INFLUENCE OF FAITH-BASED ORGANISATIONS IN COMMUNITY HEALTHCARE IN IGBO LAND

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ABSTRACT

The health sector in Igbo land has grown rapidly and the corner stone of this growth was laid by the early Christian Missionaries who combined Evangelization with education and health. This historical development led to the advancement and expansion of the healthcare system in Igbo land by contributing to the building of a firm foundation upon which Igbo land's healthcare stands today. The Church's health functional strategy cemented this milestone leading to the growth of a vibrant healthcare sector in Igbo land. This has culminated in a well-coordinated Church-Government partnership in the implementation of health programs. Today Igbo land is one of the leading regions in Nigeria in the delivery of well-established and functional healthcare system. The Church's pioneer efforts saw the healthcare in Igbo land expand rapidly to all parts of the region thus playing a significant role in the healthcare market. This study assessed the influence of faith-based organisations in community healthcare in Igbo land. The objective of this study was therefore to explore the Church's contribution to the development of healthcare sector in Igbo land, to examine the functional role of an integrated and holistic approach to healthcare as a tool for the nurturing of Christian values and faith that support spiritual growth among people, to assess the sociological implications underpinning the entire process of growth of healthcare through a Church-Government participatory partnership approach and how this approach has created a better society. This is a qualitative study and made use of case study approach to collect data from purposively selected mainstream Churches in Igbo land. Focus group discussions were also carried out in the selected churches. Use of secondary data from books, documents and Church journals provided valuable information. The findings show that the Church played a significant role in the development of healthcare in Igbo land, they also show that the use of an integrated and holistic approach to healthcare was responsible for the evangelization and medical treatment of many Christians in Igbo land. From a sociological perspective, the findings show that the Church plays a significant role in unifying society. The study recommends the development of an effective collaboration between social workers and the church leadership which may require some additional enhancement of professional competencies and including social development as part of the curriculum of the on-going theological training of ministers at seminaries or religious graduate schools, or internships via training centres. The study also recommends that the Church should be supported through government policies to continue investing in the healthcare sector, other Churches in Nigeria should adopt an integrated holistic

approach to healthcare and the Church should strengthen its unifying role for the sake of a stable nation. The study will benefit the Church, policy makers and other stakeholders.

Introduction

The history of faith-based organizations (FBOs) in healthcare dates back to the 18th and 19th centuries when Christian mission societies began offering medical assistance in colonial territories across Asia, Africa, and Latin America (Omoyajowo, 2021). Rooted in the Christian belief that Jesus was both a healer and teacher, the faith tradition emphasizes health, healing, and wholeness (Rodriguez et al., 2018; Thoresen, 2018). Over the past two decades, interest in FBOs' role in health service delivery has resurged due to the growing importance of religion in African communities, health sector reforms, the need for public-private partnerships, and efforts to strengthen weak health systems (Hanson & Berman, 2014; Schmid, 2018). Governments and international agencies now recognize FBOs as vital collaborators in achieving global health goals like the Millennium Development Goals (Marshall & Keough, 2005; Olivier & Paterson, 2011).

In Nigeria, early Christian missionaries significantly contributed to healthcare by establishing hospitals and clinics alongside their evangelization efforts (Adelaja, 2018). However, the Nigerian Civil War devastated the country's health infrastructure, especially in Igboland, where access to quality healthcare remains poor, particularly in rural areas (Laken, Wilcox & Swinton, 2020; Tuck & Wallace, 2015). The region's healthcare system operates on six levels from community services to tertiary referral facilities with objectives such as disease prevention, risk reduction, and collaboration with private sectors (Darnell, Chang & Calhoun, 2022). Despite some improvements, including increased life expectancy, access to healthcare is still limited due to outdated systems, resource shortages, poor infrastructure, and inequitable service distribution (Thoresen, 2018; Lefebvre, 2021).

FBOs have played a vital role in addressing these challenges. Notable organizations such as the Christian Health Association of Nigeria (CHAN), Isaiah 58 Care Foundation, and Life Builders Ministries International have been instrumental in delivering essential health services like family planning, immunization, nutrition, and sanitation (Otaki, 2020). While Catholic and Anglican missions pioneered these efforts, Pentecostal and other denominations are now actively participating.

Overall, the study highlights that faith-based organizations remain indispensable in community healthcare development in Igboland. It calls for the revitalization of the missionary health legacy to meet contemporary health challenges, emphasizing that a vibrant and socially responsive church can continue to drive community health improvement and development.

Statement of Problem

Poor program acceptance and support has reduced access and use of community healthcare in Igbo land. Community healthcare in Igbo land has been met with various challenges (including shortage of midwives, poor retention of midwives, high withdrawal rates, and state and local

governments' inability to contribute their expected share to the scheme) which exemplifies poor levels of support. Rural communities continue to be affected most by the government's failure to envision that effective healthcare delivery begins with making it available and accessible to the most vulnerable populations.

Nowadays perception exists that anywhere from 30% to 70% of health-care services are provided by faith-based entities of various forms worldwide and in Igbo land. Although some historical and empirical basis for these statements exists, the origins of such estimates are poorly acknowledged, and these estimates are often overstated. During the past two decades, many attempts have been made to synthesise such evidence, especially for sub-Saharan Africa and Igbo land in particular. These assessments of the role of the church in community healthcare are based on partial datasets and usually rely on rough counts of the number of hospital beds held by Christian Health Association versus the public health system. Countries tend to have a representative national faith-based health network such as a Christian Health Associations, and the estimates are based on self-reports of the number of facilities or hospital beds networked by the Christian Health Associations versus the public sector. These figures rarely include other churches that are not in-network (such as other non-orthodox Faith Based Health Providers (FBHP) that are largely invisible). Popular estimates based on comparison of numbers of hospital beds do not adequately measure primary health-care level or community outreach.

