https://journal.utripoli.edu.ly/index.php/Alqalam/index eISSN 2707-7179

Original article

Political and Religious Impacts on COVID-19 Responses in Tanzanian Healthcare Facilities: A Qualitative Cross-Sectional Survey

Edward Augustine Magwe

Department of Pharmaceutical Sciences, Institute of Health and Allied Sciences, Ruaha Catholic University, Iringa, Tanzania

ARTICLE INFO

Corresponding Email. *edwardam87@gmail.com*

Received*: 03-10-2024*
Accepted*: 04-12-2024*
Published*: 07-12-2024*

Keywords*. Political, Religious, Response, COVID-19 Pandemic, Healthcare Facilities, Tanzania*

ABSTRACT

Coronavirus disease (COVID-19), a virus-related illness that affects the respiratory system, first appeared in Wuhan province, China, in December 2019. By mid-January 2020, cases of COVID-19 were reported in numerous Asian countries, signaling the beginning of a global health crisis. Within a mere four months, the virus had spread to all continents. A qualitative cross-sectional survey was conducted from 24 August to 3 October 2022 among healthcare workers in the Dar es Salaam, Arusha, Dodoma, and Mwanza regions. A total of 96 participants were involved from 24 healthcare facilities in all four regions. Individual interviews and key informant interviews were recorded using the Kobo Toolbox and analyzed thematically. The study revealed that many participants felt that politics misled society rather than educating. The way healthcare workers in Tanzania expressed their views on the impacts of politics in fighting the outbreak of COVID-19 was found to threaten the safety of healthcare workers and general public health. A significant number of healthcare workers also expressed that religion hurt the fight against COVID-19 in their facilities and the general society. However, A few health workers believed that religion had a positive influence, while others felt that it had advantages and disadvantages depending on its application. In Tanzania, politics and religion misled the community to a large extent rather than educating it. Clean politics and good religious practices should be used when fighting pandemics such as COVID-19.

Cite this article. *Magwe E. Political and Religious Impacts on COVID-19 Responses in Tanzanian Healthcare Facilities: A Qualitative Cross-Sectional Survey. Alq J Med App Sci. 2024;7(4):1473-1481. https://doi.org/10.54361/ajmas.247478*

INTRODUCTION

Coronavirus disease (COVID-19) is a virus-related illness that affects the respiratory system [1,2]. The disease first appeared in Wuhan province, in China December 2019. By mid-January 2020, cases of COVID-19 were reported in many places in Asia, including Thailand, Japan, South Korea, Vietnam, Nepal, Malaysia, Sri Lanka, the Philippines, and India [2]. In a short period of four months, the virus had already spread to all continents [3]. This bad news caused great fear and uncertainty around the world, leading to the suspension of economic activities and weakened health services; many deaths related to COVID-19 were reported worldwide, and the panic was very great in the community and to healthcare workers in general. The World Health Organization (WHO) recommended common guidelines for the prevention and control of COVID-19 to deal with the disease when there is no cure for the disease. The recommended measures are quarantine of infected or suspected patients, contact tracing, lockdowns, travel restrictions, border closures, wearing masks, and physical distancing [4,5]. These measures were effectively followed by many countries in Asia and Europe where COVID-19 was initially very severe and later other countries also started using them [3].

East African countries implemented these standards and guidelines to varied degrees. Some countries, especially Rwanda, forced a total lockdown. Other countries like Uganda and Kenya tried partial lockdowns and partial curfews, respectively. Only Tanzania denied being locked out as an ineffective measure to deal with COVID-19 while identifying the serious consequences of the lockdown. Instead, Tanzania decided to customize its response plan by keeping all other WHO standard guidelines and implementing it in line with religion. Tanzania's response to COVID-19 was controversial, in the early months of this epidemic, between February and April 2020, the Government of Tanzania quickly implemented various measures recommended by the WHO, and by February 27, 2021, about 15 guidelines had been issued by the Ministry of Health of Tanzania [6,7]. On March 16, 2020, the first case of COVID-19 was reported from Mount Meru Hospital in Arusha, a public hospital in northern Tanzania. This situation raised fears in the community and healthcare workers for this new emerging disease, with unknown experiences among them. The Tanzanian government ordered the closure of all schools and universities the following day and banned all public gatherings except churches and mosques [10]. On the other hand, Tanzania stopped publishing data on COVID-19 as of April 2020. About 509 confirmed cases, 21 deaths, and 183 recoveries have already been reported [6].

