Challenges Experienced by Free Pentecostal Church of Tanzania in the Provision of Healthcare Services in Tanzania

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Abstract
The paper examines challenges experienced by Free Pentecostal Church of Tanzania (FPCT) in the provision of healthcare services in Tanzania. Unlike many mainline churches, FPCT represents one of the few Pentecostal denominations actively involved in healthcare delivery in Tanzania. A qualitative approach was employed, utilizing primary data collected from forty-one purposively selected participants aged between 20 and 60, and complimented by a secondary data obtained through an extensive documentary review. The data were thematically analyzed within the theoretical framework of structural functionalism and structuration theory which provided lenses for understanding interplay between institutional structures and agency in shaping FPCT's healthcare practices. The findings reveal various challenges experienced in the provision of healthcare services in Tanzania including; the traditional healing practice, the infrastructural challenges and donor dependency and shift to localization. Overall the study offers valuable insight that contribute to strengthening FPCT's healthcare initiatives, informing policymakers, guiding religious organizations and enriching scholarly and policy discourses on faith-based healthcare interventions in sub-Saharan Africa.

Keywords: *Healthcare Services, Faith-Based Organizations, Free Pentecostal Church of Tanzania*

Introduction

Health is widely recognized as a cornerstone of human well-being and as a key driver of socioeconomic development. A healthy population not only enjoys longer life expectancy but also contributes more effectively to national productivity. Social development, in turn, fosters a sustainable society grounded in human dignity by empowering marginalized groups both women and men to enhance their socioeconomic standing and secure equitable participation in society (Filho et al., 2022). The FPCT's involvement in healthcare emerges as both a religious mandate and a social necessity, especially in the Tanzanian context, where access to quality healthcare remains unevenly distributed.

Tanzania's healthcare operates within a decentralized framework, organized into three functional levels: primary (district), secondary (regional), and tertiary (referral hospitals). Healthcare provision is managed through a mix of public facilities, faith-based organizations (FBOs), and private sector institutions. Over 60% of healthcare services are provided by government facilities, with the remainder managed by FBOs (coordinated by the Christian Social Services Commission (CSSC) and private facilities (under APHFTA).

According to the 2023 health facility registry of the mainland Tanzania, the country has a total of 11,808 registered health facilities. Of these the majority about 59% is government owned and 9% belongs to faith based-organizations (FBOs) and roughly 31% are privately owned. When considering major facilities (hospitals, health centers and dispensaries) there are 9,366 in total and 6,988 are government owned which make 74.6%, 998 are owned by FBOs which makes 10.6% and the rest by private or other ownership. Regarding hospitals specifically there are 436 across the country 228 are government ownership and 121 are FBO ownership and 87 are privately owned. This means that as of 2023, FBOs own about 27.7% of all hospitals while the government owning 52% (Ministry of Health 2023).

The FBOs are given increasing space in policy making and access to contractual agreements for accessing public health funding, however despite the growing visibility of church organizations in global health and national health policy, religion has until recently been overlooked in health sciences and development studies though this is changing and religion becoming a factor to considers in both discipline (Koehrsen & Burchardt 2024, Winiger & Peng-Keller 2021, Sundqvist 2016).

The Free Pentecostal Church of Tanzania began its healthcare initiatives in the 1930s during the colonial era, under the Swedish Free Mission (SFM). Over the years, it has undergone several transformations from SFM to Pentecostal Church Social Association in Tanzania (PCSAT), then to Pentecostal Church Association in Tanzania (PCAT), and finally to FPCT signifying an evolving vision that integrates both spiritual and social missions (FPCT Evaluation Report, 1999).

Despite its long-standing involvement, FPCT's healthcare contributions remain under-documented, under-recognized, and under developed, especially when compared to the Catholic

and Lutheran churches. Historically, mainline missionary churches such as the Catholic and Lutheran churches have played a significant role in Tanzania's healthcare sector through the establishment of extensive healthcare networks supported by strong institutional structures, donor partnerships and government collaboration (Nicol et al., 2022).

Although the Free Pentecostal Church of Tanzania began providing healthcare services as early as 1932, its visibility, institutional growth, and scholarly coverage have remained limited. Unlike their Catholic and Lutheran counterparts, the FPCT's healthcare initiatives have not received adequate attention in academic discourse or policy planning.

