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Impact and Challenges of Western Medical Practice in Wukari Division 1926-1960

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Abstract

Health constituted a major concern in colonial Wukari Division, particularly because tropical diseases such as malaria and yellow fever contributed to high mortality among Europeans in West Africa. This study examines the impact and challenges of Western medical practice in Wukari Division from 1926 to 1960. The study adopted an empirical historical approach, drawing on primary and secondary sources to analyze the development of colonial healthcare services and their social implications. The findings indicate that Western medical practice contributed to technological advancement, sanitary and preventive services, and the introduction of clean pipe-borne water in Wukari Division. The study also reveals that the colonial government and missionary organizations played a significant role in shaping the health landscape of the area during the period under review. Before Nigeria's independence in 1960, efforts were made to train African doctors, nurses, and other medical personnel, who later assumed responsibility for managing health institutions previously administered by European colonial and missionary personnel.

However, Western medical practice in Wukari Division faced several challenges, including epidemics and disease outbreaks, cultural resistance, unequal distribution of medical resources, and administrative limitations. The study concludes that although colonial and missionary medical interventions contributed to the institutionalization of modern healthcare in Wukari Division, persistent structural and social challenges limited their effectiveness. It recommends deliberate policy and institutional actions to improve health services in the local government areas that formerly constituted Wukari Division.

Keywords: Western Medical Practice; Colonial Healthcare; Missionary Medicine; Wukari Division; Public Health Challenges

Introduction

Western medicine is defined as a system of medicine that is based on scientific knowledge and empirical evidence guided by logical reasoning and problem-solving. It focuses on the individual patient and their specific needs and prioritizes the treatment and cure of disease, practiced by trained professionals with specialized knowledge and skills (Freidson, 1989). Western medicine is a practice that focuses on the biological and physiological aspects of disease which breaks down the body into smaller parts to understand and treat disease (Helman, 1984). In other words, the body is viewed as a machine, with disease being a malfunction of one or more of its parts. It prioritizes the treatment and cure of disease, rather than prevention and is often centered in hospitals, with a focus on acute care, whereby the role of the doctor is seen as the primary healthcare provider and relies heavily on advanced technology, such as drugs and surgery. The European traders and missionaries who operated on the Benue and Niger Rivers were accompanied by medical doctors, nurses and Pharmacies. They were assisted by African auxiliary staff, whom they trained on arrival. The first record of western medical services in Wukari Division was during the various European expeditions in the early 18th century to mid-19thcentury. The first explorers like Mungo Park and Richard Lander were seriously stuck by diseases and so many of them lost their lives (NAK, 1936). In 1854, Dr. Baikie make known to the use of quinine, which greatly compact mortality and morbidity among the expeditioners. Liverpool merchant, Macgregor Laird, opened the river, his efforts were encouraged by the thorough reports of a pioneer German explorer, Heinrich Barth, who

travelled through much of Borno and the Sokoto Caliphate, where he documented information about the region's geography, economy and inhabitants (NAK, 1928). Thus, the Europeans introduced a new healthcare system different from the already existing traditional healthcare system in order to take care of the health needs of the expeditioners respectively. The use of quinine by the Europeans, as therapy for malaria fever, widened exploration and trade. The earliest form of Western-style health care in Wukari Division was provided by doctors brought by explorers and traders to cater for their own wellbeing. Consequently, the arrival of Christian missionaries in the Wukari Division became fundamental to the development of western medicine in the area. Western medical practice was promoted by the Missionaries right from the beginning (Ashu,1999). The colonial government equally contributed tremendously to the growth of western medical practice through the implementations of various health policies in Wukari Division from 1926. Thus, to realised their goals, both the missionaries and European traders first of all set up dispensaries and clinics. Later on, they transformed some of them into hospitals after the W.W II.

