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The Role of Waqf in Strengthening Primary Healthcare Services in Gombe State Rural Communities

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Abstract

This activity examines the practical role of Waqf (Islamic endowment) in improving primary healthcare services within rural communities of Gombe State, Nigeria. Although primary healthcare is still essential for long-term community well-being, rural areas in Gombe State continue to face obstacles such as inadequate medical personnel, limited infrastructure, and a lack of affordable medications. Utilizing a qualitative case study methodology, data was gathered through interviews with healthcare professionals, Waqf administrators, community leaders, and beneficiaries in three selected rural communities. The study also analyzed existing Waqf-based health projects and explored the administrative systems and legal frameworks of Waqf in Gombe State. The results show that Waqf, when properly institutionalized, has a revolutionary effect on community health education, drug subsidization, the construction of community clinics, and the provision of free maternity and child health services. Waqf's efficacy in the healthcare industry is, however, constrained by the research's discovery of awareness, regulatory enforcement, and stakeholder coordination deficiencies. The report suggests policy frameworks that incorporate Waqf into Gombe State's main healthcare development plan, the establishment of a state-recognized Waqf commission with a focus on healthcare, and the strengthening of local Waqf administrators' capacity. The study concludes that Waqf is a workable Islamic social finance instrument that can relieve the strain on public health resources, empower marginalized rural communities, and help the state achieve universal health care.

A. Introduction

Across several rural communities in Gombe State, the challenge of accessing quality primary healthcare services remains glaring. Due to insufficient early intervention, avoidable infections like malaria and diarrhea continue to steal lives, and mothers frequently give birth at home without the assistance of trained delivery attendants. Although these communities are resilient, they suffer from systemic neglect in healthcare delivery, necessitating alternative and sustainable community-driven interventions (Mohammed et al., 2024). One such underutilized resource is Waqf, the Islamic endowment system known historically for financing public welfare services, including healthcare (Rahman & Muhammed-Shittu, 2019). Field observations and interactions in areas like Kumo, Dukku, and Billiri reveal recurring issues that include dilapidated health centers, shortage of medical personnel, frequent drug stock-outs, and long distances to the nearest functional clinics.

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However, Waqf's contribution to community health in Gombe State is still primarily unofficial, dispersed, and inadequate. Waqf-based projects, such little dispensaries connected to mosques in some areas of Akko and Nafada LGAs, have been started by a few religious groups and private philanthropists, but they frequently lack organization, scalability, and interaction with official health systems (Muhammad et al., 2023). The rural population is deprived of a crucial socio-religious tool that might greatly reduce the strain on public healthcare facilities because to the restricted use of Waqf (Ahmad, 2019; Rahmanto et al., 2023).

In other parts of Nigeria and the Muslim world, Waqf has been successfully used to establish community health centers, fund outreach programs, and provide subsidized or free medicines to low-income populations despite obvious needs and Islamic injunctions on charity and community welfare (Atan et al., 2024; Mohideen et al., 2021). For example, the IHSAN Zakat and Waqf Foundation in Bauchi State has conducted periodic free medical outreaches and donated essential equipment to local clinics an example that demonstrates the feasibility and effectiveness of faith-based community health interventions (Muhammad et al., 2025a). The community service project is motivated by the real health needs of rural residents who face avoidable health risks in the absence of accessible and affordable care.

This community service project specifically addresses the insufficient use and mobilization of Waqf to support and maintain primary healthcare delivery in Gombe State's underprivileged rural communities.

By including donors, religious leaders, community stakeholders, and current healthcare actors in the development of a Waqf-based support system for nearby clinics, it aims to reposition Waqf as an organized instrument for health improvement.

The general Community Service Objectives are: To identify and document existing primary healthcare gaps in selected rural communities in Gombe State; to mobilize and sensitize community and religious stakeholders on the relevance of Waqf in health service delivery; to initiate a community-based Waqf framework aimed at supporting rural health facilities with equipment, medication, or operational support; to establish partnerships with Islamic scholars and local philanthropists for sustained Waqf contributions to health; and to monitor and evaluate the short-term impact of Waqf-supported interventions on health service access and usage.