The unique approach used by Tanzania in the fight against COVID-19 has raised many questions; they are often despised as weak, ineffective, soft, disappointing, and dangerous [8]. In addition to the measures outlined in the national guidelines to protect against COVID-19, the Ministry of Health in Tanzania encouraged using natural medicines as another way to fight against COVID-19 as the disease has no cure or vaccine [9]. The use of natural medicines in the fight against COVID-19 was primarily supported by the community in general, including health workers due to the experience of traditional medicine used in various diseases in Tanzania including diseases of the respiratory system, a situation that led to many people to have great faith in the use of traditional medicines in the fight against COVID-19. The approval of the use of traditional medicine was made public by the government and became more popular. The use of local herbs was further promoted by herbalists and other people who showed that they had expertise in any herbal medicine, although it was not adequately monitored. Herbs in Tanzania are available in abundance and at affordable prices in almost every part of the country. Lemon, ginger, pepper, and neem tree leaves are boiled and mixed with honey to obtain a syrup for treatment. Sometimes, the same materials were boiled, and patients incubated themselves from the steam produced [8].

In Tanzania, community engagement was also suggested as an essential strategy to raise public awareness about COVID-19. This is where religion became a priority and entered easily into the COVID-19 program in Tanzania. Religious leaders were encouraged to continue praying special prayers to ask God of mercy to cure his people from COVID-19 [9]. Prayers were organized from the national level to all subsequent lower levels. Political leaders and religious leaders were praying together while taking precautions against COVID-19. A national-level prayer session was held on April 22, 2020, where the message to take precautions against COVID-19 was given and emphasized. The method and content of prayers were completely independent [8]. Each religion was allowed to conduct its prayers in its style. Many prayer meetings were combined with sermons and songs emphasizing one or more precautionary measures against COVID-19. Some Christian churches and mosques led special prayers that lasted for several months to ask God for protection against the COVID-19 pandemic [9].

Considering the magnitude of the outbreak and how religious and political practices were fueled in Tanzania, it was necessary to assess its impacts in dealing with the COVID-19 Pandemic in Tanzanian healthcare facilities among healthcare workers. Therefore, conducting research in this area in the regions of Dar es Salaam, Dodoma, Mwanza, and Arusha where the infection of COVID-19 was high compared to other regions in the country, will add value to the existing level of knowledge, strengthen the political and religious perspective in dealing with emerging infectious diseases of similar nature to the COVID-19 pandemic.

METHODS

Study area

This study was conducted in the Dar es Salaam, Arusha, Dodoma, and Mwanza regions, respectively located in Tanzania's Eastern, Northern, Central, and Lake zones. Ilala, Arusha urban, Nyamangana, and Dodoma urban districts were selected to represent these regions due to their potential and high prevalence of COVID-19 [11].

Study design and population

A qualitative cross-sectional survey was conducted from August 24 to October 3, 2022. This study involved healthcare workers, including nurses, clinicians (doctors), pharmaceutical personnel, laboratory personnel, administrative staff, and other health support staff from selected public hospitals, health centers, and dispensaries. Only government-owned health facilities were involved; private-owned healthcare facilities and student healthcare workers in short-term field

practices during data collection were not involved, allowing the study to focus on established, long-term practices for valid and robust findings.

