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Missionary Activities and the Growth of Private Healthcare in the Wukari Area from 1972-2015

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Abstract

The study "Missionary Activities and the Growth of Private Healthcare in the Wukari Area, 1972-2015" is an attempt to examine how missionary activities culminated into the establishment of healthcare facilities and the eventual evolution and participation of private practitioners in healthcare delivery in the area of study. The missionaries came into Africa not only to preach and propagate Christianity but also to convert the people to their religion through charitable outlets like the provision of healthcare. Eventually, the healthcare system developed attracting the attention and involvement of the colonial government while the missionaries were still actively involved. The missionaries also trained a number of indigenous people to help them as health superintendents and attendants whenever they go to the field. The batch of people that were trained utilized such knowledge to render healthcare services to their people in return. This was the case of the Wukari Area under review whereby an health superintendent with the missionaries established the first private healthcare centre in the area in 1972. This study utilized historical research method through the use of primary and secondary source data. The study also examined all other factors that led to the evolution of private practitioners in the area such as inadequate facilities and hospitals, lack of motivation and lackadaisical attitudes of health workers in the government hospitals among others.

Keywords: Healthcare, Missionary Activities, Wukari Area, Private Healthcare, Christianity.

INTRODUCTION

After some unsuccessful attempts to introduce Christianity into Nigeria, the year 1842 marked its inception as the first batch of Christian missionaries landed in Badagry while heading to Abeokuta. The missionaries came as a result of the liberated slaves being returned to Nigeria. The liberated slaves were encouraged by Thomas Fowell Buxton and others to engage in useful pursuits such as agriculture, trade, and missionary work, thus, the combined introduction of "the Bible and the

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Plough" to bring light and civilization into the heart of the African continent. The first batch of missionaries landed in Badagry, which was intended to be their base, but they found the place unsatisfactory because of the losses incurred from its erstwhile flourishing slave trade. The people offered the missionaries little cooperation, which therefore prompted them to look elsewhere and enter negotiations with the authorities at Abeokuta [1].

In spite of the friendly disposition of the Egba leader, Sodeke, his chiefs were hesitant and insisted in 1845 that the missionaries be kept off, but they soon accommodated them when they realized they needed their assistance in their political orchestrations against Lagos and other hostile neighbors. By 1846, the missionaries were granted full access to the land, they soon embarked on painting Abeokuta in a good light as the veritable "Sunrise within the Tropics," their gateway into Yorubaland and regions beyond [2].

The missionary efforts of Townsend, Crowther, and Gollmer led to the establishment of mission churches and schools, and on 5th February 1845, the first set of converts were baptised. The return of the emigrants resulted in the introduction of Christianity into various towns and villages as far as Ede, Lagos, Ibadan, Ijaiye, Iragbiji, and Ilorin. From these areas, Christianity spread to other areas of Yorubaland by the second half of the 19th century [3].

In the Southeastern area, the Scottish missionaries pioneered Christian evangelization through the efforts of Hope Waddell who arrived in Calabar in 1846. He preferred a policy of concentrated evangelization, in preference to open air preaching, schools were introduced and instruction provided within the compound of various houses. The first baptism was conducted in 1853 while a church was established in 1857. In September 1858 a presbytery of the Bight of Biafra was established, which was subject to the supervision of the Foreign Mission Board. As the emigrants began to arrive in Calabar, settling especially in Duke town, the numbers of converts also swelled. Some were Presbyterians, but most were either Methodists or Anglicans who had to attend only the available Presbyterian Church. The Anglicans commenced work first in the Niger at Abo and more successfully at Onitsha in 1857, Brass in 1861, and Bonny in 1864. Rapid progress was generally recorded, which afforded the trading communities of the Delta the opportunities of schools for training literate clerks [4].

