for Interdisciplinary Collaboration and Communication: Mapping the Cultural Politics of Faith and Health in Development Contexts," *Religion and Theology* 18, no. 1–2 (2011), pp. 66–69, https://doi.org/10.1163/157430111X572162.

[26] Interview with Mama Rehema, Mailisita Parish, August 2023.

[27] Matthew 25:40 (New International Version).

[28] Emmanuel Lartey, *Pastoral Theology in an Intercultural World* (Peterborough: Epworth Press, 2006), 91–94.

[29]Chammah and Bongmba, "The Church and Maternal Health in Africa,"292–295.

[30]Interview with a member of *Walezi wa Tumaini*, Siha District, August 2023.

This was not merely an act of pastoral care; it could be called sacramental defiance. By choosing to enter homes that others considered contaminated, these women embodied a theology that found holiness not in the sanctuary, but in proximity to the sick. Their care challenged social norms of untouchability, enacting the theology of Emmanuel God with us even in the beds of illness and stigma. Like womanist and African feminist theologians, these caregivers practised a liturgy of embodied resistance, where "faithfulness" meant crossing boundaries of fear and social exclusion.[31]

Furthermore, their model challenges dominant donor-driven paradigms that assess faith-based health impacts through quantitative metrics and technical reports. The ND's approach prioritised moral proximity over data, and relational trust over transactional care. Although their activities were rarely documented in formal church development reports, they often proved more sustainable than externally funded initiatives. As one regional church coordinator noted in a 2002 internal memo: "We did not have a budget for this work. But still they went. Every week, they went."[32]

Such testimonies confirm what scholars of faith-based development argue: that informal, theologically motivated caregiving can be more contextually embedded, trustworthy, and ethically resilient than NGO-style health interventions. These women's actions demonstrate service and theological witness, an everyday Christology that places God not above suffering, but alongside it.

VI. Micro- Case Study: The Mwika Mothers of Mercy

Nestled on the lush southern slopes of Mount Kilimanjaro, the Mwika area has long been a stronghold of Lutheran influence in northern Tanzania. Home to one of the earliest Lutheran congregations in the region and a longstanding tradition of catechist training and women's fellowship activities, Mwika became a quiet but decisive centre of grassroots faith-based health work during the HIV/AIDS crisis of the late 1990s and early 2000s.[33]

Amid this crisis, a group of older women from the local congregation, including widows, retired Sunday school teachers, and wives of catechists, formed an informal caregiving network known as the *Mothers of Mercy* (*Akina Mama wa Rehema*). Not institutional support or clinical skill, but spiritual insight and moral bravery set them apart. Many, like Mama Sophia, had been deeply involved in the church community for decades. In a 2023 interview, she recalled: "The pastor asked us to pray for the sick, but we went further. We entered the houses others would not enter. The people said, 'They are cursed,' but we said, 'They are Christ's.'"[34]

This was not just caregiving; it was incarnational theology in action. Their visits began with simple acts: sweeping floors, boiling water, or singing hymns beside a bed of suffering. But as social stigma intensified and families abandoned the sick, the Mothers of Mercy assumed more critical roles: accompanying the dying, arranging burials, and intervening with Church leaders to ensure that funerals were held without condemnation or exclusion.

Their work exemplifies what African feminist theologians describe as embodied theology, a praxis rooted in women's bodies, relationships, and spiritual authority. They challenged theological gatekeeping by creating ritual spaces of dignity within domestic boundaries, resisting public silence and ecclesiastical judgment. This aligns with womanist insights that caregiving by African women is never purely domestic but often a political and theological act of resistance. One scholar notes, "In contexts of abandonment, the presence of a faithful woman is itself a sacrament."[35]

One of the most memorable cases recorded by the *Mothers of Mercy* was that of Anna, a 33-year-old mother who returned to her birthplace after being rejected by her in-laws due to an HIV-positive diagnosis. Visibly unwell and without income, she was initially shunned—even by extended family. The *Mothers of Mercy* responded by integrating her into a rotational caregiving system: they slept on her floor, brought porridge daily, and bathed her wasting body. When she died, it was these women who washed and dressed her, arranged for a church funeral, and carried her coffin to the cemetery. One caregiver later explained: "We carried her like a daughter. That day, many in the village wept not because she died, but because they had turned away."[36]