The practice of western medicine has had profound impact on the healthcare of Wukari Division. It is sure that colonial medical services had significant outcomes on health conditions on Wukari Division. The institution of healthcare services, in line with the campaign against hygiene as well as the peoples' accessibility to hospitals and benefits associated with public health services widened. Indeed, these developments reduced the level of morbidity and mortality in Wukari Division. The study examines both the impact and challenges that have risen from this encounter. This paper contribute to a deeper understanding of the healthcare care experiences of the people in Wukari Division.

Literature Review

A lot of impactful studies have been carried out on the history of medicine and diseases in Africa. Helen Tilley (2016) reported that the uneven and adequate health infrastructures established during the colonial era, the ethical ambiguities and transgressions of colonial research and treatment campaigns of concerted and inadvertent efforts to undermine African healing practices, which were not always commensurable with introduced medical techniques. The author adopts the historical method to analyze different kinds of ethical problems that have grown out of past asymmetries of power that shape the nature of international health care system. In the same vein, Ruth Rogaski

(2008), stated that hygiene became a crucial element in the formulation of Chinese modernity in the 19th century and 20th centuries. It reveals how the concept of "Weisheng" shifted from traditional Chinese cosmology to encompass modern ideas of national sovereignty, laboratory knowledge, bodily, cleanliness and racial fitness. The book focuses on the Treaty-Port city Tianjin, where foreign powers imposed their own ideas of health and hygiene on the local population. It served as a second major tool, after education, to make innumerable conversions.

Florence Ejogha Nkwamn (1988), observed that, the provision of medical and health services during World War II laid emphasis on the recruitment of medical officers. In her work she buttresses that the provision of health care facilities in rural areas was the responsibility of local authorities. The work sheds more lights on why the British authorities decided to introduce the system of indirect rule in Northern Nigeria most especially in Wukari Division. The author considers the impact of World War I and World War II on the medical administration and presents general observations on medical services in developing countries. This signifies that World War I and World War II became a turning point in the western medical practice in Africa.

Jonathan Robert (1998), reported that the European medical practice struggle to attract patient in Africa with focus on Ethiopia, East Africa and southern part of Africa that had pluralistic healing networks of herbal and spiritual therapies. Robert added that, Africa contained a diversity of healing profession including herbalist, diviner, so-called 'fetish priest', faith healers and witch finders. He pointed out that Western Medicine offered little in combating diseases such as worms, bacteria to the Upper Nile Tropics of the Indian Ocean or Velt of Southern Africa. According to him the local botanical studies diminish while western medicine took a lead. This signifies that before global expansion of scientific medicine in the 20th century each part of the world developed its own brand of healing cultures.

Cementing the argument, Brandon Stilton (2010) examines the failure of colonial powers to provide adequate healthcare to African populations during the period 1850-1939. Brandon Stilton argued that colonial powers prioritized their own healthcare outcomes to African population which is well supported by historical evidence. Stilton's work provides a critical analysis of the impact of colonialism on healthcare in Africa. His article reveals the inadequate healthcare systems established by colonial powers and the

exclusion of African health workers from decision making processes. This signifies the in adequacies in the European health care services most especially in rural areas.

Perhaps, the most outstanding personality who contributed significantly to the understanding of development of medicine in Nigeria is T. Falola (2013). The author examines the disruption of traditional healing practices and indigenous knowledge through the imposition of Western Medicine often without consideration for local context. His analysis showcased that the colonial legacies still influence the healthcare and challenges faced by Africa today. These challenges include; lack of investment in health initiatives, dependence on foreign aid. Meanwhile, Labbo Abdullahi (2011), observed that, that the healthcare for colonizers and locals was often inadequate and discriminatory. Labbo, argued that hospitals and clinics were established in urban centers staffed by British medical personnel with limited access to healthcare for rural population. In his work, he identified some epidemics that were common in Northern Nigeria during this period, these include; small pox, malaria and sleeping sickness. Two other seasoned Scholars, Shishi Zhema and Dada Adebusola (2022), argued that, argued that the disparity witnessed in the distribution of Health Center's at present was established during the colonial regime which focused more on urban center's with strategic places reserved for Europeans and senior civil servants in the colonial government. It signifies the inadequacies in the provision of health care by the colonial government.

