

Accessibility of Diaconical Services to Intended Beneficiaries in the Moravian Church in Tanzania: A Case Study of the Southwest Province

Jacob Sadock Simwanza

Department of Theology, Faculty of Humanities and Social Sciences, Teofilo Kisanji University, Mbeya, Tanzania

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ABSTRACT

This article examines perceived accessibility of diaconical services in the Moravian Church in Tanzania, Southwest Province. It draws on the first objective of a wider mixed-methods study and uses an exploratory, qualitatively led design in which questionnaire patterns were interpreted together with interview evidence. A total of 180 questionnaires were distributed and 140 valid questionnaires were analysed, giving a response rate of 77.8%. The questionnaire assessed four practical dimensions: ease of access, communication of available services, convenience of service locations, and convenience of time and procedures. For ease of access, 45.0% of respondents agreed or strongly agreed, while 47.9% were neutral. For communication, 50.0% were positive and 42.1% were neutral. For location, 52.9% were positive, 34.3% were neutral, and 12.9% were negative. For time and procedures, the source reported 59.3% agreeing, 22.9% neutral, 17.1% disagreeing, 0.7% strongly disagreeing, and none strongly agreeing. Interview evidence identified distance, poor roads during rainy seasons, transport cost, limited specialised facilities, communication barriers affecting deaf people, and delays linked to referral procedures. The survey included a mixed church-connected sample, not only confirmed service users, so neutral responses are interpreted cautiously. The findings indicate moderate and uneven accessibility rather than universal access. The article argues that servant leadership provides a useful ethical lens, but organisational capacity and practical access conditions are also necessary to explain whether service-oriented intentions become reachable support.

Keywords: diaconical services; accessibility; beneficiaries; Moravian Church; faith-based organisations; servant leadership; mixed methods; Southwest Province; Tanzania

INTRODUCTION

Diaconical ministry is one of the practical ways through which Christian churches respond to social, economic, physical, emotional and spiritual needs. In this article, diaconical services refer to organised forms of Christian service delivered through recognised church structures, programmes, committees, staff or trained volunteers. This is different from informal congregational charity, such as an individual member giving private help to another person, because institutional diakonia involves some form of organised responsibility, coordination or referral. Collins (1990) links diakonia to service carried out on behalf of others, while the World Council of Churches (2013) places life, dignity, justice and transformation at the centre of Christian mission.

For this article, accessibility means the extent to which an intended beneficiary can know that a service exists, reach the service point or responsible person, use the service without avoidable physical or communication barriers, and complete the required process within a suitable time. This operational definition is assessed through four questionnaire indicators: general ease of access, communication of service information, convenience of service location, and convenience of time and procedures. These indicators are interpreted with reference to Penchansky and Thomas (1981), who describe access as the fit between users and a service system through availability, accessibility, accommodation, affordability and acceptability. Their framework was developed for health services, so it is used here as an organising model rather than as an assumption that church diakonia is the same as healthcare.

Faith-based organisations have an established role in Tanzania in health, education, and welfare and community development. Health-sector evidence is useful because it demonstrates how distance, financing, coordination and institutional capacity can shape service reach, but hospital provision and congregational social support are not equivalent. Congregational diakonia often depends more directly on local volunteers, church committees, home visits, worship announcements and referral networks. Therefore, health-system studies are used only to illuminate general access mechanisms, while the analysis gives priority to evidence on community-based faith activity and to the study data from the Moravian Church (Leurs et al., 2011; Maluka, 2018; Henry & Makulilo, 2026).

The Moravian Church in Tanzania, Southwest Province, provides diaconical support through congregations and the provincial Diaconical Department. The wider study examined accessibility, relevance and effectiveness, and service-delivery challenges. This article focuses only on accessibility so that the practical conditions of reaching, understanding and receiving support can be examined in greater depth. It also treats a high neutral response as an empirical finding that requires explanation, rather than automatically classifying it as satisfaction or dissatisfaction.

BACKGROUND, PROBLEM AND STUDY FOCUS

The Southwest Province includes urban, peri-urban and rural communities. The study covered Kibaoni, Rujewa, Itezi, Matundasi, Mswiswi and Nsalaga congregations. Local diaconical committees, volunteers, home visits and outreach activities are intended to bring assistance closer to people in need. What remained insufficiently known was whether these arrangements made services practically reachable to intended users, especially where distance, transport cost, disability, information gaps or referral requirements could restrict access. This matters because the existence of a programme does not show that a person can use it. The article therefore contributes beneficiary-centred and church-connected evidence by examining four distinct dimensions of access and using interview evidence to explain the survey pattern. It also distinguishes the availability of church services from their practical reachability.

The specific objective was to assess the accessibility of diaconical services to intended beneficiaries in the Moravian Church in Tanzania, Southwest Province. The corresponding research question was: How accessible are the diaconical services to intended beneficiaries? The four questionnaire indicators align partly with the Penchansky and Thomas (1981) access framework. General ease and location relate most directly to accessibility, time and procedures relate to accommodation, communication supports effective availability and accommodation, and transport cost emerged qualitatively as an affordability issue. Acceptability was not measured directly and is therefore outside the claims of this article.