Either few studies have attempted to examine the Free Pentecostals Church of Tanzania (FPCT) as faith-based institutions in delivering healthcare in Tanzania, Sundqvist (2017) included FPCT in a study on church-based healthcare but failed to provide in-depth analysis due to the broad scope where by three church were involved in her study (the Catholic, Lutheran and FPCT). Muhoja (2020) examined Muslim and Bethel Revival Temple participation in healthcare but excluded FPCT, although Bethel does not represent mainstream Pentecostalism churches rather than being an independent church. Therefore, due to all these empirical studies and visibility the paper seeks to explore the challenges the Free Pentecostal Church of Tanzania faces in providing healthcare in country and the way they have challenged the institutional growth toward service provision since 1930's. Addressing this knowledge gap is critical for understanding the broader contribution of the faith-based organization in the social development in Tanzania.

Objectives of the study

The main objective of this study was to examine challenges experienced by Free Pentecostal Church of Tanzania in the provision of healthcare services in Tanzania. Specifically, the study addressed the following specific objectives;

1) To examine how traditional healers' practices affect FPCT's provision if healthcare services

2) To assess the effect of donor dependency and shift to localization on FPCT's healthcare service delivery
3) To investigate how infrastructural challenges hinder FPCT's provision of healthcare services

Empirical Literature Review

Studies on healthcare provision in sub-Saharan Africa have increasingly recognized the important contribution of faith-based organizations in supporting national health systems. In many African countries, faith-based institutions operate hospitals, health centers, and dispensaries that complement government facilities, particularly in rural and underserved communities. These institutions often provide a wide range of services including preventive care, maternal and child health services, and community health outreach programs. Their contribution is particularly significant in contexts where public health infrastructure and resources remain limited (Nicol et al., 2025). Within this broader landscape, organizations such as the Free Pentecostal Church of Tanzania (FPCT) play a crucial role in expanding access to healthcare services. However, despite their important contribution to healthcare delivery, faith-based health institutions face numerous structural, financial, and administrative challenges that affect their ability to provide sustainable and high-quality services.

Scholarly literature has documented several of the challenges encountered by church-based health providers in Africa. For instance, Green et al. (2002) examined the role of church health institutions and the difficulties they face in delivering healthcare services across sub-Saharan Africa. The study highlights challenges related to organizational management, differences in institutional culture, and limitations in administrative capacity that may influence the effectiveness of church health services. In addition, the study notes that many church-run health facilities face financial constraints, shortages of trained personnel, and difficulties in maintaining medical infrastructure and supplies. These challenges can affect the ability of such institutions to sustain healthcare programs and meet increasing community health demands. Nevertheless, the study emphasizes

that church-based health providers continue to play a vital role in healthcare delivery and remain key partners in addressing public health needs in many African countries.

Similarly, other studies have explored contextual challenges affecting healthcare provision within Tanzania. For example, Nuhu et al. (2020) investigated challenges affecting health service delivery in Kinondoni Municipality. Their qualitative findings revealed that healthcare institutions often face multiple operational constraints, including inadequate financial resources, weak monitoring and evaluation systems, and insufficient coordination among stakeholders involved in service delivery. These challenges not only affect public health institutions but also extend to non-governmental and faith-based healthcare providers operating within the national health system. While these studies provide valuable insights into general challenges affecting healthcare institutions and church-based providers, they do not specifically examine the experiences of the Free Pentecostal Church of Tanzania in the provision of healthcare services. Consequently, limited scholarly attention has been given to understanding the specific institutional, financial, and operational challenges faced by FPCT in delivering healthcare services. Addressing this gap is important for generating context-specific knowledge that can inform strategies to strengthen the capacity of faith-based health providers in Tanzania.

Theoretical Framework

The analysis adopted two complementary sociological theories which are structural functionalism by Talcott Parsons and Structuration theory by Anthony Giddens. Structural Functionalism emerged during the late nineteenth and early twentieth centuries as sociological sought to understand how societies maintain stability and order despite complicity and change. It has been developed in Europe and later expended in the United States. It was influenced heavily by biological analogies, especially the idea that society functions like a living organism in which different organs perform specialized roles necessary for survival. Talcott Parsons emphasizes that society is composed of systems and subsystems that perform necessary functions for social survival thus every institution has a function, social order and stability are essential and society is

a system of interrelated part. The theory is criticized on overemphasize on stability and ignoring social change (Parsons 1951).