This study is confronted with scanty or non-available evidence with a focus on the role of the church in community healthcare in Igbo land. This is because little evidence is available for other contexts or other kinds of faith-based groups at present. Even with this focus, robust or systematic evidence is restricted, and substantial confusion and conflicting anecdotes exists in the published work on the role of the church in community healthcare. Reports of the comparative advantages of the church versus other public and secular providers (such as the possible reach, trust and access in communities, quality care, longevity, or service to poor people) are rarely substantiated. They are usually balanced by reports of possible comparative weaknesses (such as poor human resource management, absence of financial sustainability, poor record keeping, or preferential service to particular religious groups). More and improved data are needed to provide support at management and policy levels on every aspect relating to how the church routinely functions within their health systems. The key questions asked by this study are; what are the roles of the church in community healthcare in Igbo land? And also What are the functional role of an integrated and holistic approach to healthcare in Igbo land?

Purpose of the Study

The aim of this study is to examine the influence of the faith based organisations in community healthcare in Igbo land. However, the specific objectives of the study are to:

i. Evaluate the role of the Church in the development of community healthcare.

ii. Examine the functional role of an integrated and holistic approach to healthcare in Igbo land.

Methodology

The study adopted a qualitative research approach, incorporating narrative, descriptive, and historical methods to ensure originality and authenticity of information. Data collection involved guideline-based interviews with representatives of religious communities, faith-based organisations (FBOs), research institutes, and political foundations, alongside data from quantitative surveys. These methods were integrated to create a conceptual framework aimed at helping church leaders and members promote sustainable, church-based community healthcare. Using a case study approach, data were gathered from purposively selected mainstream churches across the five core Igbo states Enugu, Anambra, Ebonyi, Imo, and Abia to trace the historical and contemporary roles of the Church in healthcare since the 19th century. Primary data came from interviews and focus group discussions with individuals in selected communities, providing historical insights into the Church's health involvement. Secondary data from books, church journals, and official documents supplemented and validated oral accounts, while archival records and in-depth interviews with elders and knowledgeable community members enriched and verified the historical narrative.

Conceptual Framework

Concept of Church

The term "church" originates from the Greek *kyriakon*, meaning "the Lord's house," and *ekklesia*, meaning "assembly." Historically, it evolved to describe both the place of Christian worship and the collective body of believers. The *Christian Church* refers not merely to a building but to a community of believers united in worship, fellowship, and service. Early Christians met in homes due to persecution, emphasizing that the church is fundamentally about people, not structures. The church fulfills three main biblical roles: worship**,** edification**,** and evangelism. Worship focuses on glorifying God; edification involves nurturing and strengthening believers; and evangelism entails spreading the gospel and showing compassion through social and charitable acts. These roles define a healthy, God-centered church.

The Bible describes the church metaphorically as the Body of Christ, with Christ as the head; the People of God, emphasizing divine relationship; and the Bride of Christ, symbolizing spiritual unity and devotion. Despite divisions and imperfections in visible churches, Christians remain united globally on essential doctrines such as the love of God, salvation through Christ, and the hope of redemption.

Concept of Community

A community is defined as a group of people sharing a common locality, interests, or values, bound by a sense of belonging and mutual identity (Kee & Young, 1981). It can be geographical people living together in a specific area or psychological/moral, based on shared traditions and values even without physical proximity (Claquin, 1989). Communities foster cooperation, shared purpose, and collective responsibility for progress. Development within a community implies

improving members' well-being through education, healthcare, spirituality, and security (Fabian, 2004). Sociologically, *community (Gemeinschaft)* contrasts with *society (Gesellschaft)* the former characterized by warmth, unity, and shared values, while the latter is based on formal, contractual relationships (Macquarrie, 1981).

Concept of Healthcare

Healthcare refers to the improvement and maintenance of health through prevention, diagnosis, treatment, and rehabilitation of diseases and physical or mental conditions (Lateef, 2019). It encompasses various professional fields including medicine, nursing, pharmacy, and psychology, operating at primary**,** secondary, and tertiary levels. According to the World Health Organization (WHO, 2021)**,** health is "a state of complete physical, mental, and social well-being and not merely the absence of disease." Healthcare involves providing accessible and quality services that promote, maintain, and restore health. WHO emphasizes Universal Health Coverage (UHC) to ensure all people receive necessary services without financial hardship. Central to this vision is primary healthcare, which offers integrated, people-centered, and lifelong services focused on prevention and holistic well-being.

In essence, the framework connects the *church* as a faith-based community with moral and social duties, the *community* as a collective of shared identity and responsibility, and *healthcare* as a human right aimed at enhancing well-being. Together, they form the foundation for developing sustainable, church-led community healthcare systems that integrate spirituality, compassion, and public health principles.