In Northern Nigeria, the Christian missionaries had high hopes of evangelization for a long time unabated, throughout the second half of the 19th century; the reoccurring theme of almost all Christian missions was how to evangelize this vast Muslim area of Nigeria. The pioneer of this thought and plan was the Reverend Samuel Ajayi Crowther, whose mission interest dates as far back as his contact with the Hausa during the Niger expeditions of 1841 and 1854. His evangelistic zeal was shared by Dr. William Balfour Baikie, who led the 1857 expedition that employed a large number of intelligent youth from the area as guides and interpreters. On becoming the head of the Niger Mission in 1857, Crowther was afforded the opportunity to realise his long-cherished ambition. After a long period of patience and persuasion, he eventually won the support of the Emir of Bida, who allowed Crowther's missionary programme for the Nupe Kingdom. He was also permitted to establish two mission stations at Kippo and Shonga in 1875 and 1876 respectively. The Emir gave one of his sons to Crowther to educate and also sent letters to the Emirs of Nassarawa and

Yola who were his subordinates to allow Crowther to kick-start missionary work in their territories, which eventually failed to win any converts [5].

By the 19th century, a group of twelve missionaries known as the Sudan Party arrived in Lokoja under Graham Wilmot Brooke. He adopted a "cultural surrender" approach to evangelize Hausaland by dressing, eating, and learning the Hausa language, the indigenous people viewed his cultural gimmicks as simply ludicrous. Brooke became a victim of black-water fever, which took his life in March 1892 with little to show for his efforts.

Bishop Tugwell headed another mission in 1899 to Hausaland; they were, however, expelled out of Kano by the Emir, who was not pre-informed of their coming. The mission was able to build a mission house and dispensary in Girku where they settled before the mission was burnt down in 1900. More missionaries arrived but their efforts were concentrated outside Hausaland, among them were the Cambridge Missionary Party in 1906, the Sudan United Mission with its missionaries settling in Wukari in the Bauchi Province, and the American Quakers who arrived in Lokoja and Wukari in 1905 [6].

The British branch of the Sudan United Mission (SUM) arrived and kicked off missionary work in the EKAS (in Hausa means Ekklesiayar Kristi A Sudan) Benue Church (now CRCN) in 1905. The missionaries preached the gospel as well as provided basic health services, particularly first aid. The missionary doctors always pray before dispensing medical services. From the year 1932-1937, most ladies from the Christian Reformed Church (CRC) in Michigan, North America, worked as volunteer nurses under the umbrella of the SUM. They were successful in erecting a health post (infirmary) in Lupwe-Takum, southeast of Wukari.

As at this period, the prevalent health problems were smallpox, leprosy, sleeping sickness, among others. The CRC Home Board made available trained physicians and a mission hospital to arrest the health conditions of this period. Though the board never planned to take the medical outreach beyond minimal medical aids; that is, first aid and clinics above educational and evangelistic ministries. Nevertheless, with the establishment of the hospital, the effort was divided: the mission was responsible for medical care, while the Ekklesiayar Kristi A Sudan (EKAS Benue Church (now CRCN) was responsible for spiritual development, visiting, praying and counseling the sick. It should be noted that it took between 30 to 50 years before the mission concentrated on full-fledged healthcare, but they still used this health service as a weapon for converting and gaining followers. Their primary aim was not the rededication of believers but the conversion of unbelievers while using healing as a potent tool in converting the unbelievers. The British branch of the SUM missionaries had two major aims for carrying out healing in Africa; to stop the spread of Islam and to propagate the gospel of Christ. To achieve this feat, they utilized healthcare as an effective weapon of conversion to the Christian faith [7].

The persistence of low-quality and inadequate medical care in Nigeria's public health institutions has forced the consumers to unavoidably resort to private practitioners for their medical needs. From the mid 1980's, the patronage of private health institutions has increased astronomically as a result of the deep economic downturn of the era, which culminated in the drastic fall of social expenditures and household earnings [8]. The evolution, growth, and development of private health institutions in

Wukari Area cannot be succinctly espoused without giving recourse to the activities of the missionaries whose contributions laid the foundation and paved the way for health care delivery generally in Wukari and environs. The evolution of private health institutions took off from the springboard of the already laid foundation by the missionaries. The missionaries in this context are the Sudan United Mission and the Sudan Interior Mission.