Therefore the theory provides a macro-level lens for understanding how social institutions emerge to fulfill essential functions that sustain societal stability. It emphasizes the way in which institutions translate broad societal needs into organized roles, norms and practices that individuals internalize and enact. From this view point the FPCT's involvement in healthcare provision is analyzed as a functional institutional response to community health needs, contributing to social order, collective well-being and the community of the health systems particularly in underserved areas.

Structuration theory was developed during the late 1970's and early 1980's. Giddens criticized theories that overemphasized either structure or agency proposing that structure shape human actions and human actions simultaneously reproduce or transform structures called duality of structures Giddens argues that while institutions provide rules resources and constraints, they are simultaneously shaped and reproduced through the everyday actions of social actors (Giddens 1984). Applying this perspective, the FPCT is understood not as an active agent capable of influencing health policies, shaping service delivery practices, partnerships and local engagement, the FPCT both adapts to existing health system structure and contributes to their organization transformation.

Methodology

The study adopted case study research design which was approached qualitatively. Case study research design was used to generate an in-depth understanding of a contemporary issue or phenomenon in the FPCT. The design helped to gain in-depth insights of individuals, groups of people, institutions and to gain an understanding of a real-life phenomenon in relation to healthcare provision. The case study design involved multiple sources of data, such as interviews, observations, or documents (Bloomberg & Volpe, 2022). The qualitative approach was used to interpret responses and experiences in order to bring sense in understanding social realities. Through the use of the collected data the approach helped the researcher to obtain, analyze and

interpret data content from visual, textual and oral materials. Key informative interview (KIIs), In-depth interview (IDIs) and non-participatory field observation was adopted as key methods for generating information in this study when investigating on challenges experienced in the Free Pentecostal Church of Tanzania in provision of healthcare services in Tanzania (Viswambharan & Priya 2016; Kothar & Garg 2019).

The study was conducted in two regions namely Tabora and Coast regions. These regions were purposively selected because they host FPCT's hospitals namely Nkinga referral hospital and Mchukwi Mission hospital. Nkinga Referral hospital has a total of 252 employees including specialist doctors, medical doctors, nurses, clinical officers, laboratory technicians, pharmacists, radiographers and other technical supportive staff (www.nrh.or.tz). Mchukwi Mission hospital on the other hand is located in Rufiji Coastal region. The hospital was established in 1969 in response to periodic disease outbreak due to floods of the Rufiji River in 1969.

The focus was the FPCT church leaders, healthcare workers and ordinary people. Purposively sampling and snow ball sampling was employed to individuals aged between 20 and 60 both male and female. The total number of six (6) FPCT Church leaders, administrators and ministers, five (5) hospital leaders, twenty (20) health workers and ten (10) ordinary people participated in this study. A total number of 41 participants were reached after realizing that there was no additional information coming from new participants. Thematic analysis was applied in identifying, processing, analysing and interpreting the patterns of meaning

Findings and Discussion

Traditional healing practices

In the context of the Free Pentecost Church of Tanzania (FPCT) most of healthcare institutions are located in the country side away from town and cities. The service delivery in the areas have experience the challenge of traditional healer (divination) practice particularly the influence of "sangoma ideologies". The ordinary people in Nkinga uses the name Sangoma referring to (waganga wa kienyeji), the term is popularly used in south Africa but unfortunately is the popular term in Nkinga village. The sangoma influences is a challenging ideology within the community

in uptake of biomedical healthcare services. The interviewed participants from Nkinga and Mchukwi hospitals respondent on this by saying that;

> *Our health institutions are located in very remote rural areas, where the majority of the population lives in poverty and lacks sufficient income to meet their basic needs. We have faced significant challenges since the departure of missionaries, because during their time medical care was provided free of charge or with minimal contribution. However following their departure and the subsequent transfer to localization and user fee introduction, the ordinary people still do not seek medical care promptly. A large number of them instead resort to traditional healers, locally known as Sangoma hoping to find a cure. Often, by the time they are brought to hospital, their condition have severely deteriorated and most of their financial resources have already been exhausted on traditional remedies."* (IDI Male and Female, Nkinga village and Nkinga hospital, 26th & 31st Jan. 2023)

From the narration above the respondent highlights the persistent role of traditional healing practice in remote and disadvantaged areas where the FPCT hospitals operates. Historically during Missionary era, healthcare was offered free or at minimal cost, reducing barriers to access. However, with the withdraw of missionaries, the localization of management and the introduction of user fees healthcare has become less accessible to economically marginalized populations. As a result many community members resort to traditional healers (sangoma), who remain culturally embedded and often more accessible both geographically and financially. This resilience on traditional healing reflects not only issues of affordability and access but also deeper question of culture trust and identity in health-seeking behavior. The consequence as noted by the respondent is that patients often arrive at hospital in critical conditions, having already exhausted limited resources on traditional remedies.