Theoretical Framework

The theoretical conversation of this paper is anchored on Social Ecological Model & Korten's Theory

The Social Ecological Model, developed by Bronfenbrenner in the 1970s, provides a framework for understanding church-based community healthcare through multiple levels influencing health behavior. These include:

1. **Intrapersonal** – individual knowledge, attitudes, skills, and behaviors
2. **Interpersonal** – family and social networks that support or hinder healthy lifestyles
3. **Institutional** – organized rules and influence of institutions such as churches
4. **Community** – relationships among organizations and community resources
5. **Public Policy** – laws and policies affecting health outcomes

By recognizing these interconnected influences, the model emphasizes that health promotion is more effective when interventions target multiple levels rather than just individuals. Churches, as

key institutions, can shape health behaviors, improve community collaboration, and help address issues like mental health stigma or limited healthcare access.

Korten's Theory (People-Centered Development Theory)

David Korten's theory advocates for bottom-up development, stressing participation, empowerment, and sustainability, especially in marginalized communities. He outlines four generations of development strategies, with focus here on:

- First-generation strategies: Short-term relief efforts such as free healthcare and food support useful for emergencies but unsustainable, as they create dependency.
- Second-generation strategies: Community-driven development that builds local capacity and self-reliance, enabling people to solve their own health challenges.

The text argues that current church healthcare efforts rely too heavily on relief-based approaches and should shift toward sustainable, empowerment-focused initiatives aligned with Korten's second-generation model. This transition will enhance community healthcare development by mobilizing local resources and strengthening cooperative community action.

Both theories support the idea that effective, sustainable church-based healthcare must empower communities across multiple social levels rather than simply provide temporary relief.

Empirical Studies

Olivier et al. (2015) in a study conducted on "*understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction*." reviewed a broad body of published works and introduced some empirical evidence on the role of faith-based health-care providers, with a focus on Christian faith-based health providers in sub-Saharan Africa (on which the most detailed documentation has been gathered). The restricted and diverse evidence reported supports the idea that faith-based health providers continue to play a part in health provision, especially in fragile health systems. The study also reviewed controversies in faith-based healthcare and recommendations for how public and faith sectors might collaborate more effectively. The study concludes that at a time when many countries might not achieve the health targets of the Millennium Development Goals and the post-2015 agenda for sustainable development is being negotiated, the contribution of faith-based health-care providers is potentially crucial. The study revealed that for better partnership to be achieved and for health systems to be strengthened by the alignment of faith-based health-providers with national systems and priorities, improved information is needed at all levels. Comparisons of basic factors (such as magnitude, reach to poor people, cost to patients, modes of financing, and satisfaction of patients with the services received) within faith-based health-providers and national systems show some differences. The study was carried out in Sub-Saharan Africa but the present study is conducted only in Nigeria to specifically capture Nigeria's

peculiarity in relation to the influence of the faith based organisations in community healthcare in Igbo land.

In a study conducted by Tuck & Wallace (2000) on "*exploring church based community healthcare from an ethnographic perspective,*" used data gathered over several months in Southern US city. The study involved 2 congregations, one African-American in urban setting with membership across socio-economic backgrounds; other predominately Caucasian in suburban area. The study sample comprised 32 key informants: 3 administrators, 5 spiritual leaders, 7 church based healthcare givers, 17 clients. Findings from the study reveal that Church based community healthcare is an established method for healthcare delivery that was well-received by this community. Church based community healthcare is seen as an alternative approach for providing care in the community and providing continuity of care in a disjointed healthcare delivery system. Church based healthcare givers are given an opportunity to bridge physical, social, emotional, and spiritual lives into their caregiving experience. As gap however, the reviewed study was carried out in the United whereas, the present study was conducted in Nigeria to specifically capture Nigeria's peculiarity in relation to the influence of the faith based organisations in community healthcare.

Chase-Ziolek (2019) researched on "*the meaning and experience of health ministry within the culture of a congregation with a church based healthcare*". Data was gathered over 14 month period in Chicago, IL large, multi-ethnic, urban, United Methodist Church. The study sample comprised 6 key participants & 13 general participants for semi-structured interviews; 20 subjects for informal interviews; no description of informants. Key findings reveal that two forms of health ministry are identified and categorized as extrinsic and intrinsic. Extrinsic activities were those with explicit purpose of promoting health. Intrinsic activities were other activities seen as health-promoting. As gap however, the reviewed study was carried out in the United whereas, the present study was conducted in Nigeria to specifically capture Nigeria's peculiarity in relation to the influence of the faith based organisations in community healthcare.

Chase-Ziolek & Gruca (2000) investigated "*Clients' perceptions of distinctive aspects in nursing care received within a congregational setting*" using Descriptive exploratory approach (used interview guide consisting of 6 questions and basic demographic information). The study area involved two Catholic churches in major urban area of USA. Church A is downtown parish with church based community healthcare services provided by nurse-employee of medical center. Church B is neighborhood parish on periphery with 3 volunteer church based healthcare givers. The study sample comprised 11 total participants 6 from Church A and 5 from Church B ages ranged from 46-79 years; 5 women, 6 men; 10 Caucasian, 1 African-American. Based on the research findings from the study, participants identified positive aspects of church based community healthcare program to include nurse physically and psychologically being present, having time available to interact. Positive benefits of setting included promoted feelings of tranquility, peace and care. Study further reveals that church based healthcare givers provide advocacy and increased accessibility to healthcare services, but do not replace those services.

Based on the gap for this study, three church denominations were studies - the Catholics, the Protestants and the Pentecostals as against only Catholic Church used for the reviewed study.