LITERATURE REVIEW

Diakonia as organised Christian service

Diakonia has a theological meaning that goes beyond occasional charity. Collins (1990) argues that diakonia concerns service carried out on behalf of another. In contemporary church practice it can include counselling, health-related support, disability inclusion, education, livelihood support, rehabilitation, material assistance and advocacy. The World Council of Churches (2013) similarly connects Christian mission with life-giving action, justice, reconciliation and attention to people at the margins. For analytical clarity, this article uses diakonia to mean organised church social service delivered through recognised structures. Informal acts of generosity may express the same Christian ethic, but they are not treated as equivalent to institutional service delivery unless they are linked to a church programme, committee or referral process.

Accessibility of faith-based services

Community roots can strengthen the reach of faith-based organisations because congregations can mobilise volunteers, use existing social networks and contact households that formal institutions may not reach regularly. Leurs et al. (2011) documented the broad development role of faith-based organisations in Tanzania. Muhoja (2024b) also shows that faith-based organisations use several communication channels, including

social media, to reach audiences, although digital communication does not replace face-to-face channels for every group. These findings support the view that information access is part of practical service access.

Community presence, however, does not remove structural barriers. Maluka (2018) shows that non-state service delivery in Tanzania depends on workable financing, coordination and institutional arrangements. Henry and Makulilo (2026) likewise show the continuing importance of faith-based providers within Tanzanian service systems and the need for cooperation with government. These studies focus mainly on health services, so their relevance to diakonia lies in the organisational mechanisms they identify, not in assuming that church welfare and clinical care are identical.

Transport and physical conditions also affect access. Manda (2003) found that improved rural roads in Tanzania reduced transport costs and increased access to social services and markets. This supports the study's concern with distance, poor roads and seasonal mobility. Disability adds another access dimension. The World Health Organization (2022) identifies physical, communication and organisational barriers as major causes of unequal service use among persons with disabilities. Although the WHO evidence is health-focused, the barrier types are transferable to church welfare settings because a deaf person can face an information barrier and a wheelchair user can face a physical barrier regardless of whether the service is clinical, social or religious.

Availability, accessibility and the research gap

Availability means that a programme, committee or form of assistance exists. Accessibility requires more: the intended user must know about it, reach it, enter or contact it, meet reasonable requirements and receive assistance within a suitable period. A counselling service may be available at a church centre but difficult to reach from a remote village. A disability programme may exist but remain difficult for a deaf person to use when no trained sign-language communicator is available. A referral procedure may improve accountability while also delaying urgent help. This distinction is central to the present analysis.

Existing institutional accounts often emphasise programmes, facilities or beneficiaries reached, while giving less attention to people who do not reach services. The present article addresses this gap by analysing perceived access through four dimensions and interpreting the quantitative pattern together with leadership and service-delivery accounts. It also recognises that the survey sample included ordinary members and church workers as well as self-identified beneficiaries. Therefore, the results indicate perceived accessibility within a church-connected population and should not be presented as a pure service-user satisfaction survey.

ANALYTICAL FRAMEWORK

Servant Leadership Theory

The wider study was guided by Servant Leadership Theory, associated with Greenleaf (1977). The theory is retained because diaconical ministry is explicitly service-oriented and because it provides a normative test of whether leadership decisions place vulnerable people's needs before institutional convenience. Van Dierendonck (2011) identifies dimensions such as empowerment, stewardship, interpersonal acceptance, authenticity, humility and direction. Eva et al. (2019) similarly describe servant leadership as leadership that gives priority to followers' needs and development.

Servant Leadership Theory is not used here as the primary measurement model for accessibility. An access-to-services framework is better suited to defining the access construct, while servant leadership helps interpret the ethical and organisational response to barriers. Street-level bureaucracy could explain discretion in frontline decisions, and resource-dependence theory could explain dependence on external resources, but neither directly reflects the theological service orientation that motivated the wider study. For this reason, servant leadership is used as a normative lens, Penchansky and Thomas (1981) guide the access construct, and an organisational-capacity lens is used to interpret material differences in transport, staff, facilities, communication and funding.

Table 1. Relationship between analytical lenses and empirical indicators

Lens or dimension	Meaning in this article	Empirical indicator or evidence	Analytical caution
Access: accessibility	Fit between user and service location or point of contact	General ease of access; convenience of location; distance and roads in interviews	Travel time was not measured directly.
Access: accommodation	How service arrangements fit users' practical circumstances	Time and procedures; communication arrangements	Waiting time and number of referrals were not measured quantitatively.
Access: affordability	Financial burden of reaching or using the service	Transport cost in interviews	No separate affordability questionnaire item was used.
Servant leadership: empowerment	Bringing capacity and decision support closer to people	Local committees; volunteer training; home visits	Evidence concerns organisational practice, not a direct servant-leadership scale.
Servant leadership: stewardship and direction	Responsible coordination and clear service pathways	Referral forms; case identification; procedures	Accountability can create delay if procedures are not proportionate to urgency.
Servant leadership: interpersonal acceptance	Respectful and inclusive treatment of vulnerable people	Disability inclusion concerns; non-discriminatory outreach	The sample did not record the number of deaf beneficiaries.
Organisational capacity	Resources required to convert service intention into actual reach	Transport, staff, specialised facilities, funding, communication systems	Used as a complementary explanatory lens, not as a tested causal model.

