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Evolution and Growth of Colonial Health Care Services in Wukari Division, 1940-1960

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Abstract

Colonial healthcare development in Wukari Division emerged from the introduction of Western medicine by European traders and missionaries operating along the Benue and Niger Rivers. Medical personnel and supplies initially accompanied these groups because malaria and recurrent epidemics threatened colonial officials, particularly in the riverine districts of Ibi and Donga. Although early colonial health policies primarily served Europeans, attention gradually extended to the local population during the 1940s. This study examines the evolution and expansion of colonial healthcare services in Wukari Division between 1940 and 1960. It employed a historical research approach using primary and secondary sources. Primary data were obtained from oral accounts, while secondary data were drawn from books and journal articles. The findings indicate that changing international attitudes toward colonialism after World War II generated impetus for improvements in healthcare provision within the division. These developments included the expansion of health facilities, the training of healthcare workers, and reforms in

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colonial health policies. The period also witnessed the emergence of nationalist demands for greater African participation in governance, including the administration of healthcare. The study concludes that colonial healthcare services in Wukari Division expanded substantially between 1940 and 1960, reflecting the combined influence of public health needs, postwar political developments, and growing African demands for participation. These findings contribute to the historical understanding of how colonial policies and nationalist pressures shaped the development of local healthcare institutions.

Keywords: Colonial Healthcare; Health Policy; Medical Services; Wukari Division; World War II

Introduction

From the late 1920s, there were neither complete nor clearly noticeable state interventions and policies on health on the borders of colonial administration, especially in Wukari. Although there were some health initiatives such as environmental sanitation, land reclamation, construction of drainages, drug distribution and vaccination (NAK, 1925). People in the remote areas of wukari did not receive any serious attention, government left the health of Africans to missionaries who had long established mission stations, most of which had rudimentary medical services. Many people from rural areas travelled long distances to access health facilities in town and at these mission stations. According to records, there was no real colonial policy to establish a vigorous medical service before 1920. The colonial government left the health of the local people must especially those in rural areas like Ussa, Rafin Kada, Tsokundi, Kente just to mention a few in the hands of the missionaries. Efforts of missionaries in creating healthy environment for their adherents, epidemic and endemic diseases still kill a lot of people in Wukari Division. For example, the epidemic of smallpox recorded mortalities among the indigenous population of two hundred people were affected in 1928. This was off course disturbing to the British economic interest, as the deaths were among the tax-payers and cash-crops producers in the area. On the other hand, the prevalence of diseases most importantly malaria became a threat to the health of the colonial officials in Wukari Division most especially in the riverine areas of Ibi and Donga District (Bruce-Chwatt, 1980). Effective control of diseases became significant provided the indigenous people were themselves free from such complications (NAK, 1955). The colonial authorities had no option other than to extend

health services to more people in Wukari Division. As a matter of fact, provision of sanitary facilities and law enforcement representatives were appointed to detain environmental polluters of which Wukari Division was closely associated with the above factor. Even far away settlements in the inner core benefited from the provision of sanitary structures based on the colonialists‟ belief that such amenities would reduce the population of mosquitoes in the areas (Bruce-Chwatt). The economic consideration in the claim of the medicine became visible when concentration was made around economic imperatives and urban centers in the division. The prominence was on workers productivity and therefore, other areas were not given due attention. It was no until 1930s when the colonial government began to formulate policies to better the health of the people in Wukari Division (NAK, 1930). Early efforts involved the establishment of dispensaries, health post, and small clinics, usually staffed by African medical orderlies under European supervision (NAK, 1934). Several factors led to the introduction and growth of health services in Wukari Division these include, World War II 1939-1945, Training and Africanization of health services, Nationalist movements and health policy reforms. From the findings, the study revealed that health services and health facilities were greatly upgraded in Wukari Division. This has therefore help in reshaping the current health care practices in the area of study.

World War II and Medical Mobilisation

World War II became a turning point in the field of health, colonial government increased investment in health infrastructure to support war efforts and maintain labour productivity. In Wukari, this led to the expansion of public health campaigns, including vaccinations, hygiene education, and malaria control programs. Health officers were deployed to monitor rural areas and train local health workers (Angye, 2025).