Wallace, Tuck, Boland, & Witucki (2002) examined *"client perceptions of church based community healthcare*". The study was carried out using a face to face interviews, data was analyzed using Spradley's ethnographic approach. The study area included One inner city primarily African-American church with membership of 780, one primarily Caucasian suburban/rural church with membership of 2200. The sample for the study comprised a total of 17 participants within the age range of 25-84. Findings reveal that five themes of client perception emerged: being available, integrating spirituality and health, helping us help ourselves, exploring church based community healthcare, and evaluating church based community healthcare. Participants perceived church based community healthcare as positive and beneficial to individuals, the church, the congregation, and the community. Church based community healthcare was viewed as a useful, meaningful, and effective health intervention. Church based healthcare givers were seen as effective and meaningful health providers. The study reviewed study used only face to face interviews, whereas the present study utilized both face to face interviews as well as content analytic reviews of other relevant literature.

FAITH BASED ORGANISATIONS AND COMMUNITY HEALTHCARE IN IGBO LAND

The term *faith-based* is widely used but sometimes criticized for being vague or politically motivated. Dionne (2019) and Safire (2019) argue that while "religious-based" might be more accurate, "faith-based" remains useful because it is inclusive of all religions and less controversial in separating religion from state affairs. Faith-based organizations (FBOs) encompass more than just local worship communities. Castelli and McCarthy (1997) classify them into three categories: (1) congregations, (2) national networks (such as denominational charities like Catholic Charities or Lutheran Social Services), and (3) freestanding religious organizations, which operate independently but retain religious roots. These groups vary in size, structure, and purpose, ranging from small congregations to large institutions.

In Igbo land, notable examples include several Christian mission hospitals such as Iyi-Enu Mission Hospital, Our Lady of Lourdes Hospital, Ihiala, Holy Rosary Maternity, Onitsha, Catholic Mission Hospital, Adazi-Awka, and Annunciation Hospital, Enugu. These institutions reflect the deep involvement of religious groups in healthcare delivery.

Globally, faith-based health providers (FBHPs) have long played a critical role in healthcare, particularly in sub-Saharan Africa. Despite their substantial contribution estimated by World Bank President James Wolfensohn (2002) as providing half of health and education services in the region they were historically overlooked in policy and research discussions. This neglect stemmed from distrust toward faith-based motives, particularly concerns about proselytization, and the dominance of public-sector healthcare models. Recently, however, there has been renewed recognition of the importance of FBOs, with increasing collaboration among bilateral and

multilateral donors, UN agencies, and governments to better understand and integrate faith-based healthcare into national and global health systems.

Financing of Faith-Based Healthcare in Igboland

Faith-based healthcare providers (FBHPs) in Africa have undergone major transformations in funding and operations since independence. Originally supported by foreign missions, many FBHPs had to find new financial sources as colonial and missionary funding declined. Today, they rely on a mix of government funding, patient user fees, donor assistance, and community or religious contributions (Charmaz, 2022). However, data on these funding streams are limited due to weak financial tracking systems and the decentralized nature of FBHPs. Many FBHPs have developed closer partnerships with governments through service-level agreements and contracts particularly with Ministries of Health to align their operations with public health goals. In exchange for serving poor and rural communities, governments often provide financial support such as salary subsidies or compensation based on hospital capacity. Yet, these partnerships can face challenges when agreements are not honored or administrative systems fail (Demark-Wahnefried et al., 2000).

Faith-based healthcare also benefits from international development assistance. Organizations like the Christian Health Associations receive funding from global sources such as the Global Fund, the Bill & Melinda Gates Foundation, and the U.S. government, with at least US$1.53 billion estimated to have flowed through faith-based NGOs for health programs. Nonetheless, tracking these funds accurately remains difficult. Additionally, local and foreign religious donations, often unrecorded, contribute significantly U.S. churches alone raised about $4 billion in 2018 for overseas ministries (Claquin, 1989). At the community level, volunteering, small donations, and in-kind support are crucial for sustaining Christian health facilities. Studies show that many faith-based HIV/AIDS programs operate without external aid, depending instead on informal local support. In Islamic contexts, Zakat and charitable donations also fund healthcare, sometimes even supporting Christian or government-run hospitals, demonstrating interfaith cooperation in health service delivery.

In Igboland, located in southeastern Nigeria and home to over 30 million people, Christianity plays a central role in healthcare. Introduced by European missionaries in the mid-19th century through the Church Missionary Society (CMS), early Christian missions—led by figures like Rev. Samuel Ajayi Crowther and Rev. John Taylor—combined evangelism with social services, especially education and healthcare. Mission schools and hospitals such as Catholic and Anglican medical institutions became key agents of both religious conversion and modernization. Over time, Christianity became deeply rooted in Igbo society, with denominations like the Roman Catholic and Anglican churches establishing extensive networks of hospitals, schools, and welfare services that continue to shape healthcare delivery in the region today.

The Advent of the Roman Catholic Mission (1885) and the Origin of the Church Missionary Society (CMS) (1857)

Between 1857 and 1885, the Church Missionary Society (CMS) held a monopoly in the evangelization of northwestern Igboland. This changed in 1885 with the arrival of Rev. Father Joseph Lutz and the Holy Ghost Fathers, who established the Roman Catholic Mission in Onitsha as a base for evangelizing the Lower Niger. Onitsha was strategically chosen for its accessibility, water routes, and absence of Islamic influence. The Catholic missionaries aimed to counter the growing influence of the Anglicans, who had already spent nearly three decades in the area. The Roman Catholics adopted a distinct strategy using charitable and social welfare institutions to attract converts and demonstrate goodwill. One of their earliest initiatives was the "freedom village," where they gathered natives, provided relief materials, and cared for converts, following a model inspired by Cardinal Lavigerie of Algiers. Despite frequent leadership losses due to illness and death Fr. Lutz (d.1895), Reling (resigned 1898), Pawlas (d.1900) the mission survived and expanded under Fr. Leon Lejeune, during whose tenure Obi Samuel Okosi of Onitsha (1900–1931) converted to Catholicism, giving the mission local legitimacy.