Sample size and sampling procedure

The qualitative research involved a sample of 96 participants sourced from 24 healthcare facilities (HCFs), with the sample size determined based on the principle of saturation. A total of 48 key informants, including healthcare workers (HCWs) and administrative leaders who played a role in the COVID-19 response team during the outbreak, were purposefully selected for in-depth interviews. In addition, individual interviews were carried out with 48 randomly chosen participants who were not directly involved in the COVID-19 response team, aiming to capture a wide range of perspectives on the impacts experienced by individuals outside of the frontline response team. The random selection was conducted utilizing a stratified sampling method to ensure adequate representation across various demographics within the study population.

Data collection and management

Individual Interview (II) and Key Informant Interview (KII) were used to collect qualitative data in this study; Kobo Toolbox was used to record and store information. The interviews comprised a series of thoughtfully constructed questions, such as: "How do you believe politics influenced public perception and response to COVID-19 in Tanzania?" and "What specific ways do you feel that political actions affected the safety and health outcomes of communities during the pandemic?" Additionally, the researcher asked, “In what ways do religious beliefs or practices impact the response to COVID-19 in your healthcare facility?” and “What concerns do you have regarding your safety as a healthcare worker amidst the political and religious contexts during COVID-19?” The procedure entailed the transcription of recorded interviews conducted in Kiswahili, followed by an accurate translation into English. This was facilitated by the reviewer's proficiency in both languages, maintaining a strong standard of language accuracy. The interviewer received training to enhance qualitative interviewing skills, focusing on avoiding leading questions for genuine responses. Thematic analysis approach was used for data analysis. “Thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data.” [12].

Ethical approval

The Open University of Tanzania approved the research clearance letter with reference number PG202001923. The regional and district medical officers of the respective areas permitted research in healthcare facilities. At the facility, participants were requested to complete a consent form to ensure the confidentiality of their information. Only participants who agreed to fill out the consent form were involved in the study.

RESULTS

Socio-demographic characteristics of participants

The research included 96 participants, comprising 56 (58.3%) females and 40 (41.7%) males. Most participants were in the young to middle-aged category: 25 (26.0%) were aged 20-29 years, while 32 (33.3%) fell into the 30-39 age range. The largest segment of professionals consisted of nurses, totaling 34 (35.4%), followed by 24 (25.0%) in administrative staff and 22 (22.9%) who were clinicians. Regarding education, 41 (42.7%) possessed diplomas, and 36 (37.5%) earned bachelor’s degrees. Significantly, half of the participants were members of COVID-19 teams, emphasizing their essential functions during the pandemic. Experience levels varied, with 32 (33.3%) having between 6 and 10 years of service, as detailed in the Table.

Table. Socio-demographic characteristics of participants (N=96)

Demographic characteristics	Frequency (n)	Percent (%)
Gender		
Male	40	41.7
Female	56	58.3
Age in years		
20 – 29	25	26.0
30 – 39	32	33.3
40 – 49	16	16.7
50 and above	23	24.0
Field profession		
Clinician (doctor)	22	22.9

Nurse	34	35.4
Pharmaceutical personnel	9	9.4
Laboratory personnel	7	7.3
Administrative staff	24	25.0
Highest level of education		
Certificate	13	13.5
Diploma	41	42.7
Bachelor degree	36	37.5
Master degree	6	6.3
Dedicated in the COVID-19 team		
Yes	48	50.0
No	48	50.0
Service experience in years		
1 – 5	22	22.9
6 – 10	32	33.3
11 – 15	20	20.8
16 – 20	14	14.6
Above 20	8	8.3

Themes and sub-themes emerged

The findings of this study revealed two predominant themes: the impacts of politics, which encompass eight sub-themes, and the impacts of religion, which include five sub-themes, in addressing the COVID-19 pandemic.

The impacts of politics in fighting against the COVID-19 pandemic

From the individual interviews (IIs) and key informant interviews (KIIs), the following eight sub-themes were identified regarding the impacts of politics in the fight against the COVID-19 pandemic.

i. Conflicting political and health guidelines

Many participants highlighted the conflict between political directives and health guidelines. Politicians sometimes disregarded or contradicted health professionals' advice, creating confusion and mistrust among the public.