By the end of World War II, there was expansion of medical amenities in Wukari between 1945 and 1956. British colonialism, among other imperial systems, attracted harsh and severe criticisms from world powers. In addition, countries such as the United States of America and Russia also admonished Britain to take radical steps in improving the living standard of the people in their colonies. These changes encouraged the nationalist politicians to intensify their agitation for reforms of socio-economic conditions and independence (Crowther, 1968). By 1945, the colonial Secretary requested that government

should submit proposals outlining their desired development project for the upcoming decade. This was known as the "Ten Year Plan of Development and Welfare". After its approval by the Secretary of State in 1945, it was rested on the Table of the then Legislative Council on 7th February, 1946 as Sessional Paper No. 24 of 1945 (NAK, 1945). This became official on 1st April, 1946. The plan covered the whole federation (NAK, 1956). It was anticipated to the rate of £55 million of which £23 million was to be approved by His Majesty's Government under the Colonial Development Act.5 the Plan provided for a Ten-Year Medical and Health Development for the country (Pearce, 1980). The outcome was the institution of one or more first class hospital in Wukari Division in 1952 with full facilities for the scientific examination and treatment of diseases. Initially, the hospital was situated in the central part of Wukari town, near the Wukari Market and the Palace of Aku Uka. In addition, the plan made provision for improvement and expansion of Native Administration Dispensaries as well as establishment in each province of a rural health center. Examples of health-related projects funded through the Colonial Development vote included the Nurses Training School, Kaduna. In addition, 216-bedded Tuberculosis Pavilions commenced operation (NAK,1945). The institution had to provide physical structures as well as required medical equipment. African doctors served in Wukari Division hospital like Dr.Samuel Manuwa . At the beginning, the Northern Government General Hospital had a medical unit with beds staffed by someone capable of doing at least some emergency surgery and equipped with a theatre, a laboratory and an X-ray plant, Mortuary and out-patient Rooms (Rautha, '2025). Complicated health challenges were referred from Native Authority Dispensary to Wukari General Hospital (Bawa, 2025).

Beyond food and shelter, healthcare services were another fundamental necessity for the wellbeing of city dwellers. These services had importance for the protection of the people from communicable and parasitic diseases characteristic of urban population in developing countries. Examples of health infrastructure which the Northern Nigerian Government provided in Wukari Division in the 1950s included the following: opening of Maternity Centers at Donga. The apartment housed a Plaster-Room for the production of artificial teeth. It comprises of a laboratory X-Ray Dark Room and a Dental Centre with a modern Dental Mobile Clinic (NAK, 1949).

All the health institutions in Wukari Division including Dispensaries, Maternity and Rural Health Centers located in the town and rural areas formed a single administrative unit. (NAK, 1958). The Principal Medical Officer had the responsibility of controlling and

managing the affairs of the unit. With the emergence of Western Region Ministry of Health and Social Welfare in 1957, medical policies of all the health institutions including mission and private hospitals became strengthened. However, several challenges arise from expansion and consolidation of hospital services such as overcrowding with insufficient beds, shortage of clinical personnel, dearth of drugs and medication became compounded. In addition, hospital services did not extend to a great number of people in the rural area (Atambi, 2025).

Unfortunately, these issues remain unsettled in Wukari and other parts of Nigeria till date due to the poor governing style which became completely different from colonial arrangement. People in the farm villages of wukari did not receive any serious attention. Consequently, it became imperative for Nigerian leaders to come up with a radical and people-oriented health policy that could address the needs of the people in the urban and rural areas.

Training and Africanization of Health Services

By the 1940s, there was a gradual shift toward training Africans in western medical practices. Dispensary assistant, nurses and midwives were trained at regional centers and dispatched to rural clinics in Wukari. This shift helped to bridge the cultural gap between western medical personnel and the indigenous population. The colonial authorities identify the link between the trained personnel and effective health service. Therefore, a number of institutions for training of medical and health personnel emerged (NAK, 1932). The school provided education for public health inspectors and sanitary overseers. It was of great importance to the health development in Kano and other parts of Northern Nigeria including Wukari Division. Graduates of the school carry out activities such as inspection and monitoring of peoples‟ houses and business sites with a view to ensuring obedience to sanitary rules and laws. In addition, they instituted legal proceedings against lawbreakers. As time went on, Sanitary Inspectors carried out their responsibility in excess, they were known to be notorious and impatient in the course of carrying out their responsibilities. Their intolerance made it difficult for the local people to adhere to the rules and regulations This situation became worsened during the post-colonial era. Another important responsibility carried out by sanitary inspectors was the vaccination of several people against smallpox and other communicable diseases (NAK, 1925). They played a pivotal role

in the control of anti-malaria, pest annihilation and preservation of hygienic and a sparkling environment. Similarly, the colonial government played a great role by establishing institutions for training nurses. For example, nurses that graduated from school of nursing in Kaduna were posted all over Northern Nigeria including Wukari Division. The colonial government employed several measures which included provision of sanitary structures, building of public latrines, clearing and draining of swamps as well as canalization of streams. By so doing, communicable diseases such as malaria, measles, meningitis, pneumonia and infantile diarrhea became controlled. In addition, initiation of portable water reduced considerably the incidence of Guinea worm, typhoid fever, dysentery and other water-borne diseases. Additionally, vaccination eradicate smallpox and other fatal illnesses that used to be a threat to human lives.

