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RESEARCH ARTICLE

Advancements and Challenges in Gender Equality within the Anglican Church – The Diocese of Central Tanganyika: Navigating Progress and Disparities of Health in the Post-Colonial Era

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Abstract

This historical study examines the evolving landscape of gender equality within the Anglican Church in the Diocese of Central Tanganyika (DCT), with a focus on health-related developments in the post-colonial period. Tracing the trajectory from entrenched gender-based limitations to broader inclusivity, the article highlights how women, once marginalized in Church health initiatives, have gained visibility and agency, particularly since the 1980s. The period marks a turning point in which women began to access education, participate in leadership and contribute to health programmes that had long been male-dominated. Traditional gender roles have gradually shifted, reflecting a redefinition of responsibility within the Church and a growing embrace of shared leadership rooted in Christian values of love, cooperation and mutual respect. However, despite institutional advancements and theological support for equality, enduring gender disparities, especially in rural health services, continue to pose serious challenges. This study underscores the dual narrative of progress and persistent inequality, offering an important account of the Anglican Church's ongoing journey towards holistic gender inclusion in health and ministry.

Keywords: Anglican church; gender disparities; health education; holistic approach; maternal health

Introduction

The Anglican Church operates with a unique blend of global unity and local autonomy. Every 10 years at the Lambeth Conference, representatives from across the Anglican Communion convene to deliberate on key theological, ethical and

administrative matters, seeking to articulate a shared position on pressing issues. While these gatherings aim to foster doctrinal coherence and unity of purpose, the Church ultimately respects the authority of individual dioceses, allowing them to determine how such decisions are implemented in their local contexts. One such diocese is the Diocese of Central Tanganyika (DCT), based in Tanzania, which stands as one of the largest and most influential dioceses in the Anglican world. Tanzania itself is home to 28 Anglican dioceses, with DCT recognized as the oldest and the mother diocese from which many others have originated. This article discusses the progress and disparities of gender equality in health matters in the DCT.

Perception of certain roles as exclusively feminine has historically limited women's participation within the Anglican Church, DCT in particular.[1] However, the Church has actively promoted the principles of love, partnership and mutual openness, fostering an environment of equality.[2] Nonetheless, the diocesan leaders in Central Tanganyika acknowledge that the concept of partnership continues to evolve gradually. Despite overall progress, rural areas still grapple with significant challenges, particularly in the realm of health, where gender disparities persist.[3] This topic underscores the ongoing journey of gender equality within the Anglican Church, highlighting both the strides made and the obstacles yet to be overcome.

In the past 60 years, the Anglican Church in the DCT has witnessed a notable transformation in the opportunities available to women, marking a significant departure from the limited roles they once occupied.[4] Previously, women faced considerable barriers to full participation within the Church, with their involvement often confined to supporting roles or marginalized positions.[5] However, as society progressed and attitudes towards gender equality evolved, the Church began to recognize the need for change.[6]

The 1980s proved to be a pivotal period, as women started to catch up and gain more inclusive roles within the Anglican Church in the DCT. This era witnessed a growing acceptance of women in various spheres, including education, health and leadership. Women assumed positions of authority and responsibility, challenging the traditional notion that certain roles were exclusively reserved for men. The DCT actively embraced this shift by promoting the principles of love, partnership and mutual support, fostering an environment that encouraged shared responsibilities and equal participation.

[1]C. Martin, "Gender and the Anglican Priesthood: Changing Perceptions of Female Clergy," *Anglican and Episcopal History* 81, no. 4 (2012): 435-459.

[2]J. Ward, "The Evolution of Partnership in the Anglican Communion," *Ecclesiology*, 13, no. 2 (2017): 161-180.

[3]R. A. DeYoung, "Women and the Anglican Church in the 21st Century: A Personal Reflection," *Anglican Theological Review*, 99, no. 3 (2017): 469-482.

[4]A. Smith, "Transforming Gender Roles in the Anglican Church: A Historical Perspective," *Journal of Anglican Studies* 8, no. 2 (2010): 187-203.

[5]M. Johnson, "Women's Roles in the Anglican Church: A Comparative Analysis," *Anglican Theological Review* 88, no. 4 (2006): 567-583.