METHODOLOGY

Design and mixed-methods integration

The wider study adopted an exploratory mixed-methods approach. The dissertation describes an exploratory design in which qualitative methods were supported by quantitative questionnaire data. The available study records do not document a formal exploratory-sequential or convergent protocol, so this article does not apply either label retrospectively. Instead, the design is reported as exploratory and qualitatively led. Integration occurred at the interpretation stage: Likert response distributions were first summarised, then interview evidence was used to explain geographical, communication, disability-related and procedural patterns. This is the documented mixing point.

Study setting, sampling and respondent composition

The study was conducted in the Moravian Church in Tanzania, Southwest Province, and focused on six congregations: Kibaoni, Rujewa, Itezi, Matundasi, Mswiswi and Nsalaga. The source dissertation reports inconsistent province-wide congregation totals in different sections, so no province-wide total is used in this article. The target groups included pastors, ordinary church members, provincial diaconical leaders, representatives from selected congregations and people who had benefited from diaconical services. Purposive sampling was used for key informants because of their direct knowledge of planning, coordination and service delivery. Ordinary church members and beneficiaries participating in the questionnaire were selected through a lottery form of simple random sampling among eligible participants.

A total of 180 questionnaires were distributed and 140 valid questionnaires were returned and analysed, giving a response rate of 77.8%. The dissertation does not report the full number of eligible individuals in each congregation, item-level missingness, or congregation-specific non-response. It also does not provide a separate service-use screening variable. These omissions prevent a valid comparison of confirmed users with

non-users and limit interpretation of neutral responses. The article therefore reports the sample transparently and avoids treating all 140 questionnaire respondents as confirmed beneficiaries.

Table 2. Questionnaire respondents by congregation and church association

CHARACTERISTIC	CATEGORY	N	%
Congregation	Kibaoni	27	19.3
Congregation	Rujewa	31	22.1
Congregation	Itezi	13	9.3
Congregation	Matundasi	31	22.1
Congregation	Mswiswi	29	20.7
Congregation	Nsalaga	9	6.4
Church association	Member	104	74.3
Church association	Beneficiary	9	6.4
Church association	Church worker	13	9.3
Church association	Volunteer	1	0.7
Church association	Other	13	9.3
Total	All questionnaire respondents	140	100

The church-association variable shows that the questionnaire sample was mixed. Only nine respondents self-identified under the specific 'Beneficiary' category. Some ordinary members may also have had service experience, but the questionnaire did not record this separately. Percentages may differ by 0.1 because of rounding.

Data collection and analysis

Closed-ended questionnaires used a five-point scale from strongly disagree to strongly agree. Interviews were conducted with church actors involved in diaconical work, including the Bishop, the Diaconical Secretary, pastors and chairpersons. The available dissertation records do not state the exact number of interviews or their duration. These details should be taken from the original field log before journal submission rather than estimated.

Quantitative data were analysed in IBM SPSS Statistics version 20 using frequencies and percentages. The four accessibility items represent distinct dimensions and were not combined into a single scale score. The retained records available for article preparation did not include respondent-level data needed to conduct valid cross-tabulations or chi-square tests by congregation or service-use status. Such analyses should only be added if the original respondent-level dataset is recovered and the assumptions of the selected tests are met.

Qualitative interview material was analysed thematically. The dissertation cites Braun and Clarke (2006) and reports that interview responses were organised into themes. The available records do not preserve a full coding audit trail, so this article does not claim a more detailed coding procedure than the source can support. For mixed-methods interpretation, themes concerning distance, roads, transport, communication, disability inclusion, local committees, referrals and service procedures were used to explain the questionnaire distributions.

Ethical considerations

Participants were informed about the purpose of the study, participation was voluntary, informed consent was obtained, and confidentiality and anonymity were maintained. Permission was obtained from the university, the Moravian Church and relevant authorities. The available dissertation does not state the name of the university ethics committee, the approval or protocol number, or the approval date. These details should be inserted exactly from the original ethics clearance record before journal submission and should not be estimated.

FINDINGS

Interpreting the survey sample

The first finding concerns the composition of the survey itself. The 140 questionnaire respondents were not a homogeneous group of confirmed service users. Most identified as church members (74.3%), while 6.4% selected the specific beneficiary category. This makes the neutral category especially important. A neutral response may reflect mixed experience, uncertainty, limited knowledge, or no direct service use. Because the questionnaire did not include a separate service-use question, these possibilities cannot be separated statistically. The following findings therefore describe perceived accessibility among the sampled church-connected respondents, supported by interviews with people involved in service delivery.

Ease of access to diaconical services

On the statement that diaconical services were easily accessible, 40 respondents (28.6%) agreed and 23 (16.4%) strongly agreed. Seven (5.0%) disagreed and three (2.1%) strongly disagreed. The largest category was neutral, with 67 respondents (47.9%). The headline result is therefore not simply that 45.0% were positive, but that almost half of the sample did not give a clear positive or negative judgement. Because service-use status was not recorded separately, neutrality cannot be interpreted as evidence of difficult access alone.