The Sudan United Mission (SUM) commenced in 1902, in Sheffield, England, as a faith mission with the name Sudan Pioneer Mission, which was later changed to Sudan United Mission in 1904. Dr. Karl Kumm and other missionaries were sent to the Sudan savannah to begin missionary work the same year. When they arrived in the area of their mission, that is, present-day Nigeria, Lord Lugard, the then British High Commissioner suggested the establishment of their mission base at Wase in present-day Plateau State. Meanwhile, Dr. Kumm, the founder and leader of the mission went on a tour of South Africa, Europe, America, Australia, and New Zealand challenging the churches to take up mission work under the umbrella of the SUM [9].

In addition, the Christian Reformed Church of Nigeria (CRCN) grew out of the mission work of the Christian Reformed Church (CRC), a branch of the SUM. The birth of this branch was occasioned by Dr. Kumm's visit to Wisconsin, USA where Miss Johanna Veentra felt the touch of God to participate in missionary work on 2nd October 1919. She left New York for Northern Nigeria, where she spent a year at Donga as a probationer under the leadership of Rev. Clarence W. Guniter. Throughout 1921, she worked at Lupwe where she performed simple medical work while propagating the gospel to surrounding villages. Following Veentra's death in 1933, the CRC took up the responsibility of the mission in Lupwe from the SUM in 1940. As the years went by, the number of communicants, worship centres and church attendance increased while indigenes were trained to provide leadership to the believers. Unfortunately, there arose a major division in the church in 1973 which split it into two. The larger part is the CRCN, while the smaller part is the Reformed Church of Christ in Nigeria (RCCN) [10].

Prior to the coming of the missionaries, medical care was solely handled by the traditional practitioners who were revered and enjoyed monopoly cum prestige among the people. It was substantiated that Mr. John Burt was the first missionary to arrive in Wukari. Mr. Burt's arrival was as a result of encouragement by Aku Agbushu Agbumanu, the reigning Aku during their visit, the Christian missionaries repeated their visit. Afterwards, Burt was joined by Mr. Maxwell and Walter Hoover, Reverend C.W. Hinter and Dr. J.S. Dale. Besides spreading the gospel, the missionaries introduced education and hygiene, they established the first primary school in the 1930's while the establishment of other schools followed suit. The hallmark of their activities was the provision of health facilities in Wukari and its environs to meet the medical needs of the people [11].

As mentioned earlier, the SUM is believed to be the first missionary group to come to Wukari. They first settled at Takum and Donga where they established hospitals before coming to Wukari. The SUM established a mission hospital which was located around the king's palace. They also trained personnel who worked with them both in healthcare delivery and the missionary work of evangelising. Eventually, the trained indigenous evangelists revolted against the missionaries, and after their exit, they changed the name of the mission to Christian Reformed Church of Nigeria (CRCN), an appellation it bears to this day, while the missionary work continued under the new

banner. The medical facility that was established during this period in the heart of Wukari town now floats under the banner of its new appellation, that is, CRCN Health Centre [12].

Furthermore, the church and the mission recognised that medical work is one of the most important means of preaching the gospel and expressing the love of Christ by caring for the people's physical bodies as well as their souls. When people go to the hospitals and dispensaries of the mission, prayer comes before treatment, there is also love emanating from the doctors and nurses. This encouraged the people to convert. However, there was no Nigerian doctor who worked with the mission, which raises the question of whether the Nigerian church never imagined that the missionaries would someday go back to their home countries. Meanwhile, nurses and other categories of health assistants were trained by the missionaries with some of them using the knowledge to cater for the health needs of the people [13]. More succinctly, a leprosarium was also established in Lupwei under the auspices of the SUM [14].

On the other hand, the Sudan Interior Mission (SIM) also took up education and medical work as an auxiliary to the primary objective of missionary work. Medical work, health care services, and treatment of diseases became the handmaids of the gospel and evangelization. It was utilized as a key to open the way for the penetration of the gospel. It was also termed the "Mission of Mercy" and was a means of introducing the people to "the Great Physician." According to the SIM: the policy, however, has been to give maximum medical care relief together with spiritual ministry, with the minimum institutional work [15].