Lay participation played a key role in Catholic expansion. Groups like the Aguleri and Awka Districts Catholic Union (A.A.D.C.U.) became central to the church's growth, promoting Catholic education, social and moral reform, and political engagement. Their constitution emphasized advancing Catholic interests, fostering unity, and supporting ministerial formation, which significantly strengthened Catholic influence across Igboland (Nwosu, 1990). The Church Missionary Society (CMS), on the other hand, was established in 1799 out of the Evangelical Revival within the Church of England. Unlike the more hierarchical SPG or SPCK, the CMS emphasized individual responsibility for evangelism and sought to build self-supporting, self-governing, and self-propagating indigenous churches, a principle championed by Henry Venn in 1851.

CMS missions spread through West Africa Sierra Leone (1804), Abeokuta (1842), Onitsha (1857), and later Owerri (1906) and Nsukka (1930). Despite early setbacks, including missionary deaths, the society remained committed to Africa. The 1857 Niger Expedition, supported by the British government and Dr. William Baikie, marked a turning point. Led by Bishop Samuel Ajayi Crowther, the mission team which included Rev. John Christopher Taylor, an Igbo convert arrived in Onitsha on July 27, 1857, where they established the first CMS church in Igboland. Crowther instructed Taylor to learn the Igbo language and traditions to better relate with the people and effectively communicate Christian teachings. Their success at Onitsha made the town the gateway for Anglican evangelism in Eastern Nigeria and laid the foundation for widespread missionary activities across Igboland. In essence, both the CMS (Anglican) and Roman Catholic missions pioneered Christianity in Igboland one emphasizing linguistic and cultural adaptation, the other social welfare and community engagement. Their presence set the stage for the lasting religious transformation of the region.

The Rise of New Spiritual / New Generation Churches in Igboland

The emergence of new spiritual and independent churches in Igboland represents a distinctly Igbo response to European Christianity. These movements were driven by the desire of local Christians to interpret and practice the faith in ways consistent with their cultural values and experiences. Many Igbos viewed missionary Christianity as alien and culturally insensitive, having been imposed without sufficient understanding of Igbo traditions. The proliferation of independent and new generation churches began in the late 1960s and early 1970s, marking a major transformation in Nigeria's religious landscape. Scholars such as Kalu (1978) observed that these churches multiplied rapidly, appearing across every part of the country. This growth was fueled by multiple factors.

First, Nigeria's independence (1960) encouraged religious freedom and the recognition of indigenous churches previously marginalized under colonial rule. Many Nigerians, disillusioned by European dominance in the mainline churches especially the Anglican (CMS) and Roman Catholic missions sought autonomy in worship and leadership. The maltreatment of African clergy, particularly Bishop Samuel Ajayi Crowther, by European missionaries symbolized racial injustice and spurred Africans to establish self-governing churches free from foreign control. This was aligned with the self-supporting, self-governing, and self-propagating church policy earlier advocated by Henry Venn, which also inspired early Nigerian nationalism. Another influence came from Edward Blyden, a Pan-Africanist whose 1890 lectures in Lagos urged Africans to form churches under African management and reject European religious domination. His message led to the creation of the African Church (1891) by Africans disenchanted with European-controlled missions. These early independent churches emphasized cultural authenticity, even supporting practices such as polygamy, which had been condemned by European missionaries.

The rise of these movements also reflected the missionaries' failure to integrate Christianity with African worldviews. The rigid insistence on Western doctrines and rejection of indigenous values caused alienation among converts. According to Horton (1971), Christianity's refusal to function as a cultural "catalyst" led to incompatibility with African spirituality, prompting many to establish churches that blended Christian teachings with traditional beliefs. A major catalyst for the expansion of these new spiritual churches was the Nigerian Civil War (1967–1970). The war's devastation marked by hunger, disease, displacement, and psychological distress—drove many Igbos to seek spiritual solutions where material help failed. As Madiebo (1980) noted, people turned to prayer houses and spiritualist movements as a means of survival amid suffering and uncertainty. Ultimately, the rise of new generation and spiritual churches in Igboland was a multifaceted development rooted in cultural self-determination, nationalist consciousness, social crises, and the search for spiritual relevance. These churches became expressions of African agency, offering emotional, social, and spiritual refuge to people dissatisfied with the foreign character of mainline Christianity.

Christian Missionary Activities in Igbo Land

The spread of Christian missionary activities into Igboland was part of Europe's broader effort to regenerate African societies through religion, commerce, civilization, and colonization. These missions were motivated by humanitarian and anti-slavery ideals, aiming to replace the slave trade with "legitimate commerce" and Christianity. However, the early efforts faced challenges such as harsh tropical climates that claimed the lives of many missionaries, the resistance of local communities, and competition from the expanding influence of Islam in West Africa.