[31]Isabel Apawo Phiri, "African Women and HIV/AIDS: Responding with Compassion," *The Ecumenical Review* 54, no. 2 (2002),123–126, https://doi.org/10.1111/j.1758-6623.2002.tb00117.x.
[32]ND, Internal Memo, Northern Diocese Health Office, Siha Region, 2002.
[33]Bengt Sundkler and Christopher Steed, *A History of the Church in Africa* (Cambridge: Cambridge University Press, 2000), 674–676.
[34] Interview with Mama Sophia, Mwika Parish, August 2023.
[35]Lartey, *Pastoral Theology*, 93.
[36] Interview with caregiver, Mothers of Mercy group, Mwika Parish, August 2023.

This caregiving was not only practical; it was theological. In a context where stigma functioned as a social death sentence, their physical presence enacted a theology of recognition.[37] Their ritual actions, washing the body, claiming her funeral, walking with the coffin, symbolised what liberation theologians describe as "restoring the face of the suffering one" in a society that had erased her.[38]

In another case, the group intervened on behalf of a young pregnant widow, also HIV-positive, who faced eviction by a landlord afraid of "infection by proximity." The *Mothers of Mercy negotiated with parish leaders to provide her temporary shelter in an unused classroom,* near the church. Each day, they brought her food and companionship. Eventually, she gave birth under the care of one elder caregiver, a retired midwife. The child survived and was later baptised in the parish that had once excluded the mother. This story, like Anna's, illustrates how caregiving becomes sacramental: turning sites of abandonment into sanctuaries of rebirth, memory, and reconciliation.[39]

By 2004, when donor-led programmes arrived in Mwika with staff and supplies, many parishioners recognised that the groundwork had already been established. A 2005 parish council report stated: "Now we speak the name of the disease at funerals, and pray without shame." Policy and embodied ministry achieved this shift from silence to speech and stigma to solidarity.

The Mwika case highlights the deep links between theology, gender, and health within communities. Working outside official institutions, laywomen used their religious beliefs to turn places of suffering into spaces of hope. Their actions demonstrate what African feminist theologians call healing justice—a spiritual and political effort that reclaims both the body and the sacred from the margins. This is not an isolated account but part of a broader, often unseen movement in which grassroots caregiving blurs the boundaries between clinical care, pastoral support, and gendered emancipation.

Taken together, the stories of Mwika's Mothers of Mercy, the Walezi wa Tumaini in Siha, and unnamed women across parishes like Hai and Mailisita, highlight a consistent pattern: faith-based, female-led care that transcended biomedical, social, and ecclesial boundaries. These women were not acting outside the Church's mission but expanding it. Their caregiving practices did not oppose clinical medicine but complemented it with an ethic of presence, trust, and theological imagination. They transformed homes into sanctuaries, stigmatised bodies into vessels of divine dignity, and despair into shared liturgy.

What emerged in the Northern Diocese between 1976 and 2004 was not simply a pragmatic response to health gaps. It was a spiritual reconfiguration of what it meant to care, to heal, and to observe the suffering of others. Through embodied, relational, and often invisible acts of service, Lutheran laywomen redefined health as the absence of disease and the restoration of worth and belonging. Their actions constituted a gendered theology of healing rooted in African Lutheranism, feminist pastoral care, and everyday resilience that deserves greater recognition in scholarly and theological discourse.

Taken together, the stories of Mwika's *Mothers of Mercy*, the *Walezi wa Tumaini* in Siha, and unnamed women across parishes like Hai and Mailisita reveal a consistent and often under-recognised pattern: faith-based, female-led care that transcends biomedical, social, and ecclesial boundaries. These women were not acting outside the Church's mission but actively expanding its meaning. Their caregiving did not compete with clinical medicine but complemented it with an ethics of presence, trust, and theological imagination.[40] They transformed homes into sanctuaries, stigmatised bodies into vessels of divine dignity, and moments of despair into shared liturgy.