Different studies done in sub-Saharan Africa shows that traditional healers continue to play a central role in healthcare especially in underserved rural populations (Mbiti, 1991; WHO 2002). Anthropological and medical studies in Tanzania shows that traditional healing systems remain deeply embedded in cultural and spiritual ontologies that interpret illness as both physical and metaphysical phenomenon. Scholars argue that healing practice among waganga wa kienyeji are grounded in relational worldviews where disease is often understood as the outcome of disruptions in social, spiritual and ancestral relations. In this context, diagnosis and treatment frequently extend beyond biomedical explanations to include spiritual affliction and ancestral intervention, thus integrating herbal pharmacology with ritual purification, divination and spirit mediation

reflecting a holistic approach and wellbeing (Nichols-Belo 2018, Hurskainen 2004, Wilkenes & Sanga 2024; Kayombo 2013). WHO (2013) further emphasizes that while traditional medicine can complement formal systems unregulated practice may delay proper treatment and worsen outcomes as the respondent indicates.

The findings add tone to existing literature by showing that reliance on traditional medicine is not solely a matter of cultural preference but structural responses to reduce affordability and weakened health service coverage. Also, the interpretation enriches understanding of health seeking behavior by revealing how cultural trust and identity interact with economic vulnerability to influence choice between biomedical and traditional care. The respondents account also support and extend prior studies by illustrating the practical consequences of these choices specifically delayed hospital attendance and more severe clinical presentations after unsuccessful traditional treatment. This contributes to policy- relevant knowledge by emphasizing the need for integrated, culturally sensitive and financially accessible health service models in mission affiliated and rural healthcare setting.

In the lens of theoretical perspective structuration theory explains how community members navigate between available health structures (formal biomedical services vs traditional healing) based on their lived realities. Poverty, cultural norm and institutional accessibility constrain their agency, pushing them toward traditional healers despite biomedical. Either structural functionalism underscores the dysfunction that occurs when traditional healing competes with formal healthcare without coordination. Instead of complimenting one another, the coexistence produces delays in medical intervention, undermining the stability of the healthcare system.

The government in collaboration with the church health institutions has put some strategies toward encouraging and educating healers and ordinary people to attend biomedical services instead of attending to traditional healers for divination related to Sangoma ideology. The village executive officer and the Nkinga nurse officer said;

> *At present we are conducting various seminars aimed at encouraging early hospital visit for treatment and educating traditional healers to refrain from misleading the public into believing they will recover through traditional mean when proper medical care is available. We are reaching them through Medias like RFA and CG FM radio which are*

> *audible in the whole region. Also various programs like the CTC village programs, Nkinga day which involves the community in marathon and provide free medical checkup etc and village gathering under their village chairperson have been used to sensitize the community*." (IDI, Male & Female Nkinga village and Nkinga Hospital 31st & 26th Jan. 2023)

The respondents account illustrates a proactive institutional response to the challenges of traditional healing ideologies and delayed healthcare seeking behavior. By conducting seminar to encourage early hospital visits and engaging traditional healers directly, FPCT hospitals are attempting to shift community perception towards biomedical care. This intervention demonstrates recognition that health-seeking behavior is not only an economic decision but also a social and cultural process (Saint-Arnault 2018, Abubakar et al., 2013). By addressing both the community and traditional healer, the approach seeks to dismantle misinformation and reshape norms that perpetuate reliance on non-biomedical remedies, which often results in deteriorated health conditions before patients arrive at hospital. Kayombo (2013) emphasizes that in Tanzania, collaboration with traditional healers rather than outright exclusion can reduce harmful practice while harnessing their social influence for public health benefits. Either WHO (2013) advocates for strategies that integrate traditional healers into broader health education networks, acknowledging their legitimacy in communities but guiding them toward evidence-based referrals.