European engagement in West Africa initially focused on trade rather than evangelism until the nineteenth century when systematic missionary work began. Protestant churches like the Anglicans, Methodists, Baptists, and Presbyterians mainly from Britain led the early wave, followed by Catholic missions under Cardinal Lavigerie and societies like the Holy Ghost Fathers, the White Fathers, and the Society of African Missions. This period was influenced by the Evangelical Revival in Europe, which inspired the creation of missionary societies such as the Baptist Missionary Society (1792), London Missionary Society (1795), and the British and Foreign Bible Society (1804). These organizations were instrumental in spreading Christianity and introducing Western education to Africa.

In Nigeria, Christianity first took root among Yoruba returnees from Sierra Leone between 1839 and 1845, facilitated by the Church Missionary Society (CMS) and figures like Rev. Henry Townsend and Rev. Samuel Ajayi Crowther. Mission stations were established in towns such as Abeokuta, Lagos, Ibadan, and Oyo before extending to southeastern Nigeria (Igboland) through missionaries like Bishop Crowther and Rev. J.C. Taylor. Other denominations such as the Presbyterians, under Rev. Hope Waddell, and the Baptists, led by Thomas Bowen, also played key roles. Catholic missionary expansion followed shortly after, led by Father Berghero and later Father Joseph Lutz, who established stations in Lagos (1868) and Onitsha (1886). Irish missionary Bishop Joseph Shanahan further consolidated Catholic presence in Igboland, notably in Anambra and Imo States. Overall, Christian missions transformed Igbo society by introducing Western religion, education, and culture. Despite initial resistance and cultural clashes, missionary activities laid the foundation for Christianity's deep entrenchment in Igboland and across Nigeria.

Advent of Community Healthcare in Igbo Land

The origins of community healthcare date back to prehistoric times, with early evidence from cave murals in Spain and China showing concern for health and hygiene, such as awareness of clean drinking water. During the Middle Ages, diseases were seen as spiritual punishments, leading to widespread suffering. However, by the 19th century, modern public health practices emerged, as demonstrated by Lemuel Shattuck's 1850 report in Massachusetts and Dr. John Snow's cholera intervention in London. In Nigeria, before the arrival of Christian missionaries, public health was in a deplorable state. Many people died from infectious diseases without effective cures, and infant mortality was extremely high. The indigenous population relied on traditional healers (Dibias), whose methods were often exploitative and ineffective. Missionaries, upon witnessing this, began to introduce Western medicine as part of their evangelical mission.

One of their major contributions was the introduction of quinine, derived from the cinchona tree, which proved effective against malaria previously known as the disease that made Africa the "Whiteman's grave."

Medical missionary work in Igboland began alongside Christian evangelization in the late 19th century. Early medical care was provided within church compounds to treat prevalent diseases like malaria, leprosy, dysentery, and wounds. The Church Missionary Society (CMS) established the first formal hospital in Onitsha in 1893. By 1896, Rev. Henry Dobinson initiated the CMS hospital project, which evolved into the Iyi-Enu Hospital in 1907—located near Onitsha in present-day Anambra State.

Initially, the medical mission relied on small dispensaries run by missionaries and nurses like Miss Taylor and Miss Maxwell, who treated hundreds of patients weekly. Following Rev. Dobinson's death in 1897, a memorial hospital was built, and medical services expanded under Dr. Clayton and later Miss Mary Elms, who introduced basic nurse training for local Igbo girls. As patient numbers grew, the medical center relocated to Iyi-Enu, where new hospital buildings were constructed and modern services established under Dr. A.E. Druit. Despite early challenges such as inadequate facilities, limited staff, and shortages of funds and medicines, Iyi-Enu Hospital became a cornerstone of healthcare in southeastern Nigeria. It pioneered medical innovations, including maternal and child health programs, rural maternity homes, traveling doctor services, leprosy treatment (leading to the Oji River settlement), and the eradication of yaws. The hospital also established Nigeria's first midwifery and nursing training programs, producing the country's first registered midwife, Miss Kemmer Fetepigi (later Mrs. Koripamo). Overall, missionary medical initiatives transformed community health in Igboland, laying the foundation for modern healthcare systems through the establishment of hospitals, medical training, and disease control programs that continue to influence public health today.