Samuel Adu, (2001), reported that the role of Christian missions in establishing hospitals gave them the opportunity to train medical personnel to complement the limited number of health personnel on the continent. He added that the establishment of hospitals and dispensaries stood as the most effective soul wining mechanism for many Christian mission. Tamilola Alanamu (2013), remarked that, that African belief about religion and Medicine was complementary and interconnected in the pre-colonial period. Tamilola added that, C.M.S practiced medical evangelism as a tool of converting many to Christianity. His work provides valuable insight into the intersection of indigenous medical evangelism in Yorubaland. Dauda P. Ashu,(1999), investigated the contributions of the missionaries in Lupwe and Takum. From the analysis the missionaries recorded numerous achievement in the field of health for example setting up dispensary at lupwe in 1936 in Vom Christian Hospital and used it to train some of the natives as nurses such as Mr.Yakubu Bete and Mr. Siman Istifanus, treatment of diseases like leprosy which was nick named "Wednesday sickness". Edgar H. Smith (1972), wrote extensively on the Western

Medical practice by missionaries (CRCN) in Lupwe and Takum in Wukari Division. Edgar Smith observed that, the missionaries played a pivotal role combating diseases like small pox, yaws, leprosy, tuberclosis, sleeping sickness amongst others which posed a serious health challenge to the people of the area. In the 1930s health care was very challenging due to limited number of Medical personnel, for example, there was no doctor to diagnose the cases which came for help. Edgar Smith buttressed that, medical services were carried under the shade of a tree, working from wobbly card table, and sterilizing instrument by boiling them in a cooking pot placed on an open fire. This is evident due to the fact that missionaries in the early 1940s resisted any move towards building a hospital until 1947 when the authorities pass a private hospital ordinance which therefore became apparent that this law will be applicable in Lupwe and Takum medical ministry. This signifies that the missionary contributed tremendously in the field of health, there by bridging the gap of the colonial medical practice which was mostly functional in urban areas.

From the existing literature and researches carried out on western medical practice, it can be assumed that efforts were made by the colonial government and missionaries in the department of health. Many scholars have dared to interpret it in different ways. The scholars have been trying to critique and critic the historiography of Western medical practice and touched many aspects which include origin of western medical practice, disease control, inadequacies in the provision of health services.

Methodology

An objective historical writing must start with sources (Arnold, 2008). In order to achieve the set objectives of this research, the study adopted the historical method which involve the use of primary and secondary sources.

In terms of the use of primary sources, extensive field work was carried out in the study area. In particular, interviews were conducted with some medical practitioners, officials of medical institutions, government officials and traditional medical practitioners in Takum, Donga, Ibi, and Wukari. The informants were of the age brackets of 45 to 84 years.

Archival materials at the National Archives, Kaduna, regarding the subject matter in relation to the study area were also consulted. These materials provided the researchers with historical information on the activities of the Colonial administration and Christian

missionaries on the provision of Western medical practice in wukari Division. The archival materials which were later transcribed, studied and synthesized to write the impact and challenges of western medical practice in Wukari Division. This was done purposely to arrive at more valid conclusion.

Lastly, the research also greatly benefited from secondary sources which included published books, journal articles, seminar papers and unpublished materials. These materials were useful in providing the necessary information on the subject matter.