Nationalist Movements and Health Policy Reforms

As discussed earlier numerous campaigns were launched to combat endemic diseases such as yaws, small pox and sleeping sickness. The colonial government work hand in hand with the missionaries thus, mobile clinics were made available for the people. Sanitation and maternal health, improved tremendously (J. Z. Sanfo). The Colonial health system in West Africa and other parts of the continent focused solely on treatment rather than prevention. Provision of health facilities were made available. Medical personnel were consequently appointed to work in Wukari Divison and other leading managerial centers in Northern Nigeria as well as West Africa. Local people became Sanitary Inspectors and Overseers. The opening of a training center for Native Administration health officials (Dubagari) in Kano enabled the employment of required personnel, headed by a Medical Officer who oversee the general cleanliness of Wukari town and villages, collection and disposal of refuse, disposal of waste water and drainage, slaughtering of cow, planning of villages, vaccination as well as formation of markets. The Europeans residential areas did not experienced ailments and diseases associated with poor environmental and sanitary conditions. This was the contrary with areas occupied by the local people. Cases of infectious diseases such as Yellow fever, typhoid fever, malaria, guinea worm were common. Epidemics such as smallpox, cholera were not rare (Arnold, 1988). The provision of sanitary facilities and law enforcement representatives were appointed to arrest environmental polluters. The organization of health service was primarily designed to

satisfy the health needs of European colonial elite with little attention for the local population.

The 1950s saw rising political consciousness and demand for greater African participation in governance, including healthcare. Nigerian professionals increasingly took over administrative roles and there was pressure to expand access to quality health services. In Wukari, this translated into improvement in hospital facilities and rural health programs. By 1959, medical services pulled hundreds of patients. For example, more than 20,000 people attended Wukari Hospital in 1959 for out-patient treatment. Commonest health problems of the adult in that year include respiratory diseases, malaria, tuberculosis, obstetric problems just to mention a few (NAK, 1936). Medical challenges for the children include stomach infections, respiratory infections, malaria, malnutrition and whooping cough. Available record. Relevant statistics about patients' treatment at the establishment in the year 1959 include 2,216 Heart Tests, 6246 sputum examinations, 3736 large X-ray and 3581 X-Ray films. And 57,330 patients attended the hospital for different types of diseases and illnesses (NAK).

Other health institutions such as Arufu, Ibi, Donga, Rafinkada, Chikai, Dampar Dispensaries, Maternity Centers at Donga, Takum, were improved and greatly supported by the people of Wukari Division. Major diseases which received medical attention include; malaria, helminthiasis, ulcers, diarrhea, malnutrition, abscesses and tuberculosis, whooping cough, measles, dysentery and hepatitis (Danjuma, 2024). Communicable diseases such as malaria, measles, meningitis, pneumonia and infantile diarrhea became controlled. Table 1 provides a general picture of trend of attendance of patients in Wukari Medical Area, made up of all the health institutions in Wukari Division and other parts of Northern Nigeria.

Table: 1 Record of Attendance, Wukari Medical Area 1958-1960.

Year	1958	1959	1960
In-patient	44, 761	35, 2288	580,157

Extract from NAK:MAK Prof. 1: 6299, Development of the Northern Region of Nigeria, 1958, 60.

Conclusion

The study brought to bear the fact that medical health care in Wukari Division were shaped by the various policies formulated by the colonial government. Wukari Division in particular has a unique healthcare history that reflects multifaceted factors which include; World War II and health mobilisation, training and Africanisation of health policy, nationalist movements and health Policy reforms. The colonial healthcare policies expanded and institutionalized healthcare services from the 1940s. It is understandable that colonial medical and health services within the study period established relevance to health needs of the local people. However, the legacy of these historical developments influenced the challenges and opportunities facing medical healthcare in Wukari Division as a prerequisite for developing effective and justifiable healthcare solutions for the region's communities.

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