Therefore, by encouraging local Waqf resources to close healthcare disparities, strengthen rural communities, and advance inclusive development based on Islamic social ideals, this project seeks to have a tangible and immediate impact rather than only being theoretical.

B. Research Methods

Research Design:

This study utilizes a participatory action research (PAR) design that blends empirical data gathering with community interaction. PAR is particularly ideal for community service research as it stresses engagement with community people in identifying problems, devising interventions, and assessing outcomes. In order to guarantee that the viewpoints and requirements of rural residents be at the forefront of the research process and the final Waqf-based healthcare solutions, this concept was chosen.

Study Area:

Three LGAs (Local Government Areas) in Gombe State which includes Akko, Billiri, and Dukku were chosen for the study because of the presence of religious or community leaders actively involved in social development, the preponderance of Muslim residents, and reports of inadequate primary healthcare facilities.

Population and Sampling Technique:

The target population consists of Community members (particularly women, the elderly, and vulnerable groups); Primary healthcare workers; Local Imams and Islamic scholars; Traditional rulers; Waqf donors and custodians; Local government health officials. A purposive sampling technique was employed to select key informants and participants who possess knowledge of healthcare delivery or Waqf practices in the community; 60 community members took part in focus group discussions; 15 healthcare workers and 10 religious leaders were interviewed one-on-one; three Waqf donors and three local health administrators attended stakeholder dialogues.

Data Collection Methods:

Community Dialogues and Participatory Mapping: During the planning stages, community dialogues were held where participants collaboratively identified existing Waqf assets (land, funds, or buildings) and brainstormed workable ways to channel them toward healthcare services.

Key Informant Interviews (KIIs): In-depth interviews were conducted with healthcare professionals, religious leaders, and Waqf donors to explore institutional perspectives on healthcare delivery and the viability of a Waqf-supported model.

Focus Group Discussions (FGDs): FGDs were held in each community to collect grassroots perspectives on primary healthcare challenges, traditional health-seeking behaviors, and awareness of Waqf as a potential health financing tool. Each FGD comprised 8–10 participants from a variety of backgrounds.

Field Observation and Facility Assessment: To evaluate personnel, infrastructure, medication supply, and operational shortcomings, health centers were visited. In cooperation with local health workers, a checklist was created to record observational data.

Questionnaires: To measure factors including healthcare utilization frequency, proximity to the closest facility, treatment affordability, and Waqf awareness, structured questionnaires were given to neighborhood families.

Community Involvement in Planning, Implementation, and Evaluation:

Planning Phase: Through FGDs and mapping sessions, community members helped identify needs. Their suggestions aided in the development of practical and culturally appropriate Waqf solutions.

Implementation Phase: Community volunteers and Waqf contributions were mobilized with the assistance of local imams and traditional leaders. In order to test the integration of Waqf-supported services like free consultation days or subsidized medications, medical professionals worked with the study team.

Evaluation Phase: Through reflection sessions and post-implementation interviews, community members offered input. They provided recommendations for scale-up based on their evaluation of the Waqf initiative's impact, difficulties, and sustainability.

Data Analysis:

Thematic analysis was used to analyze qualitative data from focus group discussions and interviews. Recurring patterns were identified and categorized into key themes such as "perceived healthcare gaps," "knowledge of Waqf," and "barriers to Waqf utilization." Descriptive statistics were used to analyze quantitative data from questionnaires.

Ethical Considerations:

All participants gave their informed consent, ethical approval was sought from the appropriate local authorities and traditional institutions, anonymity and confidentiality were strictly maintained throughout the study.

C. Results and Discussion

1. Improved Community Understanding of Waqf and Health Integration

A notable increase in public knowledge of Waqf's function as a sustainable resource for healthcare improvement was one of the community service intervention's most noticeable results. Just 22% of community members polled before the initiative connected Waqf to social services like healthcare. According to post-engagement data, participants' awareness of Waqf as a religiously based tool for community empowerment increased to 67%. This improvement is in line with Muhammad et al. (2024), who found that targeted community engagement significantly improves local participation in Waqf projects. Waqf was historically used to fund hospitals and public welfare during the Islamic Golden Age, as explained by local Islamic scholars in focus groups, interactive lectures, and mosque-based sensitizations.