The SIM attached importance to healing the sick and cleansing the leper, therefore, all major mission stations had dispensaries or health clinics. Oftentimes, healthcare tours were embarked on with mobile clinics. The medical work of the SIM was significant in the spread of the gospel and most especially, in opening up the Muslim emirates. Their contribution was the largest of all Christian missions in Northern Nigeria in the area of leprosy work, fighting eye diseases, and blindness. The health care undertakings of the SIM were concerted in provinces such as; Sokoto, Katsina, Kano, Bauchi, Borno, Zaria, Benue, Niger, Taraba, Kabba, Plateau, and Ilorin. Their undertakings consist of general medicine, which treated countless sicknesses and physical infirmities, and leprosy work. The mission's work on leprosy entailed combating leprosy epidemic, its treatment and social wellbeing. Hence, dispensaries and leprosarium were established in Northern Nigeria [16].

Several documents establish the involvement and eventual incorporation of the health sector into the colonial programme by the colonialists. The hospitals or dispensaries that were established and run under the colonial government were referred to as Native Authority Hospitals, which span Wukari, Ibi, and Takum. These towns were under the Wukari division during the colonial administration. A colonial document dated 24th March 1832 sent from the Wukari Divisional Officer to the Resident Officer, Benue Province; Makurdi provides insight into the establishment of the Wukari Native Authority. The document explained the transfer of the African hospital from Ibi to Wukari on March 21st, 1932, and the medical officer is also permanently moved to Wukari. Although the Wukari dispensary was under construction, there were rest houses to provide temporary accommodation while work should commence in earnest [17].

In another memorandum from the Assistant Director of Medical Service Northern Province to the Resident of Benue Province on the development of Native Administration Dispensaries Fees; the question on the method to be adopted in fee collection was discussed but no conclusion was reached because the local knowledge and customs of the inhabitants of the districts had to be taken into consideration [18]. In addition to the above, there was another memo dated 30th September, 1930 from the Divisional Officer Wukari to the Resident at Benue Province, Makurdi on Native Administration Dispensaries and the fees to be charged. The document contained the outline for the payment of fees:

i. Fees to be charged to all who can pay.
ii. No patient to be turned away for inability to pay.
iii. The Native Authority should be responsible for assessing the ability of a patient to pay and for collecting fees.
iv. Coloured tickets should be issued by the Native Administration on receipt of the fees.
v. The dispensary attendants should advise the Native Administration authorities as to the amount of fees to be collected from patients from scale of fees prepared by the Medical Officer [19].

Another document to complement the above was a memorandum from the Medical Officer in Wukari to the District Officer in charge of Wukari on the issue of out-patient charges at Wukari Hospital dated 31st August 1932 on the charges for outpatients at Wukari Hospital and Native Administration dispensaries under Wukari:

A. For each attendance for drinking medicines or dressings, 1d a time up to 12 attendances.
B. For Sobita or Bisoxyl – 1d per cc. average charge 3d for adults, 2d for women or adolescents, 1d for children.
C. For N.A.B. 6d for .3 grams [20].

According to an archival document from the District Officer in charge of Wukari Division about the survey of Ibi Dispensary under the Wukari Area in the colonial dispensation. The letter was a proposal to re-survey Ibi town for the possibility of re-opening Ibi dispensary for diagnosing and treating sleeping sickness while an assistant would be posted to Ibi to commence work. Before its closure for a period of time, Ibi had been popular for the treatment of sleeping sickness, especially for people coming from Shendam border to curtail the hardship of sending their relatives all the way to Wukari for treatment of sleeping sickness. The D.O. called for the co-operation of the Native Authority Police constable and District head's representatives to assist the assistant that would be sent for the smooth running of the project [21].

A letter of introduction was issued to Mallam Yakubu, the S.S. Assistant sent to carry out the re-survey of Ibi to determine the advisability or otherwise of re-opening the Ibi dispensary [22].

In another development, a memo sent to the Medical Officer Wukari for audit inspection in Wukari Hospital on 28th February 1951, which states the principal auditor of Northern Province inquiries if there is any reason against charging out-patients at the Wukari Hospital 3d instead of the present 2d.

The auditor noticed that the receipt books are for 3d which cannot be altered to 2d, therefore, the suggestion that the fee be raised to 3d per patient while the 3d receipt books be put to use [23].