The respondents reflects a shift toward preventive and educational strategies as a complement to curative services by addressing misinformation and reframing traditional healer's role in community, FPCT institutions are not only countering the challenge of delay but also building culturally sensitive and socially embedded health system, thus holding potentials in enhancing trust, improving health outcome and reducing the institutional strain caused by late stage patients arrival expecting to brig progress and achievement toward healthcare provision.

Donors' dependency and shift to Localization

This part of the paper critically examines donor's dependency and the shift to localization as a significant challenge that have impeded the progress of FPCT healthcare institutions since the 1990's. Donors' dependency in mission hospitals creates a cycle where local health systems rely on external funding for their sustainability. Withdrawing of external funding exposed the structural

weakness of the situation and institutional governance. Either the shift to localization encouraged local ownership and management of health services. This transition provided complex, because local churches lacked the necessary financing resources, managerial expertise and policy framework to sustain operations independently. In Tanzania various faith-based hospitals faced similar challenges including those affiliated with CSSC and TEC (Mboera et al 2015). Different respondents responding on donor's dependency as a contribution to slow development in the contemporary delivery of healthcare services in the FPCT health institutions said;

> "*In the past, there was a strong dependency on donor funding, particularly from Scandinavian countries. When, the donors ceased or were reduced, the concept of investing and sustaining local initiatives proved challenging. Many people's mind set kept expecting aid from them while there was little or no communication indicating that funding would eventually cease to allow the church institutions to prepare themselves adequately. As donor support declined, churches and their affiliated institutions, particularly hospitals, faced difficulties sustaining their operations."* (KII, Male & Female Nkinga hospital, 25-27th Jan 2023)

The respondent's reflection highlights a deeply rooted donor's dependency among faith based healthcare institutions, particularly those associated with the Free Pentecostal Church of Tanzania (FPCT). Historically Scandinavian donors provided substantial financials and technique support to church affiliated hospitals and social services institutions. This created a situation in which external aid became institutionalized as core mechanism for survival and growth. According to Brautigam and Knack (2004), such prolonged reliance fosters donor dependency syndrome, where local actors perceive aid as a permanent entitlement rather a transitional resource. In the FPCT this dependency shaped organizational culture and expectations. As the respondent observed "*Many peoples mindset kept expecting aid*" illustrating how reliance on external funding constrained the development of innovative, localizing financing mechanisms.

The shift to localization from donor dependency deteriorated the notion of progress and development of health based institutions especially in the FPCT because of various factors associated with the transition as one of the respondents said;

> *"By the 1990's, donors began withdrawing and promoting the concept of localization where the local citizens were expected to take over administrative and technical responsibilities. However there was a shortage of adequately trained experts, making the transition complex and fragile."* (KII, Male FPCT Office Dar es salaam, 18th Jan. 2023)

The respondent's response explains how the promotion of localization by the year 1990's did not bring the progress rather made the transition delicate and complex for the promotion of development. Either the absence of trained experts as noticed by the respondent "*shortage of adequate trained experts"* made the transfer of responsibility complex and fragile. This reflected a structural gap in human resource capacity that undermines the localization agenda. Without a deliberate investment in technical expertise and leadership development localization became a fragile aspiration rather than a viable institutional reality. This absence of trained expert from local people show how much the donors made the local people to depend not only on financial matters but also in the professionalism which brought development stagnation after their departure. However as the respondent indicated, the transition was neither smooth nor adequately supported. Donor communication about withdraw was minimal leaving the church-run institutions unprepared for the new realities.

The paradigm shift of reducing support from Scandinavian by the 1990s' coincided with broader global aid discourse which promoted local ownership, capacity building and sustainability (Green 2015). Donors encouraged local institutions to assume responsibility for governance, administration and technique operation. In principle this transition aligned with the international development agenda which recognized the importance of strengthening indigenous institution.

Theoretically the shift from donor dependency to localization can be understood through the lens of structuration theory which posits that structures both enables and constrain agency. In this case, donor withdraw represented a significant structural change. Yet local institution lacked the agency manifested in skill, expertise and financial capacity to reconstitute sustainable practices. The interaction between weakened external structure and underdeveloped local agency resulted in institutional fragility. Also from the lens of structural functionalism donor withdraw disrupted the equilibrium of the health system. Donor had functioned as a key component ensuring the survival of hospitals, much like other subsystems that maintain systemic balance. Once removed the system's ability to perform its health delivery function weakened. New structure of local resources mobilization and accountability needed to emerge, but these were slow and inconsistent, producing what the respondent called a "*challenging environment*" for sustaining service.