The study is all about the impact and challenges of Western medical practice in Wukari Division, 1926-1960. Ibi and Wukari Divisions existed in the same area but at different periods. Ibi Division was created in 1904 and lasted till 1926 (K.D. Yaro,2019). In 1926, the British authority in Northern Nigeria, decided to carryout major reorganization of its provinces and divisions for administrative efficiency. In the process of this reorganization, Ibi lost its status to Wukari and was transferred from Muri province, alongside Takum and Donga to Benue province, also created during the reorganization, out of the defunct Munchi province. The two Divisions refer to the same geographical area under study. The area was approximately located between longitudes 9˚08′ and 11˚00′ East and latitudes 6˚30′ and 8˚38′ North. It was located southwest and bounded by Tshendam Division (later in 1924, it was called Lowland Division, Plateau province) in the northwest by Muri Division (formerly called Lau Division from 1904-1911) in the northeast, the German Kamerun (1904-1916), later Bamenda Division, in the southeast and south, respectively and Katsina Ala-Abinsi Division (1904-1918), later Munchi province, in the southwest and west, respectively. Ibi was both the Divisional and provincial headquarters (J. M. Fremantle, 1972).

However, following the British territorial reorganization, the emerging Wukari Division became one of the five Divisions in the newly created Benue province (NAK, 1934). It was bounded on the north and north-west by the Lowland Division of the Plateau province and Awe District of Lafia Division, Benue province, respectively. On the northeast and east, it was bounded by Muri Division of Adamawa province; on the south-east by Bamenda Division of the Cameroons; on the west and southwest, by Tiv Division of Benue province.

Theoretical Framework

The paper studied the development theory and adopt a conceptual frame work to support the discussion. Development theories is the collection of theories that demonstrate how change in society is best achieved. The theory looks at which aspects of countries are beneficial and which contribute to the obstacle for economic development. The notion is that development assistance which is targeted at those particular aspect can lead to modernization of under-developed societies. Some scholars argued that the 20th century development theory intended a broadly positivist and evolutionary frame work from August Comte's law of three stages which proposed that societies progressed from the theological, to metaphysical and finally scientific form of reasoning (August Comte, 1830-1842). Early modernization including Walt W. Rostow and Daniel Lemer (1958), echoed this Shema by portraying development as a linear transition from traditional to modern society, characterized by industralisation. Meanwhile rational bureaucracy and scientific attitude critics are of the view that Comteam legacy contributed to deterministic and Eurocentric assumptions, meaning that western institutions and cultural forms represent the universal endpoint of social evolution and that non-western societies must follow the same historical trajectory. Basically, the development theory states that developing nations must pass through stages that is, traditional, transitional to modern. On the other hand, some historians argue that post World War II development institutions, including the World Bank, I.M.F and U.S modernization theorist adopted Comteam assumption about linear social evolution without citing him.

However, the study adopts a conceptual frame work which comprises of modernizing theory and post-independent theory to explain how western medical practice impacted on the people of Wukari Division.

Modernization Theory

Modernization Theory is conceptualized as a frame work that views development as a uniform evolutionary process whereby all societies advances from traditional agricultural structures to post-industrial, modern forms, emphasizing internal socio-economies while recognizing science and technology as critical catalyst for transformation. The modernization theory became popular in the 1950s and 1960s in relation to understanding issues of economic and social development and creating policies that would assist economic and social transition in poorer countries. It focuses on foreign influences.

W.W. Rostow argues that adoption of scientific method and scientific ways of thinking and acquisition of technoscientific skills are critical at the transition of takeoff stage of development (Chariot and Hall, 1982). Essentially, proponent of modernization theory view science and technology as a catalyst for development. Modernisation theory is simply concern with knowledge and technology transfer that is unproblematic and straight forward.

Post-Development Theory

This is a school of thought maintained that development is a reflection of Western-Northern authority over the rest of the world. According to this school of thought, the strategy of the sanitizing living standards is rests on illogical claims as to the desirability and possibility of that goal. The post-independent theory arose in the 1980s and 1990s out the criticisms voiced against the theory. The Post-Development theories see the idea of development as just a mental structure which has resulted in the order of developed and underdeveloped, of which the underdeveloped crave to be like the developed (Sachs, 1992). From the discussion above, it can be inferred that there are several development theories and it seems doubtful if only one can explain or support development of a particular society. However, when some of the elements of the theories are synthesized, it provides much closer explanation to the understanding of societal development. Therefore, this study adopts a Meta-theoretical framework which combines the elements of Modernizing theory and Post-Development theory to explain how western medical practice impacted on Southern Taraba Area and the peoples.