What arose in the Northern Diocese between 1976 and 2004 was not just a practical response to gaps in formal health services. It was a spiritual rethinking of what it means to care, heal, and recognise the suffering of others. Through embodied, relational, and often invisible acts of service, Lutheran laywomen enacted what scholars call a gendered theology of healing rooted in African Lutheranism, feminist pastoral care, and everyday resilience.[41]

This practice reflects what Isabel Phiri and Mercy Oduyoye have described as a theology "from below," where African Christian women craft liberative meaning through their bodies, vocations, and struggles. These women challenged technocratic paradigms and ecclesial silences not through protest but through presence, claiming caregiving as sacred and profoundly political. Their stories suggest a form of theological

[37] Lartey, *Pastoral Theology,* 90–94.

[38] Leonardo Boff and Clodovis Boff, *Introducing Liberation Theology* (Maryknoll, NY: Orbis Books, 1987),42–45.

[39] Isabel Apawo Phiri and Sarojini Nadar, "African Women's Theology, HIV and AIDS, and Gender Justice," in *African Women, Religion, and Health: Essays in Honour of Mercy Amba Ewudziwa Oduyoye*, ed. Phiri and Nadar (Maryknoll, NY: Orbis Books, 2006),84–86.

[40] Olivier, *In Search of Common Ground*,68–70.

[41] Kaunda and Bongmba, *The Church and Maternal Health*, 292–295.

health engagement that warrants greater recognition in both theological scholarship and global health discourse: one where healing involves restoring bodily functions and reestablishing worth, voice, and belonging.[42]

VII. Conclusion

This article has explored how the Evangelical Lutheran Church's Northern Diocese (ND) in Tanzania developed a theologically grounded model of women's health care between 1976 and 2004. Beyond formal medical institutions, the ND mobilised networks of laywomen, deaconesses, and fellowship leaders to provide pastoral, political, and deeply embodied care. Through acts of accompaniment such as sitting with the sick, bathing the dying, and naming suffering, these women redefined what it means to care, to heal, and to be present in the face of systemic neglect and social stigma. Far from being marginal, their ministries held a central moral and theological position within the ND's mission.[43] These efforts, often absent from development evaluations and theological histories, formed a gendered theology of healing that blurred the boundaries between the sacred and the clinical. Whether through the daily perseverance of Mwika's Mothers of Mercy, the spiritual defiance of the Walezi wa Tumaini in Siha, or the unseen labour of countless fellowship leaders across parishes, this caregiving was more than compassionate service. It was a form of theological resistance that challenged stigma, abandonment, and silence by affirming suffering bodies as carriers of divine presence.[44] By centring this grassroots history, the article highlights a crucial intersection between African Lutheran theology, gender justice, and public health. In this context, healing is not measured solely in clinical outcomes but expressed through presence, dignity, and solidarity. The ND's laywomen filled critical gaps left by the state and formal health systems, reimagining care as an act where theology, intimacy, and justice are inseparable.[45] Recovering their witness reminds us that faith communities, especially those shaped and led by women, possess powerful, though often unrecorded, capacities to reshape the moral imagination of health.[46] As the global Church and development sectors continue to wrestle with gendered inequalities in caregiving, the legacy of these Tanzanian churchwomen offers an enduring insight: "healing is not only what is done to the body, but how the body is seen, accompanied, and remembered."[47]

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[43]Lartey, *Pastoral Theology,* 91–96.
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[45]Clarke and Jennings, eds., *Civil Society and Faith-Based Organisations*, 98–101.
[46]Chammah J. Kaunda, "Redemptive Masculinities and Healing of Memories in Postcolonial African Christianity," *Verbum et Ecclesia* 36, no. 2 (2015),1–8, https://doi.org/10.4102/ve.v36i2.1425.
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