In response to the above letter on 7th March 1951, the A.D.O Wukari appreciated the comments raised in the earlier communiqué while giving the impression that the 2d charge is adequate and that it would appear to be an unnecessary hardship to raise the out-patient fee merely for the sake of using up a stock of receipt books [24]. A report issued on the inspection of Takum Native Authority Dispensary under Wukari Medical Area carried out on 12th November 1953, showed the building and the dispensary were kept clean while supplies of drugs were received from Wukari N.A. stores and the Dispensary Attendants did the mixing, compounding and dispensing of simple mixtures. It was suggested that a small cupboard for storing poisons, few rows of shelves in the main dispensary for keeping drugs and stocks mixtures be provided. The table used for mixtures should be converted and used as a compounding table in place of a counter and a covered receptacle for storing clean water should be put in place [25].

A confidential note sent to the District Officers in Wukari and Gboko on the Pharmacists Superintendent's Inspection notes on Wukari Medical Area on 18th February 1954 stated as follows:

1. It is noted that several dispensaries are not fitted with separate poison's cupboards, and neither the poison or their antidotes are listed. Instructions should be issued to have these differences rectified.
2. As the Regional Medical stores in Kaduna are now in operation ordering from Oshodi should cease.
3. It has been shown that water filters are a source of grave danger of infection unless they receive the most scrupulous care which they never do; dispensers should be instructed to strain water through several layers of lint, boiling, and storage in clean containers.
4. Native Authority Dispensary attendants should not compound medicines. The proper procedure is to have concentrated stock mixtures prepared in the hospitals by qualified dispensers and these concentrated mixtures are distributed to the dispensaries. Distribution is the responsibility of the Native Authority, where possible, a suitable N.A dispenser should do this compounding in the hospital under the supervision of the Hospital Dispenser, where this is not possible, the senior Native Administration Dispenser should do the compounding. The necessity for Native Authorities to provide their qualified dispensers should be urged upon residents. Two or three Authorities could combine their resources to provide for a dispenser and his transport and the Government is prepared to train suitable candidates at the Zaria School of Pharmacy for free.
5. The quarters for the dispenser should be provided at each dispensary; otherwise, the dispensary does not qualify for a grant.
6. The Native Authorities concerned should be asked to protect dispensary wells by building a cement apron, capping round the well and fitting a lid [26].

According to oral evidence, Mr. Yusuf Ibrahim Ikilama, a rural health superintendent, was the first individual to venture into private healthcare practice by opening a clinic in 1972. His clinic was

located around the Aku Uka palace before relocating to the Kwararafa University (city campus) area. He was the only individual operating a private clinic and providing health care to the people in and around Wukari alongside the missionaries. The missionaries did not allow their health workers to operate privately, but Mr. Ikilama enjoyed the wide patronage of the people, even though he was not a trained medical doctor, but he used the experience he garnered from the missionaries to treat the people. He attended to cases of illness and prescribed drugs, but he did not perform surgical operations as his clinic lacked such facilities. One of the factors that encouraged him to venture into private practice was the lack of adequate facilities all over the district and the Wukari Area as a whole. The patients that thronged the mission hospitals were more than the available facilities and manpower to cater for their health needs. With time, other private hospitals sprang up from 1985 which became a competition due to improved facilities such as performing surgery and being run by trained medical doctors. The Ikilama hospital was eventually relocated to Igwo in Donga local government area, where it was unfortunately destroyed in 1991, during the Jukun/Tiv conflict. Mr. Ikilama was already well stricken in age during this period; he therefore retired to his home where patients still trooped in for consultation [27].

According to a respondent, Mr. Ikilama's sole motivation for establishing a private hospital was because of the love for his hometown, Wukari. Having practiced with the government for a long period of time, it became imperative to come back home and contribute to the health needs of the people. Besides, working for the government is not encouraging due to poor remuneration and also in order to have a steady source of income after leaving the government [28]. Another factor that led to the evolution and spread of private medical institutions could be for economic purposes, that is, as an avenue to advance entrepreneurship and to invest in the health sector especially for an individual that is groomed in the medical field [29].