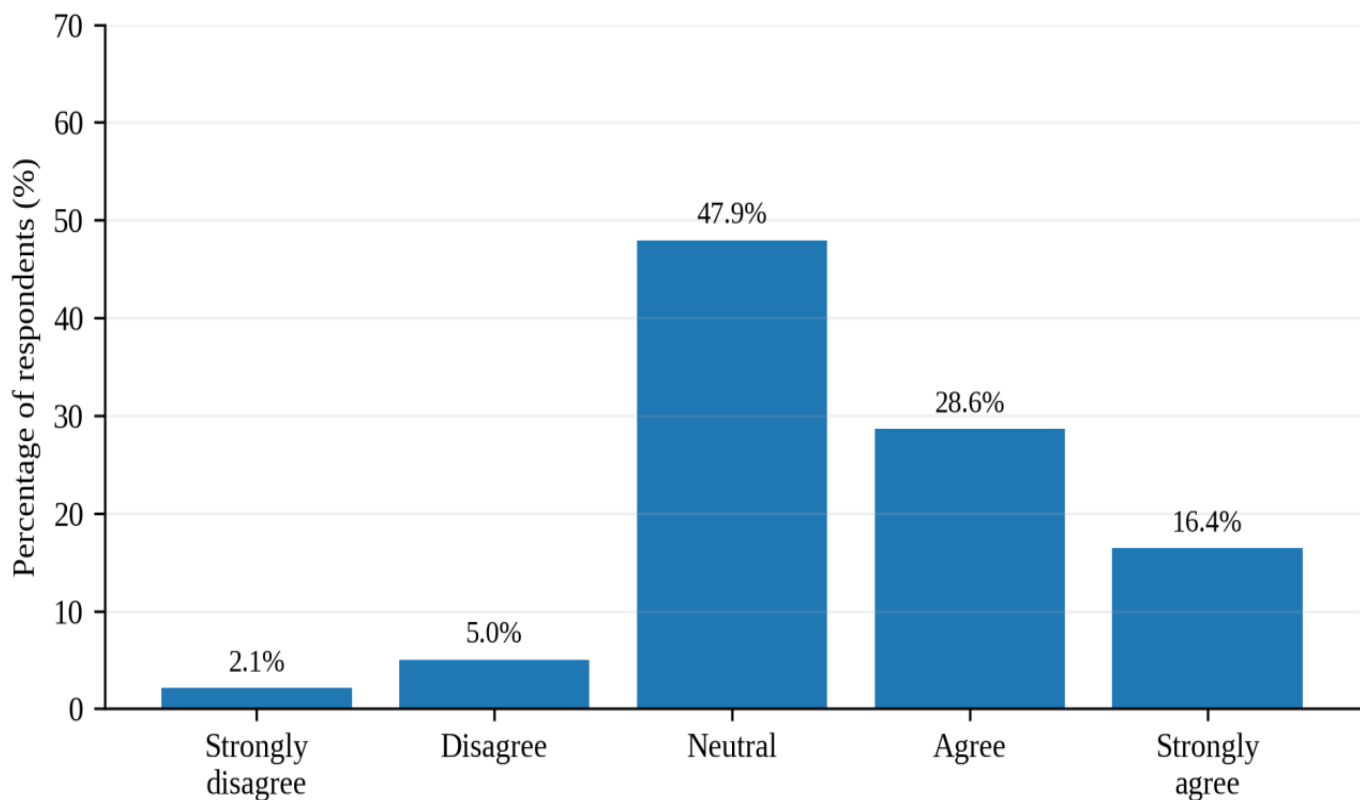


Figure 1. Perceived ease of access to diaconical services

Source: Field data (2026).

Interview evidence nevertheless identifies practical barriers that can explain uneven access among people who seek support. Respondents described greater difficulty in remote areas, especially where roads become difficult during rainy seasons. Transport cost, awareness of available programmes, household economic conditions and the need for specialised services also shaped whether assistance could be reached. The Bishop reported that more than 570 diaconical volunteers had been trained by 2025 and those congregational committees were intended to identify people in need and provide basic support locally. This shows strong local availability, but not complete reachability.

“Diaconical committees are established and trained at congregational level to identify and provide basic needs to people in need in their communities.” Bishop, interview

Communication of information about services

The questionnaire measured one overall communication statement rather than separate communication channels. Based on the rounded percentages reported in the source, 50.0% of respondents were positive and 42.1% were neutral. Because the raw SPSS frequency output was not available in the supplied records, the article reports the source percentages without reconstructing individual response counts. Interview evidence identified worship announcements, church gatherings, community meetings, home visits and outreach as communication routes. Radio and SMS were not measured as separate questionnaire channels and are not presented as measured results.