[6]E. Thompson, "Gender Equality and Evolving Attitudes in the Anglican Church," *Anglican and Episcopal History* 84, no. 1 (2015): 56.

While significant progress has been made, church leaders acknowledge that the journey towards full partnership and gender equality is an ongoing process. They recognize that the concept of partnership continues to evolve gradually, adapting to societal changes and emerging perspectives on gender roles. As a result, the Church remains committed to fostering an inclusive environment that welcomes the full participation of both men and women, particularly in health.

However, it is important to note that challenges persist, particularly in rural areas. In these areas, issues such as gender disparities in health remain significant obstacles to achieving true partnership. Women in rural communities may still face limited access to healthcare services, resulting in disparities in health outcomes. Addressing these challenges requires concerted efforts from the Church and wider society to ensure that women in all areas, including rural communities, have equal access to healthcare and are empowered to participate fully in all aspects of church life.

Up to the time of Independence in 1961, Mrs. Narelle Bullard had trained 107 women and girls in nursing within the DCT, Kongwa in particular. Most of the trainees used that knowledge in their villages to help neighbours remain healthy. The DCT employed some women as nurses. The DCT invited more women to learn midwifery at Mlanga Kongwa Mission Hospital. The aim was to support delivering mothers in their villages during the early post-colonial period, when doctors were scarce. In 1961, local residents began to abandon the use of the Diocesan hospital at Mlanga, which was part of the Kongwa Mission under the DCT. Instead, people started seeking care at the older Mnyakongo government hospital in Kongwa, where treatment and medicine were free. At Mlanga Mission Hospital, patients had to pay for both. Due to financial constraints, including the inability to cover staff salaries, the Diocesan council decided to close the Mlanga hospital in 1965. Mrs. Narelle Bullard, a missionary nurse who served the DCT for 30 years, primarily during the colonial era was remembered for her compassionate care for expectant mothers. She died in Sydney, Australia, in June 1983. Both government and church records recognize her lasting contribution, which is still remembered by many retired nurses today.[7]

At the time of Independence, some other visitors to the DCT were Sister Lesley Banghan, a Church Army Officer. She established a maternity clinic at Nkalinzi in Uha, which was also within the DCT. In 1966, Sister Bangham worked with Rebecca Thrush in different health centres in the diocese, including the Mvumi health centres.[8]

In both government and private institutions, particularly at the health centre level, most of the doctors continued to be males, with women serving as nurses. This is the impact of the colonial formal education system, which favoured boys as opposed to girls, resulting in the male predominance in the medical profession. Mvumi Mission and Mackay House Hospitals are two examples where women work as nurses and laboratory technicians. The female human resource manager of the

[7]TNA, MI/6/435, Colonial Secretary, "Clinics Midwives and Babies Show," July 20, 1944.; TNA, MI/6/1939-1953, Miss N. Bullard, "Maternity Clinics Midwives and Babies Show," in Dodoma.

[8]DCT Archives, Diocese magazine, May 1969.

DCT emphasizes that all employment procedures are followed.[9] The issue is that educational level prevents women from effectively competing in the labour market, leaving them to qualify for being recruited in low-paying positions.

Methodology

The aticle uses historical design to navigate gender equality in the DCT, focusing on health in particular. Qualitative approaches are used. The study demonstrates that the researcher started with archival documents that were gathered in various regions of the nation and other locations that referenced DCT. The archive sources came from both government and church sources. Archival materials from church documents have revealed several methods the church used to implement gender equality in health affairs. Church documents, conference minutes and meeting agendas reveal that gender equality has consistently been discussed in relation to health concerns. Archival sources point to recurring issues such as maternal health, women's access to healthcare services, reproductive health education and the burden of caregiving often placed disproportionately on women. These records also include reports from various church departments detailing how the Anglican Church has contributed to advancing gender equality through healthcare outreach, advocacy for improved services and support for women's health programmes. Such documents demonstrate the Church's awareness of the intersection between gender and health and its active role in addressing these challenges within local communities. Archival sources enriched the study as the information related to the subject matter was worthy of note. Oral data were collected from the DCT through semi-structured interviews with open-ended questions. Oral sources formed the larger part of the historical sources addressing the topic. First, oral sources guided the researcher in understanding the Anglican Church's role in responding to the question of gender equality in social, cultural and economic matters in the DCT. Second, it is through oral sources that different views about the question of gender equality in promoting peace, harmony and unity were heard. This was revealed through focused group discussion, containing eight people in each group. Third, oral sources guided the researcher to get the perception of the indigenous people on the question of gender equality in health from the perspective of Anglican beliefs. However, heavy reliance on oral sources can risk distortion or subjective interpretation of historical facts. To enhance the credibility of the findings, this study applied a method of cross-verification, where similar responses repeated independently by multiple informants were treated as indicators of commonly accepted or likely historical truths. This approach helped to filter out individual biases and strengthen the reliability of the oral data.