Figure 1. During Public lecture on Community Understanding of Waqf and Health Integration in the area

2. Formation of Community Health-Waqf Discussion Groups

The creation of three Community Waqf-Health Action Committees in Akko, Billiri, and Dukku LGAs which comprised local Imams, women leaders, health workers, and youth representatives was a significant breakthrough from the intervention. These groups were formed in response to community reflection sessions in which participants expressed the need for a standing body to oversee the allocation of Waqf donations to health services and coordinate them. The success of community-driven initiatives in Malaysia and Indonesia, where similar Waqf-based health models are thriving, and the Gombe example adds a rural Nigerian context to that expanding body of practice (Ambrose et al., 2018).

Figure 2. Dialogue with Religious Leaders as part of the Community Service

3. Development of Local Action Plans for Waqf-Based Health Services

Co-creating local action plans that were suited to the health requirements of each community and the resources that Waqf had available was another significant outcome of the community service. For example:

a. The goal of the action plan in Akko LGA is to use money and land provided by the community to renovate a run-down primary health center.

b. Organizing Waqf donations to stock necessary medications for maternity and child care is the main goal in Billiri.

c. Training community health volunteers with funds from Waqf contributions was the top goal in Dukku.

These action plans are in line with previous research by Muhammad et al. (2024a), which highlighted the necessity of participatory and context-specific local Waqf implementation.

Figure 3. During Presentation of Waqf donations to Community Health Volunteers in the Study Area

4. Tangible Community-Based Initiatives

a. Waqf commitments: During the service time, local benefactors made Waqf commitments totaling more than ₦2.3 million in cash, farms, and valuables.

b. Clinic Outreach Days: 140 people received free consultations and minor treatments at two prototype Waqf-supported outreach clinics.

c. Health Education Campaigns: Four campaigns disseminated information on maternal health, malaria prevention, and cleanliness to more than 700 community members.

These programs demonstrate how Islamic giving and community involvement can work together to directly solve gaps in service delivery. Medias et al. (2022) observed similar results, showing that healthcare access in underprivileged parts of Malaysia was enhanced via waqf-based rural clinics.

5. Reflections on PKM (Community Service) Experiences

The community service team got numerous insights:

a. Challenges: Limited past understanding of Waqf beyond mosque construction, difficulty in finding existing Waqf holdings, and initial distrust from certain community elders.

b. Strategies: These obstacles were addressed by bringing in reputable Islamic scholars, conducting all engagement sessions in Hausa, and incorporating women and young people in the planning process.

c. Lessons Learned: Continuous sensitization, open coordination, and observable effects are necessary for Waqf to be successful in rural development. Waqf is a community-driven trust that necessitates moral ownership in addition to being a legal institution (Ardo et al., 2024).

6. Contribution to Solving Identified Problems

Through awareness campaigns, community mapping, and action group formation, the project laid the groundwork for self-sustaining healthcare support systems. In contrast to top-down aid, this bottom-up model empowers the community to take charge of its health development through culturally resonant tools. These results also bridge the implementation gap identified in previous works, such as (Muhammad et al., 2025b; Ratnawati et al., 2020), who noted that although Waqf has strong potential for health development, actual community-level models in Africa are still limited. The PKM activities addressed the following issues: Low awareness of Waqf's utility for healthcare; Lack of institutional structure for community-based Waqf mobilization; and Limited access to healthcare because of poverty and distance.

D. Conclusion

This study has demonstrated that Waqf has significant potential in addressing primary healthcare challenges in Gombe State's rural communities. The findings revealed that inadequate healthcare infrastructure, shortage of medical personnel, and limited access to affordable services remain major concerns. However, through the effective mobilization and management of Waqf resources particularly land, buildings, and dedicated endowments sustainable healthcare solutions can be developed and maintained. Community

engagement during the research affirmed that Waqf-supported health interventions not only improved access to basic health services but also enhanced community ownership and participation in healthcare delivery. Furthermore, the research revealed increased awareness among local stakeholders about the broader utility of Waqf beyond religious purposes. By aligning Waqf initiatives with community health needs, especially through strategic partnerships and transparent governance, Waqf can serve as a viable and culturally rooted solution for strengthening healthcare systems in underserved areas. The success of these efforts depends on collaborative action involving Waqf managers, community leaders, healthcare professionals, and government agencies.

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