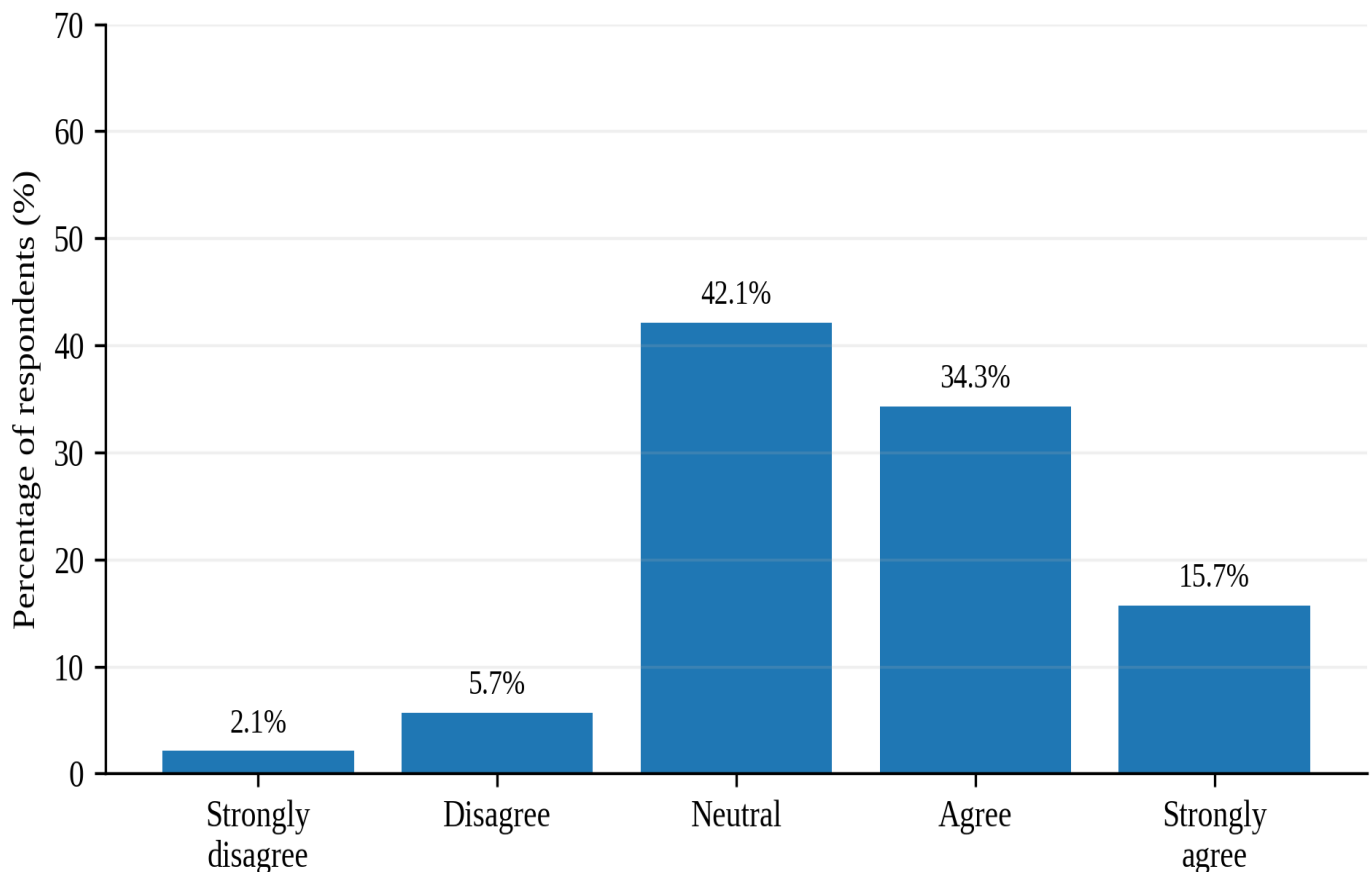


Figure 2. Communication of information about diaconical services

Source: Field data (2026).

Interview participants explained that communication was stronger where local committees and leaders actively contacted communities. In more remote areas, information could arrive late or depend too heavily on physical church gatherings. This can exclude people who attend less often or live outside normal congregational networks. Disability inclusion also emerged as a communication issue. The Bishop stated that few leaders and pastors knew sign language. The study records do not state how many deaf beneficiaries were included in the sample, so no numerical claim about that subgroup is made.

"The geographical challenge within our province is very large and it is difficult to reach all people on time in educating communities about diaconical services and their importance. Another challenge is transportation because we do not have suitable transport considering the geographical nature of our environment." Diaconical Secretary, interview

Convenience of service locations

For service location, 46 respondents (32.9%) agreed and 28 (20.0%) strongly agreed, giving 74 positive responses (52.9%). Forty-eight respondents (34.3%) were neutral. Twelve (8.6%) disagreed and six (4.3%) strongly disagreed, giving the highest combined negative response among the first three indicators, 18 respondents (12.9%). This pattern shows that the presence of congregational service points improved access for many respondents, but geographical inequality remained evident.