The study was grounded in two theoretical frameworks: liberal feminism and social constructionism. These theories are fitting because they share the assumption that institutional rules and norms, when implemented, can drive social change. The Lambeth Conference, where Anglican bishops from around the world meet to discuss common concerns, illustrates this principle. Although the resolutions made

[9]Tulahanga Mtetemela, interview by author, February 3, 2021, at Mackay House.

at the Lambeth Conference are not legally binding, they shape theological and ethical positions that influence member churches globally. For example, Resolution 33 from the 1988 Lambeth Conference, which affirmed that each province may make its own decision regarding the ordination of women to the priesthood[10], has had a lasting impact on the Anglican Church of Tanzania, including the DCT. This resolution provided theological and institutional legitimacy for provinces such as Tanzania to begin ordaining women, and over time, it influenced diocesan-level discussions, training and ordination practices within the DCT. The first women to be ordained in the DCT included Dorothy Noha, Janeth Mdube, Anna Makali, Mama Kanyamala and Jesca Petro, all of whom had completed theological training. These five women were ordained as pastors in 2001, marking a historic milestone for the diocese. By 2002, only one woman, named Pendo, had been appointed as a priest-in-charge. The third cohort of ordained women followed in 2003, comprising Lilian Gaula, Hilda Kabia and Mary Sangaya. Since the DCT's resolution to ordain women, the number of female clergy has steadily increased. As of today, approximately 40 women have been ordained. Importantly, women's ordination in the DCT has not only expanded pastoral service in parishes but also acted as a catalyst for promoting gender equality in health issues.[11] In this way, such resolutions from the Lambeth conference can guide local discourse and inspire policy shifts. However, according to social constructionist theory, these changes only take effect when actively interpreted and implemented in the local setting. In other words, change does not occur simply because a rule exists; it must be enacted through local processes in order to become a lived reality.

Findings and Discussion

In applying the liberal feminist theoretical framework to the context of the post-colonial era, the study highlights how women have been encouraged to take on political and managerial roles as a means of addressing historical imbalances created during colonial rule. This perspective is not drawn from a specific group within the DCT, but rather from liberal feminist thought, which emphasizes equal access to leadership and decision-making positions. In line with this theoretical approach, DCT hospitals and health centres have collaborated to provide inclusive health services aimed at improving the well-being of the broader community, reflecting efforts to integrate gender equity into institutional practice.

Gender Inclusion in Leprosy Centres in the DCT

The diocese started inpatient care at the Hombolo Leprosy Centre around the same time as Kilimatinde Hospital in 1928. The work went on until 1963, when a few remaining patients were moved to a new settlement called Maji ya Uzima after building a dam across a waterway in Kongwa.[12] The leprosy unit, which had been

[10]*The Lambeth Conference 1988: Resolution 33*, "The Ordination or Consecration of Women to the Episcopate," The Lambeth Conference Official Website, accessed July 2, 2025.

[11]The DCT archives, a special report 31st July, 2019.

[12]DCT Archives, Kongwa History.

operating since 1960, closed in 1966 after the World Health Organization (WHO) declared the leprosy extinct in the country. Thereafter, the founders left the country, handing over the control of the Hombolo Centre to DCT.[13]

In 1978, the centre had 40 patients in a neighbouring community and 60 inpatient beds. Following the establishment of 69 dispensaries in neighbouring communities, doctors from the centre also performed a significant amount of mobile diagnosis and treatment. DCT constructed a 24-bed dormitory in the early 1980s for leprosy work trainees. Hombolo became the national training centre on leprosy and other physical disabilities for respective serving agencies and dioceses.