- KII Insight: *"Later dramas dominated, such as forbidding people to wear masks"* (KII, Hospital W).
- KII Insight: *"Politics greatly affected the wearing of masks especially in the street"* (KII, Hospital M).

ii. Impacts on public compliance

Political statements and actions significantly influenced public behavior, often negatively impacting compliance with health measures such as mask-wearing, vaccination, and social distancing.

- II Insight: *"The effect happened where people were convinced not to wear masks believing that the disease does not exist"* (II, Dispensary G).
- KII Insight: *"It affected us greatly because there was a lot of misinformation"* (KII, Health Center O).

iii. Undermining vaccination efforts

Political stances, particularly early in the pandemic, led to skepticism and resistance to vaccination, even after official approval and promotion of vaccines.

- II Insight: *"Politicians caused negative impacts such as imparting bad faith against vaccination"* (II, Hospital V).
- KII Insight: *"Politics had negative impacts such as people relying heavily on traditional steam inhalation"* (KII, Dispensary H).

iv. Positive political influence

Some participants acknowledged that political actions, especially those by the current president, eventually helped raise awareness and promote accurate information about COVID-19, leading to better public health responses.

- II Insight: *"Politics had a positive impact after the change of president because the current president told the truth about vaccination"* (II, Dispensary D).
- KII Insight: *"On my part, politics helped us because we were not locked in, people continued to work and avoided starvation"* (KII, Dispensary G).

v. Negative impacts on healthcare delivery

Political interference often hindered the healthcare system's ability to respond effectively, with healthcare workers facing challenges due to misinformation and a lack of resources like personal protective equipment (PPE).

- II Insight: *"We were completely affected by the political trends"* (II, Health Center J).

- KII Insight: *"The challenge came when PPEs started to become scarce according to the negative response of the government"* (KII, Hospital X).

vi. Public perception and fear

Political messaging influenced the public's perception of the pandemic, sometimes reducing fear and at other times leading to negligence and a false sense of security.

- II Insight: *"Politics helped us negatively because it accelerated the risk of infections, although it made people less afraid of the disease"* (II, Health Center L).
- II Insight: *"In fact, politics relieved people from fear, but it had no other help in fighting the disease"* (II, Hospital F).

vii. Impacts of traditional medicines

There was a significant push from political figures for the use of traditional medicines and methods like steam inhalation, which were not scientifically proven, leading to further confusion and potential harm.

- II Insight: *"Insisting people use traditional medicines especially steam ventilation"* (II, Hospital X).
- KII Insight: *"Politics didn't help us much because it made people rely on methods that have not been scientifically proven"* (KII, Dispensary C).

viii. Healthcare workers' struggle with misinformation

Healthcare workers had to combat the disease and the misinformation spread by political figures, complicating their efforts to enforce health guidelines.

- II Insight: *"Politics gave us a difficult time to direct people to understand us to follow professional advice"* (II, Health Center D).
- II Insight: *"Even healthcare workers were overwhelmed by politics"* (II, Health Center S).

These themes illustrate the complex and often contentious role politics played in managing the COVID-19 pandemic in Tanzania, highlighting both the detrimental and occasionally beneficial impacts political actions and statements had on public health efforts.

The impacts of religion in fighting against the COVID-19 pandemic

Based on the statements provided from individual interviews and key informant interviews, the following five themes regarding the impacts of religion in fighting against the COVID-19 pandemic were identified.

i. Religion as a challenge to health guidelines

Many healthcare workers reported that religious beliefs and leaders often encouraged people to resist health guidelines such as wearing masks, social distancing, and getting vaccinated. This resistance made it difficult for healthcare workers to enforce these measures.

- II Insight: *"Religion gave us a very difficult time in directing people to follow health guidelines because people have a lot of faith in their spiritual leaders, it is not easy to change them"* (II, Hospital X).
- II Insight: *"Religion brought a big challenge because many sects followed health guidelines, but many also ordered their people to not follow health guidelines believing that it is a time to show loyalty to their God and not to be shaken in their faith"* (II, Health Center T).