In some cases, private health institutions are patronized as a result of personal relationships with the owner, whether as a friend, uncle, brother, distant relative, or a neighbor. In the same vein, some of these doctors are being patronized because they have demonstrated wide knowledge, prowess, and expertise in certain areas of health. Some are experts in diagnosing and treating stomach related issues; some are experts in surgeries while some are experts in childbirth and delivery [30].

The available facilities and manpower are insufficient to cater for the people's medical needs, so private practitioners come in to fill the gap [31]. In addition, the lack of adequate coverage of the existing health institutions is a major challenge. There are no standard government owned hospitals or clinics to provide such coverage except for the General Hospital in Wukari, which services the whole local government and surrounding towns. Also, there are not enough health staff to service the teeming population of patients in and around the metropolis and Wukari Area as a whole [32]. The issue of deficient manpower or human resources adds insult to injury. On the other hand, doctors and other medical workers are unwilling to practice in rural regions, which leaves the rural areas underserved while the few health personnel are too few to adequately cater for the teeming number of patients. In addition, public health institutions are bursting with heavy or unmanageable patient load coupled with the fact that the primary health centres are not functioning to their full capabilities [33].

Corruption in government owned and controlled health institutions is very rift, very little is budgeted for the sector, even though there are agitations for increased funding, but when conceded the allocation from the budget rarely gets to the targeted layers captured in the implementation of the budget. A major part of the funds get misappropriated, diverted, and 'stolen' by corrupt government executives in collaboration with contractors and suppliers [34].

Apparently, the lack of infrastructure and adequate medical equipment to use in public hospitals are a major bane as well as an impetus for the growth of private health institutions. In government establishments, lack of enough bed space to admit patients; some patients had no bed space and had to lie down on the floor of the hospital while some stayed on the corridor [35]. The researcher has also experienced this firsthand in a general hospital somewhere in southwest, Nigeria, where some "unlucky" patients were admitted on the corridor of the ward in the open, exposed to cold, mosquitoes, and other vectors, and the most "unlucky ones" had to sleep on the bare floor of the hospital [36]. Inherently, the general lackadaisical and unfriendly attitude of the health workforce, especially in these public hospitals, are nothing to write home about, they are rude and uncultured in their approach and disposition towards the patients and sometimes treat them as something less than human [37].

It is of utmost importance to state that the non-full implementation of the National Health Insurance Scheme (NHIS) also contributed to the rise of private hospitals. The NHIS was projected to deliver social and financial risk coverage by cutting down on medical care and providing equal access to primary medical services especially for the old and weak population in the country, that is, pregnant women, children, senior citizens, people with disabilities, unemployed, displaced, sick and pensioners. These groups are supposed to enjoy free healthcare or pay a certain percentage, but they have to pay for their medical care due to the absence of free medical care because the NHIS was politically motivated and poorly implemented. Across the country, the major crop of beneficiaries of the NHIS are the civil servants, unfortunately, they still have to pay for medical care most of the time as a result of non-remittance of the healthcare fund to their various accredited or registered centres. The study area is not left out in this misdemeanour, thereby giving rise to more patronage of private health institutions [38].

CONCLUSION

From the foregoing, it is important to emphasize that missionary activities through the propagation of the gospel and healthcare delivery revolutionized healthcare delivery in West Africa, in Nigeria and the Wukari Area specifically. The activities of the Sudan United Mission (SUM) and the Sudan Interior Mission (SIM) laid the foundation for healthcare services and delivery in the study area. Their efforts caught the attention of the colonial government who also became fully involved in the provision of health for the indigenous people and not just British officials and by independence in 1960 handed those established facilities to the Nigerian government. The first private healthcare practice in the area was undertaken by a former health superintendent who had gained experience and expertise from the missionaries through various outreaches and therefore brought succor to his people. From there, other practitioners were ushered into private practice and establishing their private clinics/hospitals. These hospitals became an alternative to the ever teeming and overpopulated government owned hospitals.