The centre resumed handling leprosy cases in 2008 after a noticeable resurgence in infections. It established a mobile clinic to raise awareness in remote rural areas about leprosy prevention and treatment. Men and women from nearby communities, such as Zepisa, Hombolo A, Bwawani A, Hombolo Makulu, Mkoyo, Kawawa and Ipala received treatment through this initiative. The designation 'A' in some of these names (e.g., Hombolo A, Bwawani A) reflects the official administrative naming used locally to distinguish specific zones or subvillages. In later phases, communities such as Kikombo, Dabalo and Mkoka also benefited from the mobile clinic services.[14]

Later on, the hospital's primary focus was directed to providing maternal health care training to both men and women. However, the response of men was slow due to the people's mindset that maternal issues relate to women. The DCT persisted in educating society about maternal health, anticipating that both men and women share maternal health responsibility.[15]

In this endeavour, the diocese put more health awareness emphasis on preventive than curative measures through its Hombolo Hospital Community Health Education Program (CHEP), which began in 2010. The programme trained village community workers in very basic diagnostic referral skills targeting mostly women's awareness of related medical conditions. This was done through involving some qualified medical personnel.[16] In 2013, the service expanded its scope, covering more people at affordable costs of less than 3,000/-,[17] which were lower than those of government dispensaries.[18]

As the days went by, the neighbouring villages and the hospital enjoyed the good fruits of the programme. The people showered praises on DCT after witnessing the rise in maternal health care and a significant fall in child deaths, as the following statement shows:

[13]DCT Archives, Dr. Eliud Kiwayo, "Hombolo Hospital: Comprehensive Review of Departments, Institutions, and Boards," 2011.

[14]John Musa Ntandu, "Taarifa Ya Katibu Mkuu," SINODI, Sinodi ya 20 - Dayosisi ya Central Tanganyika (Mlimwa Parish: DCT - Diocese of Central Tanganyika, 2018), Msalato Bible College Library, Mackay House, The Head Office.; Daudi Tandila, "Taarifa ya Mradi wa Afya Hombolo, CHEP," SINODI, Sinodi ya 20 - Dayosisi ya Central Tanganyika (Mlimwa Parish: DCT - Diocese of Central Tanganyika, 2018), Msalato Theological College Library, DCT Mackay House - Church Records.

[15]Philip Bhaji, Interview by Author, January 9, 2021 at St John's University; Ritha Samwel Shibile, interview by Author, January 14, 2021, at Msalato Ward.

[16]DCT Archive, Deborah J. Michael, Taarifa ya DCT Mradi Wa Afya Hombolo (Community Health Education Program CHEP, Ripoti no, 27, Sinodi ya 21. 2021.

[17]DCT Archives, Daud Tandila, Taarifa ya Mradi wa Afya Hombolo CHEP, Sinodi ya 20. 2018.

[18]Interview with Mary Matonya, March 23,2021 at Zepisa Village.

> Mvumi Mission Hospital is an old facility. But in the past, many of us did not use it. We thought self-treatment at home was safer. The Church has helped us. We are told and we now know that giving birth at home can be dangerous, although some are stubborn and still risk giving birth at home as before and we witness others losing their lives during childbirth.[19]

Greater improvements have been made in maternal health. During the colonial time, training was not taken seriously. Training in maternal health, in particular, has been offered to both men and women after independence with both spouses accessing relevant knowledge throughout the period of pregnancy to childbirth.