Impact of Western Medical Practice on Wukari Division

Improved Healthcare Outcome

The emergence of colonial healthcare in Wukari Division spanning from the period 1926- 1960 opens a new chapter in the history of Western medical services. The establishment of dispensaries improved the healthcare needs of the people of Wukari Division, although at first their responses were not encouraging. As time went on, Sequel to changes in the reactions and sensitivities of hospital treatment, the people of Wukari Division began to Patronized the various dispensaries and other medical services within their reach. It is interesting to note that common diseases treated in these dispensaries were mostly infectious diseases. Malaria appears to be the more alarming (all over West Africa)

disease that plagued the people (Bawa K.I. Boyi, 2025). Malaria affects both young and adult including infants. Pregnant mothers were not spared. Of course, their vulnerability to malaria was very high. This was because women conceive, their level of immunity and disease resistance became reduced greatly; therefore, they become more helpless when malaria parasites strike. Some common diseases that needed treatment in hospitals included; yellow fever, typhoid fever, tuberculosis, dysenteries, pneumonia, Guinea worm, coughing and hernia. People began to show interest due to accuracy as a matter of fact, out-patient clinics at Native Dispensaries and General Hospital were patronized greatly from the 1930s-1950s due to the fact that diseases which were attributed to witchcraft were being treated without difficulty (NAK, 1932).

The colonial medical department showed interest on maternal and child health care. This interest became translated into reality through the distribution of maternity and child health services. Besides, post-natal and pediatric services available at Wukari General Hospital and other colonial maternity centers contributed greatly to the improvement of maternal and child health services in the study period (NAK, 1955). The health challenges that posed serious threat to the lives of children like measles, malaria, whooping cough, jaundice, anemia, and upper respiratory tract infection received medical attention.

Technological Advancement

Western medicine introduced advanced diagnostic tools and treatment methods, improving the management of various diseases including infectious diseases like malaria and tuberculosis. This was a period when germ theories of disease began to predominate in many parts of the world and pharmaceutical treatments and vaccination campaigns were on the rise. It was also a time when hygienic regimes in cities became more uniform (M.Vaughan, 1991). These new ideas and techniques increased people's faith that diseases could be mastered and human lives extended, if only the new knowledge were applied.

Healthy and Preventive Measures

This health policy was associated with the beginning of British colonialism in Wukari Division; this was a campaign for a clean and healthy environment. This motion became manifest due to the need to get rid of mosquito bite, which transmit malaria fever. This was made effective with the formation of Health Board in 1904, colonial administration in Wukari adopted some measures against poor hygiene and sanitation (NAK, 1904). The colonial government residential areas were well equipped. Efforts were

made to provide dustbins, public latrines and similar sanitary structures in different parts of Wukari Division. They also launched several campaigns against indiscriminate urination and random defecation, this was intensified around the 1940s. Most importantly, markets for example Wukari market was equipped with slaughter slabs, incinerators and public latrines in other to ensure a clean environment (Iliya Danjuma, Abongabe, 2024) .

Moreover, colonial health authorities organized a section within the Health Office to manage conservancy and sewage disposal. This steps in coincided with the provision of public latrines became important in order to safeguard disposal of excreta. In the manner, the Health Board supervised drainage, canalization of streams and reclamation of swamps. The colonial heath policy in Wukari Division emphasized the need for food hygiene and safety. For example, the Dubagari in Wukari Division carried out thorough inspection on any cow before it was slaughtered.