Religious gatherings continued despite public health advice against them, which contributed to the spread of COVID-19.

- II Insight: *"Most of the time, you can find people avoiding gatherings in other places like hospitals and bars, but they go to churches and mosques to gather as usual"* (II, Dispensary H).

ii. Religious Influence on Beliefs and Behavior

Some patients believed that their faith alone could heal them, leading to a reluctance to follow medical advice or accept treatment.

- II Insight: *"There were many patients who believed that their God was the one who caused the illness and that only their God could heal them"* (II, Health Center Q).
- KII Insight: *"Religion made healthcare workers have a hard time, especially because they made people neglect health guidelines"* (KII, Health Center V).
- KII Insight: *"Religions were divided, some educated people, others forbade people to follow health guidelines by holding prayer gatherings, believing in healing through prayer"* (KII, Hospital M).

Religious leaders' influence sometimes overshadowed healthcare professionals' advice, reducing the effectiveness of public health measures.

- KII Insight: *"What really saddened me was that people trusted religious leaders; we health professionals were not trusted more"* (KII, Dispensary B).

iii. Religion as an educative force

Some religious leaders positively impacted by educating their congregations about COVID-19 precautions and encouraging compliance with health guidelines.

- II Insight: *"To some extent, religious leaders helped greatly because they educated people"* (II, Health Center N).
- II Insight: *"Sometimes religion cost us, sometimes it helped us, some religious leaders gave good education to the community, others misled people to hold religious gatherings and refuse vaccination"* (II, Dispensary A).
- II Insight: *"Religion helped because they gave education about self-protection; even in churches, they put water for washing hands"* (II, Health Center I).

iv. Practical challenges faced by healthcare workers

Healthcare workers faced practical challenges when dealing with patients who refused to follow health guidelines due to religious beliefs, sometimes leading to conflicts and compromised care.

- KII Insight: *"There are patients who came and refused to wear masks for religious reasons, even though we asked them to wear masks, but when they left, they took off their masks"* (KII, Health Center Q).

v. Psychosocial support of religion

Despite the challenges, religion provided psychological support to many people during the pandemic, helping them cope with fear and uncertainty.

- KII Insight: *"We didn't get too much of a religious challenge, we followed the guidelines a lot, I think in the street religion was just build people psychologically"* (KII, Dispensary P).

These themes capture religion's complex and multifaceted role during the COVID-19 pandemic, highlighting both the challenges and contributions of religious beliefs and leaders in public health efforts.

DISCUSSION

Concerning the impacts of politics in fighting against the COVID-19 pandemic, many participants highlighted that politics misguided society and advocated for ethical and transparent political strategies in combating COVID-19. Healthcare workers in Tanzania are concerned about the impacts of politics on the fight against COVID-19, posing a threat to their safety and the public. Countries prioritizing ethical political practices, public education, and heavy investment in healthcare workers were successfully managed to control the spread of COVID-19. Vietnam's strong leadership and unwavering commitment at the highest political level, led by the Prime Minister and the Taskforce Group, mobilized crucial sectors to prevent and control the spread of COVID-19 [13].

In February 2020, the WHO African Region confirmed its initial imported case of COVID-19. The countries in the region reacted with different levels of preparedness, receiving collaborative assistance from the regional office and various partners [14]. The strong leadership of African governments and the support of partners has played a crucial role in limiting the spread of COVID-19 throughout Africa. Various measures were implemented in response to WHO's guidance to combat the COVID-19 virus and ensure the well-being of the African Region. Schools and other activities, including religious and social gatherings, were closed down in many countries. Additionally, many countries implemented a lockdown. Despite this, the late President of Tanzania refused to implement a lockdown, unlike his neighbors. He expressed skepticism about the effectiveness of imported masks and testing kits [15].