REFERENCES

[1] T.G.O. Gbadamosi, J.F Ade Ajayi. "Islam and Christianity in Nigeria," Obaro Ikime (Ed.), Groundwork of Nigerian History. (Heinemann Educational Books, Ibadan, 1980), 147-150.
[2] T.G.O. Gbadamosi, J.F Ade Ajayi. "Islam and Christianity in Nigeria…"
[3] T.G.O. Gbadamosi, J.F Ade Ajayi. "Islam and Christianity in Nigeria…"
[4] P.O. Olatunbosun. History of West Africa from A.D. 1800 to the Present Day. 223.
[5] P.O. Olatunbosun. History of West Africa…
[6] P.O. Olatunbosun. History of West Africa…
[7] Isaiah B. Hikon, "Healing Beliefs and Practices in Jukun Society." Unpublished Paper.
[8] Ogunbekun Ibukun, Ogunbekun Adenike, and Orobaton Nosa, Private Health Care in Nigeria: Walking the Tightrope. Health Policy and Planning;14:2, (1999): 174.
[9] Mark Hopkins. The Story of Tekan. (ACTS: Plateau, 2005), 71-72.
[10] Hopkins. The Story of Tekan… 79-80.
[11] Shishi D. Tonku. "Urbanization in Wukari." (Undergraduate Project, Federal University Wukari, 2017), 25-27.
[12] Oral Interview with Joel Zando Aji, Civil Servant, 48 years, Wukari. 12th December 2018.
[13] Agomy Tara Borokini, LCCN and the Historical Root of Christianity in Africa. 1985, 118-120 and Kalu Ogbu, Christianity in West Africa: The Nigerian Story. (Ibadan: Daystar Press, 1978), 51.
[14] Susan United Mission: Leprosy Self-Segregating Centre at Lupwei. (May 10 1948).
[15] Turaki Yusufu, Theory and Practice of Christian Missions in Africa: A Century of SIM/ECWA History and Legacy in Nigeria, 1893-1993, vol. 1. (Nairobi: International Bible Society, 1999). 312-330.
[16] Turaki, Theory and Practice of Christian Missions...312-330.
[17] NAK no.52/1930/80.
[18] NAK, No.25, 1930.
[19] NAK, No.25/1930/76.
[20] NAK, No.3W/F/32.
[21] NAK, No.SSB.29/426.
[22] NAK, No.SSB.29/430.
[23] NAk, No.33/195.
[24] NAK, No.66/654.
[25] NAK, Takum N.A. Dispensary (Wukari Medical Area).
[26] NAK, No.304/14.
[27] Oral Interview with Rose Yusuf Ikilama. Civil Servant. 55 years. Wukari. 2nd February 2018.
[28] Oral Interview with Dr. Simon Yerima. Medical Doctor. 66 years. Puje. 12th February 2018.
[29] Oral interview with Dr. Bawa K.I. Boyi. Medical Doctor. 62years. Wukari. 12th February 2018.
[30] Oral interview with Favour Yerima, Corp Memeber. 30years. Wukari. 11th July 2021.
[31] Oral Interview with Joel Zando Aji…
[32] Oral interview with Dr. Godwin Amedu. Medical Doctor. 56 years. Wukari. 10th February 2018.

[33] Bajpai Vikas, "The Challenges Confronting Public Hospitals in India, Their Origins and Possible Solutions." Advances in Public Health, vol.4, (July 2014): 1-27.

[34] Eme Okechukwu Innocent. "Building a Solid Health Care System in Nigeria: Challenges and Prospects." Academic Journal of Interdisciplinary Studies. Vol 3 No 6, (November 2014): 508.

[35] Oral Interview with Hamisu Sani Ali, Civil Servant, 50 years, Wukari. 8th November 2019.

[36] The researcher at the time he was admitted in a government hospital experience this anomaly first hand. He was able to get a bed space because the mother was a senior staff of the hospital. In the turn of events, one of the patients that was admitted on the corridor passed away and the corpse was left out there until the mother of the researcher raised an alarm that the corpse be removed and taken to the mortuary. Unfortunately, this is the state of many government hospitals in the country.

[37] Oral Interview with Hamisu Sani Ali…

[38] B. Aregbesola, Healthcare in Nigeria: Challenges and Recommendations. Accessed on 19th March, 2021. http://socialprotection.org