The nature of the local people and the expertise who engaged in day to day activities after the departure of the donors did not bring quick recovery and health transition because of their mindset and experience as one of the respondent said.

> *"The local People knew nothing about this, they only observed that things were happening attending prayers, receiving free medication and seeing vehicles operating without knowing the price of fuel or the cost of spare parts. Gradually the local began to participate in these activities and some even started working in, however very few understood the day to day operations of those undertakings."* (KII Male Nkinga hospital, 31st Jan, 2023)

The respondent's reflection reveals the deep effect of donor dependency toward localization. The statement "*the local knew nothing about this, they only observed things happening"* underscores the passive role of local communities, who were recipients of services rather than active stakeholders in the institutions' operation. This is what Dolye, (2020) and Adu-Gyamfi, et al., (2020), described as charitable legacy of mission medicine in Africa where healthcare provision was guided by compassion rather than capacity building or local empowerment. This shows that early missionary mission healthcare focused primarily on curative and charitable services delivery rather than institutional development or local health system strengthening. The respondent's observation reflects a structural disconnection between service delivery and local knowledge. The people's lack of understanding about operational cost –such as fuel, car maintenance or medicine supplies demonstrates how donor-driven systems created a dependency mindset where services were expected to continue forever without local financial contribution or accountability. Within FPCT health institutions, donors not only financed but also defined operational priorities, leaving minimal space for local learning or decision making.

From the interpretation on donor's dependency and shift to localization in the FPCT healthcare provision adds new and context-specific insight to the broader field of faith-based health systems in Africa. The studies mentioned donor dependency as a general structural issue in Africa development but the analysis extends this understanding into micro-level institutional and community dynamics within church based context, by examining how local communities observed things happening without understanding the cost structure or operational mechanisms. This paper reveals how donor-funded systems unintentionally fostered a culture of passivity and limited institutional learning among the stakeholders.

Also the study adds the new knowledge by demonstrating that dependency was not only economic but also cognitive and structural- a finding that deepens our theoretical understanding of how power and knowledge are embedded within aid relationships. Through structuration theory the study contribute to the theory by showing how missionary established institutional structures continued to shape the behavior and decision making even after donors withdrew, constraining local agency and innovation. This theoretical integration advances the application of structuration theory in development studies by linking it with organizational transformation in faith-based healthcare systems.

Practically this interpretation informs policymakers, church leaders and global health actors about the need for participatory and capacity-focused localization strategies that empower local institutions to manage resources, staff and systems autonomously. By unpacking the Tanzanian FPCT case, the paper also provide a comparative framework for other African mission hospitals transition from donor driven to locally sustained model of healthcare delivery.

Infrastructural Challenge

This part of the study is explaining the challenge related to road accessibility, mobile network challenge and aging infrastructure in the FPCT healthcare institutions. In Tanzania infrastructures particularly the road network and communication faces significant challenges depending on location context. The Free Pentecost Church of Tanzania healthcare institutions are mostly located in remote areas with accessibility and mobile network being challenging. For example Nkinga hospital is located in Nkinga village which is 77 kilometres from district headquarters (Igunga district) and Mchukwi hospital is located in Mchukwi village 8 kilometres from Kibiti-Kilwa road. Both hospitals had its history of its inception that why are located in a remote area. Either location of these institutions facilitates a challenge in healthcare delivery toward bringing health progress as one of the respondents said;

> *"Here we have the challenge with the good accessible road mobile network and the absence of enough public transport thus creating hardship in health provision and client accessibility. Also most of health infrastructures in church-run hospitals were constructed many decades ago while those facilities were suitable for the population demands of the*

> *time, they are now inadequate and deteriorating despite of the effort put to meet the current projected needs."* (KII, Male Mchukwi hospital 31st Feb. 2023)

The respondent reflects two interrelated dimensions of infrastructural challenges in FPCT healthcare institutions which are external access infrastructure (road, mobile network, public transport) and internal health facility infrastructure (ageing buildings, inadequate facilities). The presence of poor road networks, weak mobile connectivity and lack of reliable transport hinders both patients' ability to reach hospitals and the institution capacity to deliver timely services.