Introduction of Clean Pipe-Borne Water

The availability of clean and drinkable water was a great challenge on Wukari Division. Obtainable sources of water at the time were rainfall, streams, pools and waterholes in marshy valleys. Radical steps were taken to prevent the entry of guinea worm infected persons into brooks, streams and rivers which provided some protection against pollution. However, all these steps proved unproductive. Consequently, the colonial administration became stunned and convinced on the necessity to modify her policy on water supplies by digging of wells (rigia line) enhanced with pumping plant in different areas like market places and communities within Wukari Division (Joseph Sanfo, 2025). Around 1958, so many communities within Wukari Division had access to pipe-pumping plants. This development improved tremendously the health conditions of the people in Wukari Division. The clean water reduced the outbreak of diseases like, dysentery, diarrhea, typhoid fever and many more (J.A. Oluyitan, 2012). Moreover, the provision of clean water also heightened the level of sanitation in the area of study.

Campaign on Health

Western medicine played a crucial role in sensitizing the public on vaccination programs, to put on check the spread of infectious diseases in Wukari Division. The medical team tackled outbreaks of smallpox with keen interest and great sensitivity. The vaccination team was employed by the colonial government to tackle epidemics such as smallpox. Initially, people did show interest to these health measures. This campaign

initiative was received with so much in difference, despite the health risk on general public. Consequently, with time it became compulsory to be vaccinated. Thereafter, health enforcement agents ensure that the entire population that formed Wukari Division were vaccinated regularly to prevent the outbreak of diseases. According to report, a great number of people were vaccinated in Wukari Division specifically in 1945 (NAK, 1945). The colonial government campaigned against smallpox and other communicable diseases such as tuberculosis, yellow fever, Guinea worm infestation and measles. Several people benefited from free clinics and medical programs purposely designed to reduce and eradicate these health challenges.

Training of Health Personnel

The colonial authorities identify the linkage between the trained personnel and effective health service. They therefore, established a great number of institutions for training of medical and health personnel. First, a training center at Kano for Sanitary Inspectors which served Northern Nigerian towns was opened in 1932. The school provided education for would-be public health inspectors and sanitary overseers, the latter for the local authority services only. It was of great importance to the health development in Kano and other parts of Northern Nigeria (NAK, 1930). Graduates from these schools rendered services which include inspection and monitoring of peoples‟ houses and business premises with a view to ascertaining submission with sanitary rules and laws. There were certain legal proceedings against offenders. As time went on sanitary inspectors began to lose popularity due the manner at which they carry out their responsibilities for example, their intolerance for filth and their arrogance made people of Wukari Division unwilling to observe strictly colonial sanitary laws. This situation became worse during the post-colonial era. However, their role in health development in the study period and beyond is very important. In addition, another responsibility carried out by sanitary inspectors was the vaccination of several people against smallpox and other communicable diseases (D. Arnold, 1988).

Equally, the colonial government played a pivotal role by establishing institutions for training nurses. It is obvious that colonial medical and health services demonstrated relevance to health needs of the local people. Infectious diseases such as malaria, measles, meningitis, pneumonia and infantile diarrhea became controlled in a number of ways. These measures included provision of sanitary structures, building of public latrines,

clearing and draining of swamps as well as canalization of streams. In addition, advent of portable water reduced considerably the incidence of Guinea worm, typhoid fever, dysentery and other water-borne diseases (R. Rogaski, 2004). Furthermore, inoculation and vaccination completely wiped out smallpox and other fatal illnesses that used to be a threat to human lives. Organisation of Free Tuberculosis Clinics and treatment equally checked the spread of these draining diseases.