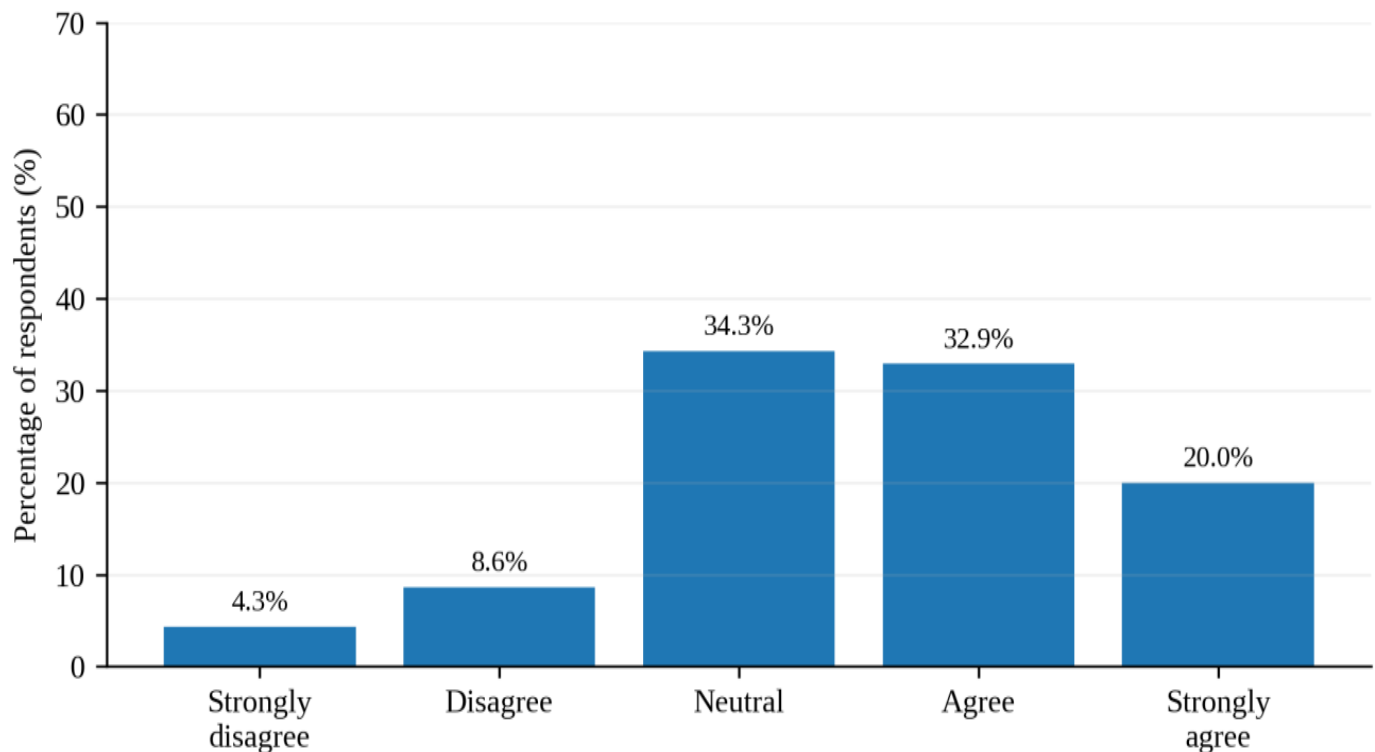


Figure 3. Convenience of diaconical service locations

Source: Field data (2026).

Interview accounts linked location problems to long distances, poor roads, transport cost and the size of the province. The Bishop also explained that a congregational committee could not be established where there was no Moravian congregation. Physical suitability was another concern because some programmes used church buildings or other spaces that were not barrier-free for persons with disabilities. The questionnaire did not record travel time or distance in kilometres, so the study cannot quantify the geographical burden. This should be added as a direct measure in future access studies.

“Geographical accessibility barriers, especially in the rain season create big challenges for the diaconical department at provincial level to reach people in need. The province is very large so it is not possible to cover all areas, and where there is no Moravian congregation it is also not possible to establish a diaconical committee.”

Bishop, interview

Convenience of time and procedures

For time and procedures, the source reports 59.3% agreeing, 22.9% neutral, 17.1% disagreeing, 0.7% strongly disagreeing and 0.0% strongly agreeing. The dissertation text does not provide the corresponding raw frequencies, and the supplied records do not include the original SPSS frequency table. The article therefore reports percentages only for this indicator. The original questionnaire asked whether 'the time and procedures for receiving diaconical services are convenient for beneficiaries'.