During the outbreak of the first wave of COVID-19, the Tanzanian government mobilized the use of Herbal steam (common as Nyungu in Swahili), natural remedies, and exercise were the main interventions introduced by the Ministry of Health to fight against the COVID-19 pandemic in Tanzania [15]. However, after the death of the President who had that direction in the fight against COVID-19, the new President made policy changes in the fight against COVID-19, including looking at the practices of other countries worldwide. The government underestimated the seriousness of the coronavirus and did not implement lockdown measures. It allowed religious services to continue and encouraged public activities. It also delayed the use of vaccines and instead recommended traditional medicines. In contrast, India's government imposed a nationwide lockdown on March 25, 2020, which effectively controlled the infection rate and received international appreciation for its effectiveness [16].

Therefore, the inadequate response of the Tanzanian government in combating COVID-19 as per WHO's recommendations may have led to the further spread of the disease as revealed by Ilesanmi et al. [17] in Nigeria that, poor political will and management support are factors that contribute to poor compliance of infection prevention and control, then resulted to highly spread of the disease. A similar finding was corroborated in an Ethiopian study where management support in health facilities positively impacted healthcare workers' compliance with infection prevention and control [18]. Thus, Tanzania should have a quick response, provide public education, and protect frontline healthcare

workers during outbreaks of infectious diseases like COVID-19 for the public health interest.

Many healthcare workers have expressed their views on the impacts of religion in combating the COVID-19 pandemic. According to their feedback, a majority believe that religion has hurt the fight against COVID-19 in their workplaces and in society at large. However, a smaller number of healthcare workers mentioned that religion has also made a positive contribution, while some stated that it had both advantages and disadvantages, depending on how it was utilized. The research conducted by Hamis *et al.* [15] found that the Tanzanian government did not enforce closures of churches and mosques, instead allowing religious services to proceed as usual. Additionally, citizens were actively encouraged to maintain their regular economic activities. This approach to religious practices in Tanzania may have contributed to increased COVID-19 cases due to heightened human interactions.

The whole world should have a positive direction aimed at eradicating any emerging epidemic, as was the case in Italy when the philosopher Giorgio Agamben reacted to the coronavirus crisis in a way that markedly contrasts with most other positions in contemporary political philosophy; his position has been described as irrational, politically incorrect, and unfair towards the victims of COVID-19 [19]. In South Korea, during the end of the first week of March 2020, almost two-thirds of coronavirus infections (approximately 5,000 cases) were traced back to "Patient 31," an individual who worshipped at Shincheonji Church of Jesus in Daegu. The church insisted on abandoning the use of health masks, continuing with gatherings involving many people and worshiping by touching each other and later the church was blamed for contributing to the spread of the disease outbreak [20]. In Southeast Asia, around 14,000 members of the Islamic Tablighi-Jamaat in Kuala Lumpur were widely believed to have sparked the second wave of the pandemic in Malaysia. Attendees of the event later traveled to Brunei, Cambodia, and Indonesia and tested positive for the virus [21]. In this situation, regulating religious gatherings is vital to combat COVID-19 and other similar diseases. Healthcare workers should take the lead in spreading this awareness.

In Poland, churches have limited or suspended religious services to help control COVID-19 infections. They stay connected with the faithful through modern technologies and are ready to cooperate in pandemic education [22]. Since the COVID-19 pandemic began, there has been a debate among British Muslim religious leaders about closing mosques. This is influenced by the impending closure of the holy area of Makkah for international pilgrims. The closure of mosques in the United Kingdom due to COVID-19 prompted British Muslim leaders to adapt and agree on the best ways to protect themselves during religious activities [23]. During pandemic outbreaks such as COVID-19, Tanzania needs to regulate all religious activities to help minimize the spread of the disease within the community.

CONCLUSION

The role of politics and religion in fighting COVID-19 raises concern, as many believe they misled society instead of educating. Clean politics and religion are essential in addressing pandemics like COVID-19. Healthcare workers in Tanzania fear that politics and religion threaten their safety and public health. For the public's well-being, Tanzania should act swiftly, provide public education, and protect healthcare workers during outbreaks like COVID-19.