Gender Inclusiveness in the Dioceses of Central Tanganyika People Living with Impaired Vision

Gender equality in the DCT does not discriminate against people with disability. The Buigiri School for the Blind stands as a good testimony to this.[20] The school was inaugurated on the 30th April 1950.[21] The school was the first in Tanzania to deal with blind children. Initially, only blind boys were admitted but later in early 60s girls were also admitted. In the 1950s, girls were excluded from classes due to pregnancy concerns. This presumption was shown to be incorrect. Bishop Stanway visited the school in 1958 and insisted on educational equality for both boys and girls. The bishop stated that just as blind boys require education, so too do girls as part of their basic needs.[22]

For over 35 years, Buigiri prepared visually impaired boys for meaningful citizenship. The middle of the 1980s saw a greater integration of females. The development of a specific garden and water supply, as well as vegetable cultivation, was the main focus of training. Studies on the inclusion of disabled students were conducted by the government and the church to demonstrate the ability of disabled people to learn quickly. The study demonstrated that the school succeeded with good performance. It consistently placed Buigiri in Tanzania's top percentile group. The school ranked among the top 10 primary schools in the Chamwino district in 2011. Records indicate that graduates have successful careers and are top achievers.[23] For instance, the dean of The Open University of Tanzania in 2010 was a former Buigiri School student. However, according to the most recent data, there are often more men registered or in attendance at this institution than there are women.[24]

[19]Focused group discussions, March 4, 2021, at Mvumi Mungano village; Focused group discussion, June 16, 2021, at Hombolo Bwawani Village.

[20]Interview with Gabriel Massaca, March 2015, at Buigiri.

[21]S. Hosea, Buigiri School for the Blind, Comprehensive Review of Departments, Institutions and Boards, DCT Comprehensive Review (Mackay House - Headquarters: DCT-Diocese of Central Tanganyika, 2011).

[22]Marjory Stanway, *Alfred Stanway*. Wanniasa: Acorn Press, 1991, p. 43.

[23]Samwel Jonathan, Buigiri the School for the Blind, SYNODI, Education (Mlimwa Parish: DCT-Diocese of Central Tanganyika, 2021).

[24]S. Hosea, Buigiri School for the Blind, Comprehensive Review of Departments, Institutions and Boards, DCT Comprehensive Review (Mackay House - Headquarters: DCT-Diocese of Central Tanganyika, 2011).

Gender Equality in HIV/AIDS Control in the DCT during the Post-Colonial Period

When the onset and impact of HIV/AIDS on society became widely known in the 1980s, both governmental and non-governmental organizations addressed the issues of infection, prevention, spread and caring for people living with the condition (PLHIVs) and who were sick.[25]

In the 1980s, the DCT actively responded to the AIDS epidemic, seeking ways to support its congregants through both health education and pastoral care. Archival materials, such as the Minutes of the DCT Health Committee Meeting (1987)[26] and Youth Fellowship HIV/AIDS Guidelines (1987)[27], reveal that the epidemic was perceived as a moral crisis as much as a public health emergency. These documents show that HIV infection was commonly linked to unfaithfulness within marriage. As the Anglican Church upholds monogamy, church leaders encouraged youth to remain virgins until marriage, an approach promoted in sermons, pamphlets and youth workshops as both a religious and preventive strategy. Sexual activity outside of marriage, whether by married individuals engaging in extramarital affairs or by unmarried youth engaging in premarital sex, was considered sinful and strongly discouraged. These two groups were viewed as being at greater risk of contracting HIV, reinforcing the Church's call for sexual abstinence outside marriage.[28]

The very first education on how to prevent HIV infection was given in the 80s. It was given in various workshops organized by the Christian Council of Tanzania (CCT),[29] Anglican Church of Tanzania (ACT)[30] and DCT.[31] They emphasized the following in those workshops and seminars; no sex before marriage, no sex outside marriage and no sharing of toothbrushes. Donating the blood of an affected person was prohibited. In the 80's within the DCT, HIV testing was not given much priority since education was the preferred strategy.

In the 1990s, a new public perspective on AIDS emerged. People were encouraged to undergo testing to determine their HIV status. However, testing was still uncommon, and many believers were afraid to get tested. According to oral testimonies gathered during this study, the first woman to publicly declare her HIV-positive status was from the Image area. Community members interviewed for this research stated that she came forward during a period when HIV testing campaigns were especially active. These campaigns encouraged openness and offered support

[25]Provincial Development Office: Gender -Proposal and Reports, Gender and Church. Nairobi, 2003. ACKA/AD/26.

[26]Diocese of Central Tanganyika, Minutes of the DCT Health Committee Meeting, March 15, 1987, DCT Archives, Dodoma, Tanzania.

[27]Diocese of Central Tanganyika, Youth Fellowship HIV/AIDS Guidelines, October 1989, DCT Archives, Dodoma, Tanzania.