Challenges and Prospect of Western Medical Practice in Wukari Division

Cost and Accessibility

Western medicine was expensive and unreachable, especially for rural populations, leading to reliance on traditional medicine. Europeans' lofty ambitions to establish far-reaching medical services in each territory were often thwarted in practice. Directors of medical departments found it difficult to communicate and coordinate both within and across their territories, making it harder to find solutions to shared health problems. As they were the first to admit, the scale of their responsibilities was daunting. Money was in short supply and the number of trained personnel was rarely sufficient for the tasks. Colonial rule was expensive and, because most European governments believed colonies should generate their own revenue, occasionally where the funds necessary to build health services were expensive to meet people's immediate needs. Although many medical professionals understood the financial and staffing challenges, they could not remedy the situation on their own since they played no part in raising revenue and only a modest role in setting policy priorities (S.Feierman,1985). Health systems were also typically understaffed and underfunded, making it difficult to fulfill their mandate and raising questions about distributive justice (H. Tilley,). In research and treatment campaigns, people's permission was rarely sought, and they may have viewed such medical interventions differently from health care professionals, leading to mistrust, misunderstanding, and resistance and appropriation.

Wukari Division had limited healthcare infrastructure, with only one Hospital and clinics and inadequate equipment and supplies. The British found it difficult to establish and maintain healthcare services in the area. The colonial government faced several constraints which include limited funding, equipment.

Cultural Clash

In Wukari Division traditional healers and diviners were highly respected for their knowledge of local medicinal plant and spiritual practices. The introduction of Western medicine was seen as a threat to their authority and livelihoods, leading to resistance and skepticism. The local population in Wukari Division most especially Wukari town had strong emphasis on community and holistic methods to health, which conflicted with the individualistic and scientific focus of western medicine. This led to cultural clashes stemming from differing beliefs about illness, treatment and the role of healthcare providers, often resulting in a perceived devaluation of traditional practices. The dominance of western medicine promoted by the colonial and missionary's health care helped to marginalized and stigmatized the traditional health care system. Equally, another challenge faced by the British was language barrier when interacting with the local population who spoke various languages such as Kueb, Chamba, Jukun as well as Hausa. This made it difficult to communicate effectively and provide quality healthcare services.

Unequal Distribution of Resources

Health facilities and services were often intense in urban areas and reserved for Europeans and senior civil servants, leaving rural areas and the majority of the local population underserved. Colonial government focused more on the urban areas neglecting rural areas in the hands of missionaries. To this effect it led to congestion in towns leading to increase susceptibility to several diseases like malaria, yaws, small pox, sleeping sickness just to mention a few. In addition, inadequate facilities and healthcare services influence the rural population to seek alternative care to promote their health and wellbeing (W. Rodney, 1972). Also, some resort to unqualified health personnel and traditional healers.

Epidemics and Outbreaks

Wukari Division, most especially riverine areas were susceptible to tropical diseases such as malaria, which required specialized knowledge and treatments. The British faced significant challenges in controlling and treating these diseases. Equally, outbreaks of diseases in Wukari Division required instant and effective public health measures. The local population lack resistance to certain diseases which made them more liable to certain diseases. In the same vain, the Bristish had little knowledge about local health issues in Wukari Division, which hindered their ability to developed effective healthcare solutions.

They faced significant challenges in understanding the disease patterns, health behaviors and cultural factors that influenced health outcomes.

Administrative Challenges

The British administration in Wukari Division was often ineffective and inefficient, leading to delays and inadequacies in healthcare provision. The administration's priorities often conflicted with the needs of the local population. Hence, the application of medical policies in Wukari Division was often hindered by administrative delays, lack of organisation and inadequate training. This led to mix-up and mistrust among the local population (Gani Danjuma, 2025). There was a challenge of mixing western medicine with traditional practices, which made it difficult to introduce western medicine.

Conclusion

This study has shown that western medical practice in wukari Division had profound impact on the Wukari Division healthcare landscape. These impacts include; improved healthcare outcome, Public Health Initiative, Training of Health Personnel and new treatments. Hitherto it faced challenges which include; cultural resistance, epidemics outbreaks, Unequal Distribution of Resources and limited infrastructure. It is noted that the African medical personnel who took over western medical practices faced challenges previously faced by departed missionaries and British medical personnel. The study recommends that, deliberate action should be taken to better the health services in the local government made up of former Wukari Division. Health practitioners can work towards developing more effective and culturally sensitive healthcare systems that meet the needs of the local population.

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