Acknowledgments

The author extends his gratitude to all participants for their consent to participate in this study and to the regional and district medical officer's office for their permission, which made this study possible.

Conflicts of Interest

No any conflict of interest in this study.

REFERENCES

1. Amon JJ. COVID-19 and detention: respecting human rights. Health and human rights journal. 2020; 22(1):366–370.
2. Omran E, Elfzzani Z, Bshaena A. Complications Linked to Acute COVID-19 Phase during its Second Wave Era. AlQalam Journal of Medical and Applied Sciences. 2024 May 23:356-62.
3. Iroulo LC, Boateng O. African states must localise Coronavirus response. (GIGA Focus Afrika, 3). Hamburg: GIGA German Institute of Global and Area Studies Leibniz Institut für Globale und Regionale Studien, Institut für Afrika-Studien. Available at: https://nbn-resolving.org/urn:nbn:de:0168-ssoar-67242-7. Accessed February. 2023;24.
4. World Health Organization. Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19: interim guidance, 2020. World Health Organization; 2020. Available at: https://iris.who.int/handle/10665/331707, Accessed February. 2023;25.
5. World Health Organization. Advice on the use of masks in the context of COVID-19: interim guidance, 6 April 2020. 2020. World Health Organization: Geneva, Switzerland. Available at: https://apps.who.int/iris/handle/10665/331693 Accessed March. 2023;23.

6. Makoni M. Tanzania refuses COVID-19 vaccines. Lancet (London, England). 2021;397(10274):566.
7. Mtani FA, Ngohengo J. Africa at the crossroads: An overview of the COVID-19 pandemic and its drama in Tanzania. African Journal of History and Geography. 2023;2(1):1-6.
8. Wagana P. The role of religion in response to COVID-19 pandemic challenges in Tanzania. In Religion and the COVID-19 Pandemic in Southern Africa. 2022: (pp. 115-125). Routledge.
9. Mpota SS. The role of religion and traditional medicines in fighting COVID-19 in Tanzania. Africa at LSE. 2020. Available at:https://eprints.lse.ac.uk/106307/1/Africa_2020_08_12_role_of_religion_and_traditional_medicines_fighting_covid.pdf Accessed May. 2023;26.
10. Magwe EA, Varisanga MD, Ng'weshemi SK. Healthcare workers' perceptions of COVID-19 in four regions of Tanzania: A quantitative cross-sectional survey in healthcare facilities. Nigerian Health Journal. 2023;23(2):666-77.
11. Magwe EA, Varisanga MD, Ng'weshemi SK. Implementation effectiveness of infection prevention and control measures during the first wave of COVID-19: A cross-sectional survey among healthcare workers in four regions of Tanzania. G Ital Psicol Med Lav. 2023;3(1):21-33.
12. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology. 2006;3(2):77-101.
13. Ha BT, Ngoc Quang L, Mirzoev T, Tai NT, Thai PQ, Dinh PC. Combating the COVID-19 epidemic: experiences from Vietnam. International journal of environmental research and public health. 2020;17(9):3125.
14. Atia A, Abdullah H, Bazza A. Impact of COVID-19 on Libyan Laboratory Specialists: A Cross-Sectional Survey. Medical Laboratory Journal. 2021 Nov 10;15(6):8-12.
15. Hamisi NM, Dai B, Ibrahim M. Global Health Security amid COVID-19: Tanzanian government's response to the COVID-19 Pandemic. BMC Public Health. 2023;23(1):205.
16. Kar SK, Ransing R, Arafat SY, Menon V. Second wave of COVID-19 pandemic in India: Barriers to effective governmental response. E Clinical Medicine. 2021;36.
17. Ilesanmi OS, Afolabi A, Akande A, Raji T, Mohammed A. Infection prevention and control during COVID-19 pandemic: realities from health care workers in a north central state in Nigeria. Epidemiology & Infection. 2021;149:e15.
18. Ilesanmi O, Afolabi A. Time to move from vertical to horizontal approach in our COVID-19 response in Nigeria. SciMedicine Journal. 2020;2:28-9.
19. Duque Silva GA, Del Prado Higuera C. Political theology and COVID-19: Agamben's critique of science as a new "pandemic religion". Open Theology. 2021;7(1):501-13.
20. Channel News Asia. Church at centre of South Korea COVID-19 sits silent as infections surge. Channel News Asia. 2020. Available at: https://www.channelnewsasia.com/news/asia/coronavirus-covid19-church-south-korea-empty12458786. Accessed February 2023;25.
21. Che Mat NF, Edinur HA, Abdul Razab MK, Safuan S. A single mass gathering resulted in massive transmission of COVID-19 infections in Malaysia with further international spread. Journal of Travel Medicine. 2020;27(3):taaa059.
22. Sulkowski L, Ignatowski G. Impact of COVID-19 pandemic on organization of religious behaviour in different Christian denominations in Poland. Religions. 2020 May 19;11(5):254.
23. Al-Astewani A. To open or close? COVID-19, mosques and the role of religious authority within the British Muslim community: A socio-legal analysis. Religions. 2020;12(1):11.