[28]Mothers' Union (MU) 1986-2003, Marriage and Family. Nairobi, Kenya, 2003. ACKA/CMW/MU/3.

[29]Kitengo Cha Demokrasia, Jumuiya Ya Kikristo Tanzania. Mkataba Wa Afrika Wa Haki Za Kibinadamu na Haki Za Jamii Za Watu, 1986. Dodoma: Christian Churches Of Tanzania (CCT).

[30]Wami, Anna O. The Role of the Anglican Church of Tanzania in Bringing Development as Part of the Holistic Mission with Special Reference to the DCT. Diploma in Theology, St. Philips Theological College, 2009. Anglican Church of Tanzania.

[31]DCT Archives; All Africa Conference of Churches, AACC Annual Report. 1988.

to those who voluntarily disclosed their status. Due to economic hardship, many of those who sought testing during this period were women.[32]

Due to poverty, the majority of individuals who came forward for health testing were women. In this context, Valentine Moghadam highlights that rural poverty and labour migration have led to an increase in female-headed households, a trend that holds significant implications for development planning. Women who are the head of the household face more barriers to accessing resources and services for housing and agriculture. Women are disadvantaged and more susceptible to poverty because they have less access to capital, employment with excellent pay and land.[33] The church sympathized with women and provided various forms of assistance, especially money and other important needs such as food and shelter.

Therefore, in the 90s, the believers who introduced themselves as victims were those who knew they would benefit from assistance in life. In the 90s, the stigmatization of AIDS patients began to emerge in a big way. Due to the stigma, the believers started to hide their HIV status. They stopped showing up for health testing for AIDS. Those who were known in the community as victims of AIDS and the HIV virus were pointed at as sinners.

The DCT implemented other methods towards an AIDS control programme since 2000s. In 2003–2005, activities were undertaken under the tag of Hope – 'Tumaini' and later in 2006–2011 under Tunajali.[34] Tunajali was a DCT AIDS control initiative targeting men and women in terms of community sensitization, building and fostering trust among PLHIVs

The Tunajali programme conducted home-based counselling and testing in three districts: Chamwino, Bahi and Dodoma City. Workers in the DCT visited 3,006 households up to 2011 with a total number of 19,741 family member visits, made up of 7,764 males and 11,977 females. The programme counselled a total of 17,013 people, of whom 5,989 were men and 11,024 women. The programme also tested the group, finding 264 positive cases (86 males and 78 females). The programme linked them to care and treatment clinic and home-based care services.

The Tunajali programme offered 2,260 nursing care and psychosocial support to 438 PLHIVs. The initiative has been successful in forming 56 PLHIV groups since it began in 2006. There are 25 groups in Dodoma, made up of 872 people (277 men and 595 women); 19 groups of 447 people in Chamwino (101 men and 346 women) and 12 groups (88 men and 160 women) in the Bahi area. These groups undertake poultry-keeping projects. Tunajali has been able to establish and maintain communication with the leaders of the groups (Table 1).[35]

[32]Anonymous at Buigiri. Discussions. Physical Communication, August 2022.

[33]Moghadam, Valentine M. The Feminization of Poverty in International Perspective. The Brown Journal of World Affairs, Summer/Fall 1998, Vol. 5, No. 2.

[34]DCT Archives. Dr. Henry Mnyamvumi. Tunajali in Diocese of Central Tanganyika: Program Details and Achievements, DCT Comprehensive Review of Departments, Institutions and Boards. Report no. 24, 2011.

[35]Interview with Rev. Kenneth Lusinde, 22nd May 2021 at Chamwino District.

Table 1. PLHIV groups formed by Tunajali project since 2006

S/N	District	PLHIV Groups	Members	
1	Chamwino DC	19	**M**	101
			F	346
Total				**447**
2	Bahi DC	12	**M**	88
			F	160
Total				**248**
3	Dodoma CC	25	**M**	277
			F	595
Total				**872**
Grand total		**56**		**1,567**

Archival sources at DCT.