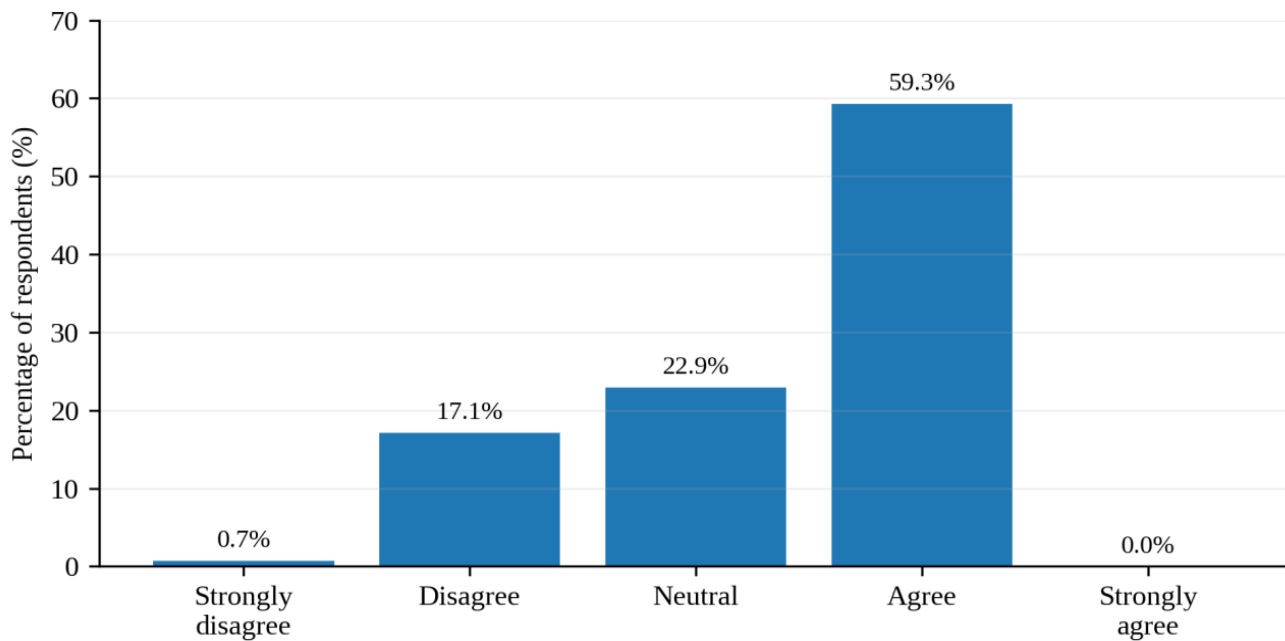


Figure 4. Convenience of time and procedures for receiving diaconical services

The interview evidence helps explain the mixed response. Congregational committees identify cases, provide basic assistance where possible, and refer cases to the provincial Diaconical Department when local capacity is insufficient. The Diaconical Secretary reported that standard forms were used to record beneficiary information and the assistance required. These practices support stewardship and accountability, but referrals can also slow urgent assistance when transport, staff or provincial resources are limited. The study did not measure waiting time or the number of referrals, so the relationship between accountability and speed can be discussed qualitatively but not quantified.

"Diaconical committees are established and trained at congregational level to identify and provide basic needs to people in need in their communities. They are also trained to refer cases to the provincial level of the Diaconical Department where the needs of the community member are too high for the committee to provide locally." Bishop, interview

Table 3. Summary of percentage responses across the four accessibility indicators

Indicator	SD %	D %	Neutral %	A %	SA %
Easy access	2.1	5.0	47.9	28.6	16.4
Information communicated	2.1	5.7	42.1	34.3	15.7
Location convenient	4.3	8.6	34.3	32.9	20.0
Time/procedures convenient	0.7	17.1	22.9	59.3	0.0

Note. SD = strongly disagree; D = disagree; A = agree; SA = strongly agree.

Availability and practical reachability

Table 4. Availability versus reachability of selected diaconical service mechanisms

Service or mechanism	Evidence of availability	Evidence affecting reachability
Congregational diaconical committees	Committees identify needs and provide basic local support.	Coverage depends on the presence and capacity of a Moravian congregation and committee.
Home visits and outreach	Used to identify and contact vulnerable people.	Rainy-season roads, transport shortages and distance can reduce frequency and timeliness.
Information about	Shared through church	People outside regular church networks may

services	gatherings, community contact, home visits and outreach.	receive information late; sign-language capacity is limited.
Training and rehabilitation activities	Programmes are organised through church or other local facilities.	Some venues are not barrier-free and specialised facilities are limited.
Referral to provincial level	Referral forms and provincial procedures exist for needs beyond local capacity.	Travel, limited resources and additional procedural steps can delay urgent cases.

DISCUSSION

Accessibility is present but not uniform

Across the four indicators, positive responses ranged from 45.0% for general ease of access to 59.3% for time and procedures. At the same time, neutrality was high for general ease of access (47.9%), communication (42.1%) and location (34.3%). A simple reading of positive categories would therefore overstate the strength of access. The mixed sample composition provides an important alternative explanation: some neutral respondents may have had limited or no direct service experience. This is a measurement limitation, not proof that access was poor.

The results support a multidimensional view of access. Location was rated more positively than general ease of access, showing that geographical proximity alone does not determine whether a person can obtain support. Information, transport cost, disability inclusion, referral arrangements and the type of assistance required also matter. This fits Penchansky and Thomas's (1981) argument that access involves several forms of fit between a service system and its users. In the present setting, the survey captured some of these forms directly, while affordability and acceptability were only partly or not at all measured.

The findings also refine the role of faith-based networks described by Leurs et al. (2011). Congregational structures can bring services close to communities, but local presence is not sufficient when committees differ in capacity or when specialised cases must move to a provincial level. This connects with Maluka's (2018) finding that non-state service delivery depends on workable institutional arrangements and resources. Muhoja (2024b) emphasises changing communication practices in Tanzanian faith-based organisations. The present study adds that communication diversity is important not only for visibility, but also for inclusion of people who do not attend church gatherings regularly or who require accessible forms of communication.

Servant leadership and organisational capacity

The local committee system provides evidence consistent with empowerment and stewardship. Training volunteers and allowing congregational committees to identify needs shifts some capacity towards communities. Home visits and outreach also fit the servant-leadership priority of attending to vulnerable people rather than waiting for them to reach a central office. Referral forms and case records show direction and stewardship because they create a clear and accountable pathway for support.

The same evidence also shows where the servant-leadership ideal is incomplete in practice. Limited sign-language capacity weakens interpersonal acceptance and inclusion. Inaccessible venues weaken the practical dignity of persons with disabilities. Transport shortages and difficult roads limit outreach even when leaders are committed to service. Referral procedures can protect accountability but become less responsive when urgent cases face delay. These findings show why servant leadership alone is under-powered to explain variation in access. Ethical commitment must operate through organisational capacity, including transport, trained people, facilities, communication systems and funds.