https://journal.utripoli.edu.ly/index.php/Alqalam/index eISSN 2707-7179

التأثيرات السياسية والدينية على استجابات كوفيد-19 في المرافق الصحية التنزانية: دراسة استقصائية نوعية مقطعية

إدوارد أوغسطين ماجوي

قسم العلوم الصيدلانية، معهد الصحة والعلوم المتحالفة، جامعة روها الكاثوليكية، إيرينغا، تنزانيا

المستخلص

ظهر مرض فيروس كورونا (كوفيد-19)، وهو مرض مرتبط بالفيروس يؤثر على الجهاز التنفسي، لأول مرة في مقاطعة ووهان بالصين في ديسمبر 2019. وبحلول منتصف يناير 2020، تم الإبلاغ عن حالات إصابة بكوفيد-19 في العديد من البلدان الآسيوية، مما يشير إلى بداية أزمة صحية عالمية. وفي غضون أربعة أشهر فقط، انتشر الفيروس إلى جميع القارات. وأُجري مسح مقطعي نوعي من 24 أغسطس إلى 3 أكتوبر 2022 بين العاملين في مجال الرعاية الصحية في مناطق دار السلام وأروشا ودودوما وموانزا. وشارك ما مجموعه 96 مشاركًا من 24 منشأة رعاية صحية في جميع المناطق الأربع. وتم تسجيل المقابلات الفردية ومقابلات المخبرين الرئيسيين باستخدام Kobo Toolbox وتحليلها موضوعيًا. وكشفت الدراسة أن العديد من المشاركين شعروا بأن السياسة ضلل المجتمع بدلاً من تثقيفه. تبين أن الطريقة التي عبر بها العاملون في مجال الرعاية الصحية في تنزانيا عن آرائهم بشأن تأثيرات السياسة في مكافحة تفشي كوفيد-19 تهدد سلامة العاملين في مجال الرعاية الصحية والصحة العامة. كما أعرب عدد كبير من العاملين في مجال الرعاية الصحية عن أن الدين أضر بمكافحة كوفيد-19 في مرافقهم والمجتمع بشكل عام. ومع ذلك، يعتقد عدد قليل من العاملين في مجال الصحة أن الدين له تأثير إيجابي، بينما شعر آخرون أنه له مزايا وعيوب اعتمادًا على تطبيقه. في تنزانيا، ضلل السياسة والدين المجتمع إلى حد كبير بدلاً من تثقيفه. يجب استخدام السياسة النظيفة والممارسات الدينية الجيدة عند مكافحة الأوبئة مثل كوفيد-19.

الكلمات الرئيسية. السياسية، الدينية، الاستجابة، جائحة كوفيد-19، المرافق الصحية، تنزانيا.