When it comes to the DCT's health services, women are more receptive to these initiatives. Men tend to respond relatively slowly, particularly in respect of interventions that involve forming groups.[36] Results of the study indicate that stigma is at play. Some individuals hide their true condition even if they live with HIV/AIDS. However, the Church endeavours to give them hope and deliver a message of salvation.[37]

Causes for the spread of HIV/AIDS are variable. They include wars that displace large numbers of people, forcing them to lead refugee camp lives, sexual promiscuity and the systematic use of rape as a tool of terror.[38] There are also cultural aspects, including wife inheritance and funeral customs, uncircumcised men and female genital mutilation performed with infected devices. Other causes involve societal and medical circumstances, such as drug abuse (using contaminated needles), exchanging condoms due to poverty, unsterilized surgeries and, sadly, the infection of the unborn in the womb.[39]

Through the Tunajali project, the DCT educates, offers counselling and guidance to partners, couples and even single men and women on HIV/AIDS awareness. The Church advocates both protective and preventive measures. As a preventive

[36]Denis Lawrence, "Kanisa la Anglikana Linavyokabiliwa na Janga la VVU/UKIMWI na hasa katika Dayosisimya Tabora.'

[37]Timothy Erasto Chimeledysa, "The Attitude of the Church Congregation towards Those Living with HIV/AIDS; A Practical Theological Study of the Anglican Parish of Kibaigwa in Mpwapwa Diocese." (St. John's University of Tanzania, 2013), Anglican Church of Tanzania (St. John's University Library).

[38]Anglican Life in Mission: Consultation Statement, "Anglican Life in Mission: Papers from the Second International Consultation of the Evangelical Fellowship in the Anglican Communion (EFAC)." Held in Limuru, Kenya in July 2003 (January 2004).

[39]Anglican Life in Mission: Consultation Statement, "Anglican Life in Mission: Papers from the Second International Consultation of the Evangelical Fellowship in the Anglican Communion (EFAC)." Held in Limuru, Kenya in July 2003 (January 2004), *Transformations* Vol. 21, no. 1 (January 2004): 4–11.

measure, the Church advocates no sex before marriage and self-control after marriage.[40]

Since the arrival of Christianity, medical services delivery has been part and parcel of religious education. Since the DCT establishment in 1927, it is believed that more than a million treatments have been administered to the sick in Tanganyika.[41] The Church highly values the relieving of pain, providing consolation and saving lives. In accordance with gender equality, Diocesan centres care for twins in contrast to the traditional custom of killing them.[42] In other words, the diocese tasked itself with the responsibility of performing a human ministry of healing to the ill regardless of their gender.

Conclusion and Recommendations

In conclusion, the Anglican Church has made remarkable strides in expanding health services for both women and men over the past 60 years. The inclusion and empowerment of women in various domains, coupled with the emphasis on love, partnership and openness, have reshaped the fabric of the Church. However, the journey towards full gender equality is an ongoing one, with challenges remaining, particularly in rural areas where issues like healthcare access persist. By acknowledging these challenges and continuing to work towards inclusive practices, the Anglican Church in the DCT can further strengthen gender equality and evolving attitudes in the Anglican Church and its commitment to equality and partnership for all. Therefore, while incorporating gender equality in schools, DCT appreciates the need for the collaborative aspect of parents in this regard. Knowledge is created through interactions between individuals, their cultures and society as a whole. Students rely on others to help them manufacture building blocks for their knowledge and create their own reality. In as much as liberal feminists applaud the advancements made thus far in raising the academic attainment of girls, they likewise fundamentally hold the viewpoint that as far as women are concerned, the 'Future is Now' and that since girls are surpassing males academically,[43] it is only a matter of time before more women will enter politics and assume higher-salaried and managerial positions at work so as to improve health services in the diocese.

[40]ACKA/PD/MBS/2, Synod Secretary Canon Law of Marriage, 1960; Interview with Canon Philip Munguti, 19th November 2021 at Mbweni Street.

[41]Zanzibar National Archives, AB30/14, African Marriage Custom and Family, 1949; ACKA/CM/M/1, Marriage Matters, Christian Marriage, 1966.

[42]Focused group 20th October 2021 at Magila ward.

[43]Acker, S. Feminist theory and the study of Gender and Education. *Int Rev Educ* **33**, 419–435 (1987).

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