This reflects broader finding in health system research where geographical and logistical barriers remain key determinants of health access in low resource settings (Peters et al., 2008). Also the FPCT institutions being constructed during the missionary era designed for smaller populations with low service demands have outpaced these facilities capacity leaving them inadequate and deteriorating despite of efforts at renovation. This illustrated what Bloom et al. (2014), describes as a health infrastructure gap, where facilities fail to keep up with demographic and technological changes.

Mboera et al. (2015) identifies rural road access and inadequate facility infrastructures in Tanzania as a major obstacles to effective service delivery especially for maternal and child health. Olivier et al. (2015) illustrates that while missionary era infrastructures provided critical foundations, most facilities are now outdated underfunded and ill-equipped to handle current patient loads and modern technology demands. Moreover the World Bank (2016) highlights that infrastructures inadequacies excessively affect rural and marginalized communities, reinforcing inequities in health access.

Another respondent complemented by showing how the infrastructure challenges affects a number of health progress in the area of maintaining medical professionalism and timely treatment when in use of ambulance for referral as said;

> *"This is indeed a challenging location, especially maintain a valuable professional medical expert who would add value to our institutions and during the time of using ambulance for quick treatment becomes a delaying challenge."* (KII, Female Nkinga Hospital, 25th Jan, 2023)

The respondent's statement reveals two closely connected systemic challenges affecting service delivery in difficult to reach location; the retention of skilled medical professionals and delays in emergency care. The characterization of the areas as a challenging location suggests that geographical remoteness limited infrastructure and professional isolation reduces the ability to health institutions to attract and retain highly qualified medical experts, thereby weakening institutional capacity and quality of care. This shortage of expertise increases reliance on referrals and emergency response, yet the respondent notes that ambulance use itself become a source of delay, indicating weakness in emergency transport and referral system related to road challenge. The delays compromise timely treatment, particularly for acute and life threatening conditions and illustrate how human resource constrains and transport inefficiencies interact to intensify service delivery challenges. The response highlights how structural and contextual factors jointly undermine health systems performance especially in rural or underserved setting in the FPCT healthcare institution.

From structural functionalism theory infrastructure is a core subsystem that enables the health system to fulfill its social role of maintaining population health. Also structuration theory helps to interplay between institutional agency and structural constrains. While the FPCT institutions may seek to expand and modernize facilities, their actions are constrained by broader structural realities such as limited government investment, donor fatigue and rural development. This duality highlights that infrastructures challenges are not merely technical but also deeply embedded in historical economic and government frameworks.

Conclusions and Recommendations

The interrelated structural challenges shaping the healthcare delivery in the FPCT institutions such as Nkinga and Mchukwi emerged depending on different reasons. The reliance on traditional healers emerges not merely as a cultural preference but as a rational response to poverty, user fees, weakened biomedical coverage, and deep-seated trust in culturally embedded systems of healing. The withdrawal of missionaries and donors exposed institutional fragilities, including limited financial autonomy, managerial capacity gaps, and a dependency-oriented organizational culture

that constrained local agency. Simultaneously, poor road networks, weak mobile connectivity, and outdated infrastructure undermine patient access, emergency referrals, and staff retention. Together, these challenges illustrate how historical aid structures, socio-cultural beliefs, and material conditions interact to delay healthcare utilization. The findings extend existing literature by demonstrating that barriers to healthcare access in FPCT institutions are multidimensional economic, cultural, cognitive, and infrastructural and best understood through structuration and structural functionalist perspectives that highlight the dynamic interplay between agency and constraining structures.

Based on the findings of this study it is recommended that FPCT healthcare institutions and their partners should adopt an integrated, capacity-centered, and culturally responsive strategy that aligns biomedical services with local realities. First, structured collaboration with traditional healers through regulation, referral training, and health education should be strengthened to reduce harmful delays while leveraging their social legitimacy. Localization efforts must move beyond administrative transfer to deliberate investments in human resource development, financial literacy, and participatory governance, ensuring that local actors possess the skills and institutional knowledge required for sustainable management. Also the targeted infrastructural interventions, including advocacy for rural road improvement, expansion of digital connectivity, and phased rehabilitation of aging facilities, are essential to improve access, emergency response, and professional retention. Policymakers, church leadership, and development partners should prioritize long-term capacity building over short-term service provision, embedding accountability and community ownership within faith-based health systems. Such an approach would not only mitigate the negative legacies of donor dependency but also enhance trust, equity, and resilience in rural healthcare delivery within FPCT and comparable mission-affiliated institutions in sub-Saharan Africa

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