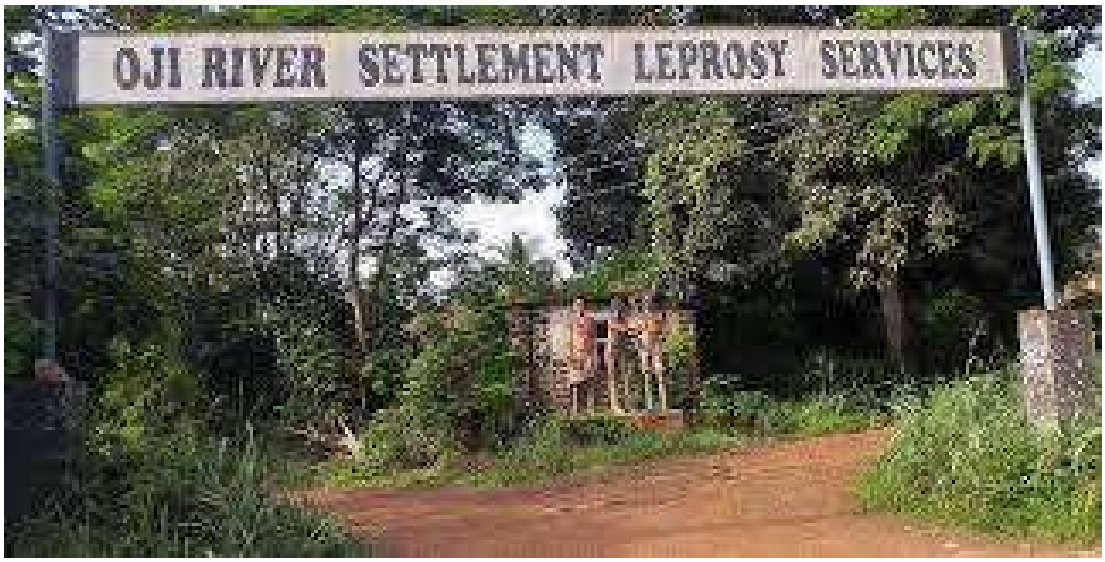

Figure 5. *Oji River Leprosy Settlement, established as an extension of Iyi-Enu Hospital's leprosy treatment program. The settlement became a central hub for the care, isolation, and rehabilitation*

of leprosy patients in southeastern Nigeria, following systematic efforts led by missionaries and medical staff in the early 20th century.

Exactly 25 years after Iyi-Enu Hospital celebrated its 75 years anniversary, the hospital has grown in leaps and bounds. In spite of the proliferation of hospitals and doctors clinics in and around Ogidi, Nkpor and Onitsha, Iyi-Enu Hospital is still putting more smiles on the faces of patients and people living in some parts of the former Anambra State (now Enugu and Anambra States).

Figure 6. *Entrance gate of Iyi Enu misiion Hospital Located at Ogidi*

The hospital has maintained a class of medical excellence specializing in managing healthcare holistic challenges. For instance, the hospital has put in place various Ultra-modern equipment and services which could compete favourably with any specialist hospitals within Nigeria . These include the following ultra sound machines, dental, intensive care units, x-ray facilities, cold chain refrigerator (from pathfinder), specially equipped ambulances donated by an NGO Max and Syl Foundation - California USA, computerized pharmacy, internet and electronic library, GHAIN project a bid to stem the rising profile of HIV/AIDS infection in Nigeria, modern mortuary facilities with trained morticians. In addition to these, there are new building projects to enhance the standard of medicare services. Some of these are New Midwifery classroom block, New Building Complex for the School of Midwifery, Canteen facilities, catering for in-patients and outsiders.

Figure 7. *New face of Iyi Enu hospital now University on the Niger Teaching Hospital Iyi-Enu.*

Other mission hospitals include Mary Slessor Hospital, established at Itu by the Church of Scotland Mission in September 1905. Another mission hospital was the Mary Slessor clinic, which was founded in September 1905 by the Presbyterian Church at Itu. Agha (2004) noted that the same group started mission in Unwana on 25th October, 1888 and a mini-hospital was established in 1899 but it became defunct with the establishment of Uburu Hospital in 1913 which is now known as the Presbyterian Joint Hospital. The Methodist church built a hospital at Amachara in Umuahia in 1929.

Church Congregations as Context for Reawakening Faith-Based Sustainable Community Healthcare

Church congregations are worshipping communities. Through worship, prayer, fellowship, sermons, evangelism, teachings and discipleship congregations provide opportunities for people to connect and be reconciled with God and to connect with others and to be reconciled with them so that people can grow spiritually, mentally, morally and socially. The worship, prayer, fellowship, sermons, evangelism, teachings and discipleship are spiritual empowering processes which address people's values, attitudes, behaviour and relationships. This is the empowering role of church congregations aimed at the individual person as well as the congregation as a collective. The intended outcomes of these empowering processes are that people become transformed, have strong faith and become spiritually and morally mature in their character in terms of their values, attitudes and behaviour and are confident in their abilities to relate to others (Warren, 1995; Zimmerman, 2000; Pope, 2002; James, 2019). Warren (1995) summarises the purposes of church congregations as illustrated in Table 4.1 below according to the book of Acts 2: 42-47.

The congregation's leader or minister is the highest spiritual authority in the local church congregation. Leading and equipping are to be among the leader's primary responsibilities. According to Pope (2002), the job description for a congregation leader or minister is to discern

God's guidance regarding the future direction of the church, set goals for the church according to the will of God, obtain goal ownership from the people and share the vision and goals for the coming year of ministry and see that each member of the church is properly equipped to do his or her part in accomplishing these goals.

The Contribution of Faith in Church-Based Community Healthcare

Faith is said to influence the initiation of church-based community healthcare programmes. Green (2019) confirms that studies affirm Christian faith as an important factor in shaping and motivating volunteerism. She emphasizes that several community volunteers express the roots of their involvement as stemming from - their calling as Christians (Green, 2019). Faith can be a positive influence in church-based community healthcare. Adelaja (2018) suggests that helping people to discover their purpose can be done by asking oneself the following questions: (i) What do you love and enjoy doing? (ii) What do you have passion for? (iii) What sets you on fire and consumes you with zeal? (iv) What makes you angry and frustrated? Bradley (2021) confirms that the desire to help others is rooted in the Christian notion of compassion. For instance she notes that the link between feeling compassion and a sense of duty that results from the emotion of compassion accounts for the dedication and long term commitment of the Church (Bradley, 2021). These findings indicate that the premise for the involvement of congregation members in church-based community healthcare is from perceiving it as a personally appropriate way to live out their faith and as an expression of their religious or spiritual ministry, calling, or beliefs to empower and improve the quality of life of poor people in local communities, motivated by passion, love, and compassion.