This combined interpretation avoids a circular conclusion in which every church activity is labelled servant leadership merely because it is church-based. The relevant empirical test is whether leadership and organisational choices reduce barriers in ways that intended users can experience. Where committees improve local identification and first-line response, the service ethic is translated into access. Where infrastructure,

information or procedures continue to exclude people, the ethical commitment remains only partly realised.

PRACTICAL IMPLICATIONS AND RECOMMENDATIONS

The findings of this study show that access to diaconical services is affected by several practical barriers, including long distance, poor transport, limited communication, inadequate facilities for persons with disabilities, delays in referral procedures and weaknesses in monitoring service access. Based on these findings, the following recommendations are proposed.

- **Strengthening communication at community level;** Congregational diaconical committees should improve the way information about available services is shared with people in remote communities. Each congregation should identify contact persons who can help community members understand the available services, eligibility requirements and referral procedures. Existing volunteers, church announcements, notice boards, telephone communication, home visits and community meetings can be used to improve communication. This can help people receive information on time and know where to seek assistance.
- **Improving outreach services;** The Provincial Diaconical Department should increase outreach activities in areas that are difficult to reach. Special attention should be given to remote communities and places where poor roads, especially during the rainy season, limit access to services. The church should plan for transport costs and, where possible, work with partners who can support transport for outreach activities. Regular outreach visits can help bring services closer to people who cannot easily reach church centres.
- **Improving access for persons with disabilities;** The Provincial Diaconical Department should work with organisations serving persons with disabilities to improve communication and physical access to diaconical services. Selected pastors, volunteers and committee members should receive basic training in sign language and other suitable communication methods. Buildings used for diaconical activities should also be assessed to identify physical barriers that make access difficult for persons with disabilities. Where possible, such barriers should be corrected.
- **Improving referral procedures;** The church should develop clear procedures for dealing with urgent cases. Congregational committees should be allowed to provide basic assistance where immediate support is needed, while keeping proper records and reporting the case to the provincial level. This can reduce unnecessary delays and help vulnerable people receive timely support without weakening accountability.
- **Strengthening cooperation with other service providers;** The Provincial Diaconical Department should strengthen cooperation with government institutions, health facilities, rehabilitation centres, disability organisations and development partners. Such cooperation is important where the church does not have enough resources, specialised staff or facilities to address certain needs. Clear referral contacts should be prepared so that beneficiaries can be directed to appropriate services when necessary.
- **Improving monitoring of service access;** The provincial monitoring team should strengthen the collection of information on access to diaconical services. Routine records should include information such as service-use status, congregation, travel time, waiting time, referral procedures, disability-related barriers and unmet needs. This information can help the church identify areas where beneficiaries face difficulties and guide future planning and service improvement.
- The implementation of these recommendations should depend on the available resources, approved church budgets and existing administrative structures. Regular review of progress is also important in determining whether the proposed measures are improving access to diaconical services among intended beneficiaries.

LIMITATIONS AND CONTRIBUTION

Several limitations affect interpretation. First, the questionnaire sample mixed ordinary members, church workers, volunteers and self-identified beneficiaries. Because direct service use was not recorded separately, neutral responses cannot be separated into uncertainty, limited exposure and genuine middle-position judgements. Second, respondents were church-connected and may have felt pressure to rate church services favourably, creating a risk of social-desirability bias. Third, respondents were clustered within six congregations, but the available summary data do not permit item-level adjustment or valid cross-tabulation by congregation. Fourth, disability status and travel time were not measured quantitatively, so the study cannot estimate subgroup differences or geographical burden precisely.

Fifth, the study had no comparison group from another denomination or public social-welfare service. The results therefore describe the Moravian Southwest Province rather than relative performance. Sixth, the source records do not report item-level missingness, congregation-specific non-response, the exact number and duration of interviews, or a full thematic coding audit trail. Finally, communication and time/procedure percentages were rounded in the source material, while the supplied records did not contain the original SPSS frequency output needed to verify exact response counts.

Despite these limits, the article contributes a careful account of church-based access. It shows that local structures can increase availability without guaranteeing reachability, and that access should be assessed through information, geography, physical inclusion, timing, procedures and material capacity. It also demonstrates the analytical value of separating a normative leadership framework from an empirical access framework.

CONCLUSION

Diaconical services in the Moravian Church in Tanzania, Southwest Province were perceived as accessible by a substantial part of the sample, but the evidence does not support universal or equal access. The strongest feature of the service system is its local organisational base, including congregational committees, trained volunteers, home visits and referral structures. The main barriers identified in interviews were distance, transport, uneven communication, limited specialised and disability-friendly facilities, and procedural delay. High neutral responses, especially for general ease of access, must be interpreted cautiously because the questionnaire included many church members who were not separately identified as confirmed service users.

The findings also show that servant leadership is most useful when treated as an ethical test of whether organisational decisions serve vulnerable people in practice. Variation in access is better explained when that ethical lens is combined with access dimensions and organisational capacity. The findings are most directly transferable to similar rural and mixed urban-rural faith-based service systems in Southern Tanzania where local volunteer structures operate alongside resource and transport constraints.

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