Principle of Collaborative Leadership in Community Healthcare

The sub-strategy to establish collaborative relationships is aimed at building working relationship between congregation leaders, congregation members, local community members and other necessary partnerships in the initiation and facilitation of church-based community healthcare projects, as well as to establish partnerships with other role players such as churches, NGOs, government and other agencies aimed at supporting and facilitating access to resources and human capital to positively influence church-based community healthcare.

Collaborative leadership (Chrislip & Larson, 1994) assume that by cooperating and coordinating their efforts, groups of people collaborate when they transcend personal interests to pursue goals. In a leadership context, the purpose of collaboration is to create a shared vision and joint strategies to address public concerns that go beyond the purview of any particular party. In collaborative leadership, Chrislip and Larson (1994) test the hypothesis that if appropriate people are brought together in constructive ways with good intentions, they will create authentic visions for addressing the shared concerns of the organisation or community.

According to Chrislip and Larson (1994) the advantages, challenges and successes of collaborative leadership can be summarized as sown in the table 4.2. The hypothesis shifts attention away from a vision of leadership as heroes who tell us what to do to a vision of leadership

as servants who help us do the work ourselves. Implicit in the hypothesis is a facilitation role and a belief that diverse people can solve their most pressing problems and address their needs if they have the information they need and are brought together in constructive ways.

CONCLUSION AND RECOMMENDATION

Summary of Findings

Findings show that the community healthcare development process can be powerful in uniting the efforts of the people to improve the social, economic, spiritual, and physical conditions of communities, to integrate these communities into the life of the nation and to enable them to contribute fully to national progress. faith-based community healthcare in Igbo land brought sustainable change and improved standard of living as well as enhanced quality of life. This process is cemented together by the connections between people that are based on values of respect, trust, mutuality, reciprocity and dignity and which result in conviviality, compassion and cooperation. The findings open an opportunity for church congregations to be recognised as community healthcare agents for facilitating sustainable community healthcare development programmes to fight healthcare challenges. The findings show that church congregations are essential to the functioning of the larger community healthcare system especially in addressing healthcare challenges in communities.

The findings also open an opportunity for congregation-based social workers to work in collaboration with church leaders and other congregation members, who are also community members towards establishing congregation-based social development ministries in church congregations. This can be especially impactful in facilitating congregation-based social development interventions to address healthcare challenges in local communities in Igboland. These findings align with the work of proponents of congregational, collaborative, social work such as Tirrito (2012); Adams (2014); and Garland and Yancey (2014) all of whom suggest that the social work agenda for the coming decade must include efforts to link social work with the Church. The goal of the strategy is to guide church leaders and congregation members in facilitating sustainable Church-based social service programmes to fight healthcare challenges. The strategy responds to the challenges and the need of local church congregations to enhance their current Church-based community healthcare programmes from first generation strategies of social relief and welfare as emerged in the research findings, to second generation strategies of sustainable community healthcare development.

Conclusion

To enhance faith-based community healthcare from first generation strategies of social relief to second generation strategies of community healthcare development, the strategy concerns a holistic empowerment approach which is about empowering the people to empower themselves; helping them to identify the strengths they have that can be utilised to capacitate them in solving their own challenges, empowering people to utilize their hidden competencies fully through various community healthcare developmental programmes. The people‘s empowerment is a

process fed by information, knowledge and experiences, that brings them confidence in their own abilities.

The strategy also advocates for a collaborative approach. Participants expressed emphatically that members of the congregation are also members of the community who are put in a congregational context to be encouraged by the gospel to take responsibility and to invite the community to be in dialogue with itself, to identify assets, capabilities, needs and resources. Church congregations therefore need to encourage self-determination by allowing community members to make their own decisions about how to address their problems, because every individual adult, whether relatively poor, poor, or the poorest of the poor, has the right to be part of the decision-making mechanism regarding his/her development.

The strategy for reawakening the co-operativeness of church congregations to facilitate sustainable community healthcare development programmes to fight healthcare challenges and advocate for the establishment of community co-operatives. By their very nature community co-operatives are a bottom-up approach and play a triple role: as economic actors they create opportunities for jobs, livelihoods and income; as social organizations built on a common goal and a common bond they extend protection and security, and contribute to equality and social justice; and as democratically controlled associations of individuals they play a constructive role in communities and nations, in society and politics. These three roles cannot be dissociated one from another because they are inherent to the very nature of co-operatives (Smith, 2014).

Recommendations

Based on the findings of this study, the following recommendations are made:

i. This study suggests moving beyond efforts to measure the relative size of the Church's involvement in community healthcare in Igbo land. It recommends beginning with the development of clear, comparative, and organized evidence, followed by deeper analysis using complex systems approaches.

ii. The study also recommends the development of an effective collaboration between social workers and the church leadership which may require some additional enhancement of professional competencies and including social development as part of the curriculum of the on-going theological training of ministers at seminaries or religious graduate schools, or internships via training centres.

iii. Church congregations should be recognized as contexts for community healthcare and for social work practice, utilizing unemployed and retired social workers who are already in church congregations; as well as students who can be placed in congregations for their practicals for community healthcare development.

iv. The researcher urges policy makers to recognise local church congregations as contexts for community healthcare by opening local offices for the co-ordination of Church-based

social delivery programmes, recognising their caring, compassionate and morally oriented approach to community healthcare as well as recognising the benefits of their relatively low overheads and administrative costs, which are as a result of their utilising committed volunteers in their programmes.

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